Colorado Department of Health Care Policy and Financing

COLORADO
Department of Health Care Policy & Financing

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

and

Special Connections: Postpartum Months Three through Twelve

Submitted March 2, 2018
for
Waiver Period July 1, 2018, to June 30, 2023
Revised May 1, 2018, May 15, 2018, January 1, 2020, October 2, 2020, March 23, 2023, and July 1, 2022
An Amendment Effective July 1, 2025, to September 30, 2028

Table of Contents

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

Factsheet

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

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

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

Type of request. This is a(n):

___ Initial request for new waiver

_X__ amendment request for existing waiver, which modifies ***Sections A, B, and D***

__ Replacement pages are attached for specific Section/Part being amended

_X_ 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: The State's request for a waiver renewal for a period of five years was approved with the effective date of ***April 1, 2024*** and ending ***September 30, 2028.*** This

amendment request is for an effective date of ***July 1, 2025.*** (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 ACC Program under this waiver is Dave Ducharme, and he can be reached at (303) 866-2254 or email at david.ducharme@state.co.us

The State contact person for the Special Connections Program under this waiver is Jennifer Holcomb, and she can be reached by e-mail at jennifer.holcomb@state.co.us

The State contact person for the cost effectiveness portion of this waiver is Lawrence Tam, and he can be reached by telephone at (303) 866-4053 or e-mail at lawrence.tam@state.co.us

Section A: Program Description

Part I: Program Overview

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

> ***The Department of Health Care Policy and Financing (the Department) sent the new Accountable Care Collaborative PCCM-PIHP Program, Accountable Care Collaborative: MCO Payment Reforms and Special Connections Postpartum Months Three to Twelve waiver to the federally recognized tribes in Colorado for their review and comment on January 25, 2018. The recognized tribes are the Southern Ute Indian Tribe and the Ute Mountain Ute. Additional native stakeholders include Denver Indian Health and Family Services, Utah Navajo Health Systems, Four Corners Regional Health, and New Sunrise Regional Treatment Center. As of February 26, 2018, 0 comments had been received from the tribal stakeholder groups. An amendment was sent to the federally recognized tribes in Colorado for their review and comment on September 25, 2019. As of November 1, 2019, 0 comments had been received from the tribal stakeholder groups. This amendment, regarding cost-effectiveness recalculations, was sent to the federally recognized tribes in Colorado for their review and comment on November 25, 2019. As of January 2, 2020, 0 comments had been received from the tribal stakeholder groups. An amendment was sent to the federally recognized tribes in Colorado for their review and comment on January 29, 2020. As of April 28th, 2020, 0 comments have been received from tribal stakeholder groups.***
>
> ***Notice of the Department's intention to renew the 1915(b) waiver was sent to federally recognized tribes in Colorado on December 8, 2023. As of February 20, 2024, 0 comments had been received from the tribal stakeholder groups.***
>
> ***Notice of the Department's amendment was sent to the federally recognized tribes in Colorado for their review and comment on December 30, 2024. As of March 20, 2025, 0 (zero) comments had been received from the tribal stakeholder groups.***

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

> ***Colorado Medicaid serves on average 1.3 million people and has an annual budget of $14 billion. The Department of Health Care Policy and Financing's (the Department) mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. Colorado Medicaid clients***

are currently served through two major programs: Accountable Care Collaborative (ACC) and Long-Term Services and Supports Program (LTSS). There are no significant programmatic changes included in this waiver renewal submission.

<u>Accountable Care Collaborative History</u>

The Accountable Care Collaborative: Primary Care Case Management Entity (PCCM Entity)-Prepaid Inpatient Health Plan (PIHP) program represents the merging of two long-standing Colorado Medicaid Programs:

- ***The Colorado Medicaid Mental Health Capitation and Managed Care Program (later retitled the Community Behavioral Health Services Program) was implemented in 1995 under the Centers for Medicare and Medicaid Services (CMS) authority for PIHP.***
- ***The ACC began in 2011 as a managed fee-for-service model operated under a State Plan Amendment approved by CMS.***

Beginning in July 2018, Phase II of the ACC established Regional Accountable Entities (RAEs), which operate both the Capitated Behavioral Health Benefit and managed Fee-For-Service program under single regional entities. The RAEs are responsible for promoting an integrated, whole-person approach to members' physical and behavioral health. The RAEs are authorized by CMS under the current 1915(b) waiver as both a PCCM Entity and a PIHP following the applicable federal requirements in 42 CFR § 438.

The ACC represents an innovative way to accomplish the Department's goals for Medicaid reform by investing directly in community infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The ACC makes the people and organizations that actually provide the care accountable for the quality and the cost of that care.

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

The ACC was designed to be iterative. Under the initial waiver period, Phase II of the ACC built upon the first seven years of the program and advanced the Department's goals to improve Member health and life outcomes and to use state resources wisely. The ACC PCCM Entity-PIHP initial waiver focused on the following objectives:

- ***Join physical and behavioral health under one accountable party.***

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

Under the initial ACC 1915(b) waiver, Colorado was divided into seven geographic regions for the ACC with each region being served by one RAE. Members were assigned to a region and RAE or Managed Care Organization (MCO) based upon the county within which they resided or the county in which their provider was located.

RAEs oversee all aspects of the ACC PCCM Entity-PIHP program within each region. The RAEs manage a network of primary care physical health providers and specialty behavioral health providers to ensure access to appropriate care for Medicaid Members in their region. A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to Members. Having one entity improves the Member experience by creating one point of contact and clear accountability for whole-person care.

In addition to the RAEs, the Department has contracts for two capitated physical health MCOs. Under the initial waiver, these MCOs operated in ACC region 1 and ACC region 5. To support continuity of care for Members receiving care through the MCOs and to encourage the continued engagement of the providers participating in these MCOs, the Department incorporated the MCOs into RAE region 1 and RAE region 5 as the ACC: Limited Managed Care Capitation Initiative (ACC: MCO). These MCOs functioned as a formal part of the ACC in these two regions. In region 1, the MCO was operated by the RAE. In region 5, the MCO operated the ACC PIHP program for all members enrolled in the MCO, while the region 5 RAE operated the ACC PCCM Entity-PIHP for members in region 5 not enrolled in the MCO. In addition, the ACC: MCOs were held accountable for improving health outcomes and Member satisfaction, incorporating value-based payments for providers around achieving these goals, and maximizing the integration of behavioral health and physical health services within the ACC infrastructure. ACC: MCO payment reform efforts emphasized provider value-based payments tied to quality metrics that increase care coordination between physical and behavioral health; improved patient outcomes; and improved patient experiences. Achieving a set of defined quality metrics allowed an ACC: MCO to reduce its Medical Loss Ratio by a set percentage, but not less than the federal minimum of 85%.

The following are new features of the ACC under the most current waiver amendment:

- ***The Department has consolidated the number of RAE regions from seven to four in order to simplify and standardize the system for Members and providers.***
- ***In line with updating the number and composition of the regions, the ACC: MCO previously operating in region 5 now operates in region 4. The ACC: MCO in region 1 will continue to operate in that region. Both ACC: MCOs will operate as physical health managed care capitation plans.***

<u>Community Behavioral Health Services Program History</u>
Prior to the creation of the ACC in 2011, the Department provided behavioral health services to Medicaid members through the Community Behavioral Health Services Program. The federal Health Care Financing Administration (HCFA) originally granted the State waivers to implement a managed mental health program in 1993. These waivers covered a two-year period, beginning July 1, 1995, and ending June 30, 1997 and were extended by HCFA through March 8, 1998.

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

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

<u>Special Connections History</u>
The Department also operates Special Connections as part of the initial waiver. The Special Connections portion of the waiver extends postpartum substance use disorder benefits from sixty (60) days postpartum to twelve (12) months postpartum.

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

Special Connections is now jointly administered by the Behavioral Health Administration (BHA), previously the Office of Behavioral Health, and the Department. Since 1992, assessment, treatment and case management services have been provided to pregnant and postpartum Members with substance use disorder issues. The BHA contracts with Behavioral Health and Administrative Services Organizations who enter contracts with licensed women's treatment programs for the provision of Special Connections treatment. These programs provide American Society of Addiction Medicine (ASAM) level of care assessments to perinatal individuals seeking treatment, and the individual's RAE reviews the ASAM assessment to determine medical necessity and provide prior authorization for treatment. The BHA holds an Interagency Agreement (IA) with the Department, which outlines expectations and reporting requirements for both organizations. This is a result of Colorado Revised Statute 27-80-112 - 115, which requires BHA and Department collaboration to support this specific population as unique from the general population of individuals with substance use disorders.

The Special Connections portion of the waiver extends the Medicaid postpartum substance use disorder benefits from sixty days to twelve months postpartum to ensure that the perinatal Member remains drug free and able to care for their new infant. Extending treatment for these Members increases the likelihood that they remain in recovery and able to care for their infant. The rationale is that a Member in recovery for an additional ten months postpartum would decrease Medicaid expenditures for these infants. Additionally, these pregnant and parenting individuals require specialized services that are gender responsive and trauma informed. The unique needs and concerns in treating this population require a specialized endorsement from the BHA, and, as such, should continue to be delivered in a specific program.

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A. Statutory Authority

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

a. ✓ **1915(b)(1)** – *(Applies to the ACC PCCM Entity-PIHP)* The State requires enrollees to obtain medical care through a primary care case management entity (PCCM Entity) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ✓ **1915(b)(3)** - *(Applies to the ACC PCCM Entity-PIHP and Special Connections)* The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. ✓ **1915(b)(4)** - *(Applies to the ACC PCCM Entity-PIHP, ACC: MCO and Special Connections)* The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

✓ MCO (*Applies to the ACC: MCO*)
✓ PIHP *(Applies to the ACC PCCM Entity-PIHP)*
___PAHP
✓ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting Program (please describe)

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

a.___ **Section 1902(a)(1)** – State wideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b. ✓ **Section 1902(a)(10)(B)** – *(Applies to the ACC PCCM Entity-PIHP and Special Connections)* Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope.

c. ✓ **Section 1902(a)(23)** – *(Applies to the ACC PCCM Entity-PIHP)* Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM Entity.

d. ✓ **Section 1902(a)(4) –** *(Applies to the ACC PCCM Entity-PIHP)* To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

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B. Delivery Systems

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

a. ✓ **MCO:** *(Applies to the ACC: MCO)* Risk-comprehensive contracts are fully capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ✓ **PIHP:** *(Applies to the ACC PCCM Entity-PIHP)* Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

✓ The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

c. ___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3)
does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d. ✓ **PCCM Entity:** *(Applies to the ACC PCCM Entity-PIHP)* A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM Entity is a PAHP.

e. __ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___the same as stipulated in the state plan
_____ different than stipulated in the state plan (please describe)

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

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

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

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

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

___ **Sole source** procurement. CMS Regional Office prior approval required.

_✓_ **Other** (please describe)

The region 4 ACC: MCO is operated by Denver Health and Hospital Authority, a political subdivision of the state. The State of Colorado Department of Personnel and Administration Procurement Code (the "Code") §24-101-105 allows for contracts between the state and its political subdivisions or other governments without requiring a full competitive procurement. In 2019, the General Assembly of the State of Colorado enacted House Bill 19-1285 requiring the Department "to enter into a direct contract with the MCO operated by or under the control of Denver Health and Hospital Authority, created pursuant to article 29 of title 25.".

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

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

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

___ Two or more MCOs
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
✓ Other: (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* (please describe)

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

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

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

3. **Rural Exception.**

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

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

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

_✓_ Beneficiaries will be given a choice of providers in their service area. (ACC PCCM Entity-PIHP)

The ACC PCCM Entity-PIHP includes a program known as the Medicaid System of Care (M-SOC) for children and youth with complex behavioral health needs who are also at risk for out-of-home placement. Provision of services for the M-SOC children and youth will be limited to providers who are selected through a state identified workforce capacity center or other state verified certification/credentialing process for Multisystemic Therapy (MST) though MST Services or their affiliates, National Wraparound Implement Center (NWIC) for Intensive Care Coordination, and FFT, LLC or their affiliates for Functional Family Therapy (FFT). Enhanced Standardized Assessment, certification and credentialing through the Child and Adolescent Needs and Strengths certification though The Praed Foundation and the Enhanced Standardized Assessment training through the Behavioral health Administration Learning Management System (LMS) These identified providers will be trained and certified in the state selected evidence-based treatment models. These selected providers will be the only providers allowed to bill under an enhanced set of services under M-SOC or providing an Enhanced Standardized Assessment.

D. Geographic Areas Served by the Waiver

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

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

_✓_ **Less than Statewide** *(ACC: MCO)*

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

ACC PCCM Entity-PIHP and ACC: MCO Geographic Areas of Service

Current RAE Contract Regions	Entity Type	Entity Name	Counties Served
Region 1	ACC PCCM Entity-PIHP	Rocky Mountain Health Plans	Alamosa, Archuleta, Chaffee, Conejos, Costilla, Custer, Delta, Delores, Eagle, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, La Plata, Lake, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Pitkin, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit
	ACC: MCO	Rocky Mountain Health	Delta, Garfield, Gunnison, Mesa, Montrose, Ouray, Pitkin, Rio Blanco, San Miguel

		Plans PRIME	
Region 2	ACC PCCM Entity-PIHP	Northeast Health Partners	Baca, Bent, Cheyenne, Crowley, Elbert, Kiowa, Kit Carson, Larimer, Lincoln, Logan, Morgan, Otero, Phillips, Prowers, Sedgwick, Washington, Weld, Yuma
Region 3	ACC PCCM Entity-PIHP	Colorado Community Health Alliance	Boulder, Broomfield, Clear Creek, El Paso, Gilpin, Jefferson, Park, Teller
Region 4	ACC PCCM Entity-PIHP	Colorado Access	Adams, Arapahoe, Denver, Douglas
	ACC: MCO	Denver Health	Denver

E. Populations Included in Waiver

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

   ✓ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

   - ✓ Mandatory enrollment *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO).* ***All full benefit beneficiaries are enrolled in the ACC PCCM Entity-PIHP. The Region 4 ACC: MCO mandatorily enrolls children)***
   - ✓ Voluntary enrollment *(Applies to Special Connections).* ***Special Connections waiver services are for 12-months postpartum members; postpartum adolescents are eligible to participate in the program.***

   ✓ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

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

   ✓ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

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

✓ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

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

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

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

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

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

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

___ Mandatory enrollment
___ Voluntary enrollment

✓ **Other** (Please define):

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

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

Special Connections Included Populations

i. ***Medicaid Eligible***
ii. ***Pregnant or up to 12 months postpartum***
iii. ***Assessed at a high risk for poor maternal and infant health outcomes 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***
    a. ***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***

M-CHIP Populations

i. ***Colorado serves the CHIP population through a combination CHIP program, consisting of a separate CHIP program and a Medicaid Expansion Program (M-CHIP). Members of the M-CHIP program receive Medicaid services as part of the ACC. Under or uninsured children 6 through 18 years of age with family income above 100% FPL and at or below 142% FPL are covered through a Medicaid Expansion.***

CHP+ 1115 Adult Prenatal Coverage in Child Health Plan Plus:

i. ***Under or uninsured pregnant women with family income above 142% FPL and at or below 195% FPL are covered through 1115 Waiver (Title XXI funds for Title XIX benefits)***

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 Special Connections)***--** Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

___ **Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program

___ **Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

___ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

_✓_ **SCHIP Title XXI Children** *(Applies to the ACC PCCM Entity-PIHP and Special Connections)* – Medicaid beneficiaries who receive services through the SCHIP program. (*Applies only to the SCHIP program and does not apply to the to the entire MCHIP program funded under Title XXI*)

_✓_ **Retroactive Eligibility** *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* – Medicaid beneficiaries for the period of retroactive eligibility.

_✓_ **Other** (Please define): *(Applies to the ACC PCCM Entity-PIHP)*

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

A. Qualified Medicare Beneficiary only (QMB-only).

B. Qualified Disabled and Working Individuals (QDWI)

C. Qualified Individuals 1 (QI 1).

D. Special Low Income Medicare Beneficiaries (SLMB).

E. Undocumented aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar who are eligible for Federal Medicaid for care and services related to the treatment of an approved medical condition.

F. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).

G. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.

H. All individuals while determined presumptively eligible for Medicaid.

F. Services

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

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2). State plan services, as listed in Appendix D2.S of Section D, Cost Effectiveness, are:

ACC PCCM Entity – PIHP Services	***D2.S Cost Effectiveness Services***
• Hospital	
○ Inpatient Psych Hospital Services	• Inpatient Hospital (includes psych) • Under 21 Psychiatric • 65 and Over Psychiatric
▪ Acute Care/General Hospital	• Inpatient Hospital (includes psych)
▪ Free-Standing Psych Hospitals	• Under 21 Psychiatric • 65 and Over Psychiatric
▪ State Hospitals	• Under 21 Psychiatric • 65 and Over Psychiatric
○ Outpatient Hospital Services	• Outpatient Hospital (includes psych)
• Emergency and Post Stabilization Care Services	• Emergency
• Professional Hospital Services	• Outpatient Hospital (includes psych)
• Substance Use Disorder Residential Services	• Residential
• Residential Treatment for members under the age of 21	• Residential
• High Intensity Outpatient Services	• Outpatient Hospital (includes psych)
○ Intensive Outpatient Program	• Outpatient Hospital (includes psych)

○ Partial Hospitalization Program	• Outpatient Hospital (includes psych)
• Outpatient Services	• Rehabilitation • FQHC • RHC • School-Based Mental Health • Medication Management • Clinical Services • Specialized Services for Addressing Adoption Issues
○ Crisis Services	• Under 21 Psychiatric • 65 and Over Psychiatric • Other Practitioner Services
▪ Mobile Crisis Response	• Under 21 Psychiatric • 65 and Over Psychiatric • Other Practitioner Services
▪ Behavioral Health Secure Transportation	• Under 21 Psychiatric • 65 and Over Psychiatric • Other Practitioner Services • Emergency Transportation
○ Screening and Assessment Services	• Under 21 Psychiatric • 65 and Over Psychiatric • Other Practitioner Services • Physician Services (includes psych) • Prevention / Early Intervention
○ Treatment Services	• Clinic Services, Case Management • Medication Management • Under 21 Psychiatric • 65 and Over Psychiatric • Other Practitioner Services • Physician Services (includes psych) • Prevention / Early Intervention
○ Physician Services	• Physician Services (includes psych) • Other Practitioner Services

ACC: MCO Services	*D2.S Cost Effectiveness Services*
• Inpatient Hospital Services	• Inpatient Hospital
• Outpatient Services	• Outpatient Hospital • FQHC • RHC • Clinical Services
• Physician Services	• Physician Services • Other Practitioner Services • Pediatric or Family Nurse Practitioners
• Rehabilitation	• Rehabilitation • Home Health
• Emergency and Post Stabilization Care Services	• Emergency • Emergency Transportation
• Prescription Drugs	• Pharmacy
• Laboratory Services	• Outpatient Lab Services • Lab and Xray
• Durable Medical Equipment	• Medical Supplies • Prosthetic Devices
• Family Planning Services	• Family Planning Services
• Medical Services	• Medical Dental Services • Clinical Services
• Occupational and Physical Therapy	• Physical Therapy, Occupational Therapy and Speech Pathology
• Surgical Services	• Medical/Surgical Dental Services
• Vision Services	• Optometrist • Eye Glasses

- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b).

1. **Assurances.**

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

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of these regulatory requirements for PIHP or PAHP programs. Please

identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement. (See note below for limitations on requirements that may be waived).

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable, for the period of ***July 1, 2025*** through ***September 30, 2028***.

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

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

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

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

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

___ The PAHP, PAHP, or 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): ***ACC: MCOs are required to pay for family planning services from network providers and out-of-network providers.***

_____ Family planning services are not included under the waiver.

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

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

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

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

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

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

5. **EPSDT Requirements.**

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

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

✓ *(Applies to the ACC PCCM -PIHP and Special Connections)* This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

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

Regarding 1915(b)(3) services, all populations are eligible, the benefits are statewide, and reimbursement is provided through capitations to the PIHP, unless plans are required to use a state directed payment methodology.

All b(3) services must be performed by or under the supervision of one of the following licensed practitioners: licensed health practitioners (Physician/Psychiatrist, Advanced Practice Nurse (APN), Physician Assistant (PA)) or licensed clinicians (clinical social worker, professional counselor, marriage and family therapist, addiction counselor, psychologist, PhD/PsyD).

1915(b)(3) services:	***D2.S Cost Effectiveness Services***
• Mental Health Residential Services	• Residential
• Crisis Stabilization Units	• Residential
• Acute Treatment Unites	• Residential
• Adult Mental Health Transitional Living Homes	• Residential
• Intensive Outpatient Services	• Intensive Case Management • Assertive Community Treatment
○ SUD Partial Hospitalization Program	• Outpatient Hospital
• Outpatient Services	
○ Recovery Supports	• Vocational Services • Clubhouses/Drop-In Centers • Recovery Services • Prevention/Early Intervention Services

o Assertive Community Treatment	• Assertive Community Treatment
o Supportive Housing	• Intensive Case Management
o Respite Services	• Respite Care

Mental Health Residential Services: Residential services are defined as any type of twenty-four (24) hour psychiatric care, excluding room and board, provided in a non-hospital, non-nursing home setting. Residential services are appropriate for children, youth, adults and older adults who need twenty-four (24) hour supervised care in a therapeutic environment. Mental Health Residential Services includes:

Crisis Stabilization Units: An agency, endorsed for Behavioral Health crisis and emergency services and that provides short-term, bed-based crisis stabilization services in a 24-hour environment for individuals who cannot be served in a less restrictive environment, as defined by Rule 2 CCR 502-1.

Acute Treatment Units: An agency or a distinct part of an agency with an endorsement for short-term psychiatric care, which may include treatment for substance use disorders, that provides a 24-hour, therapeutically planned and professionally staffed environment for Members who do not require inpatient hospitalization but need more intense and individualized services than are available on an outpatient basis, such as crisis management and stabilization services, as defined by Rule 2 CCR 502-1.

Adult Mental Health Transitional Living Homes: Mental health transitional living homes provide an interim space for Members discharging from an inpatient setting back into community-based care or provide a higher level of care to Members experiencing treatment resistant mental illness to avoid hospitalization. Adult mental health transitional living level 2 homes provide individuals additional structured Behavioral Health intervention and support within a home-like setting providing services including, but not limited to, individual and group therapy, medication management and dispensation, therapeutic services, group activities, and support with activities of daily life including life skill activities and training.

Intensive Outpatient Services:

SUD Partial Hospitalization Program: A treatment alternative to a higher level of care (residential and inpatient hospitalization) as a step toward community reintegration. Treatment is comprehensive in a structured, non- residential program of therapeutic activities lasting more than four hours but less than 24 hours per day, including associated laboratory services as indicated.

Outpatient Services:

Recovery Supports: Recovery-oriented services (includes vocational services, clubhouse / drop-in centers, recovery services, and prevention / early intervention services) promote self-management of psychiatric and/or SUD symptoms, relapse prevention, treatment choices, mutual support, enrichment, social supports and rights protection. Services may be provided at schools, churches or

other community locations. 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.

Assertive Community Treatment (ACT): A service-delivery model providing comprehensive, individualized, locally-based treatment to adults with serious behavioral health disorders. ACT services are provided by a multidisciplinary treatment team and are available 24 hours per day, seven days per week, 365 days per year. 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.

Supportive Housing: Services to assist individuals in securing and maintaining housing that are therapeutic, or skill building in nature and aimed at reducing symptomatology and promoting community integration and social functioning.

Respite Services: Temporary or short-term care of a child, adolescent or adult provided by adults other than the birth parents, foster parents, adoptive parents, family or caregivers with whom the member normally resides, that is designed to give the usual caregivers some time away from the member to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges.

Special Connections from three through twelve months postpartum:

1. ***Case Management – Medically necessary case management services provided in a licensed substance abuse treatment center by a CAC II, CAC III or LAC.***
2. ***Individual Counseling – Substance use disorder counseling and treatment services provided by a CAC II, CAC III or LAC with one consumer.***
3. ***Group Counseling – Substance use disorder counseling and treatment services provided by a CAC II, CAC III or LAC with more than one consumer, of up to and including two hours.***
4. ***Family Counseling – Substance use disorder counseling and treatment services provided by a CAC II, CAC III or LAC with one consumer and their family of more than 30 minutes, but no more than two hours.***
5. ***Group Health Education – Contact with more than one consumer, of up to and including two hours, on health education of pregnancy, postpartum issues, infant care and development, and parenting. The following provider types are eligible: Hospital – General; Hospital – Mental; Physician; Clinic – Practitioner; Non-Physician Practitioner – Individual; Non-Physician Practitioner – Group; Federally Qualified Health Center; Community Mental Health Center; Licensed Psychologist; Licensed Behavioral Health Clinician; Physician Assistant; Nurse Practitioner; Rural Health Clinic; & Substance Use Disorder – Clinics***
6. ***Outpatient – A program of care in which the consumer receives substance use disorder treatment services in a BHA licensed treatment program, but does not remain in the facility 24 hours a day.***

7. ***Residential*** ***–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. The residential benefit is administered by a specialty network of providers that have a specific license from the BHA, that demonstrates expertise in substance use disorders, gender-responsive treatment, trauma-informed care, and pregnancy/postpartum care that make the service distinct from that delivered by providers having other, non-postnatal specific licensing for residential treatment. Residential also includes social model detoxification benefits. Provides for a stable and safe living environment to develop recovery skills to attain and maintain drug and alcohol-free lifestyle. Room and board are not covered.***

7. **Self-referrals.**

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

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

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

Members who meet criteria for Special Connection Program may self-refer into the program.

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Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The* CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services.

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

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

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

1. ✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* PCPs (please describe):

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

	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
Required Providers	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Primary Care - Adult	20	10	30	15	40	20	60	30	90	60
Primary Care - Pediatric	20	10	30	15	40	20	60	30	90	60

The Department defines each county as follows:

- ***Large Metro: a county that meets the following combinations of population sizes and density parameters:***
  - ***Greater than 1,000,000 persons with a population density greater than 1,000 persons per square mile.***
  - ***A population size greater than or equal to 999,999 persons with a population density greater than 1,500 persons per square mile.***
  - ***Any population size with a population density greater than 5,000 persons per square mile.***
- ***Metro: a county that meets the following combinations of population sizes and density parameters:***
  - ***Greater than 1,000,000 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 999.9 persons per square mile.***
  - ***A population size greater than or equal to 500,000 persons and less than or equal to 999,999 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 1,499.9 persons per square mile.***
  - ***A population size greater than or equal to 200,000 persons and less than or equal to 499,999 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 4,999.9 persons per square mile.***

- ***A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 100 persons per square mile and less than or equal to 4,999.9 persons per square mile.***
- ***A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 1,000 persons per square mile and less than or equal to 4,999.9 persons per square mile.***

- ***Micro: a county that meets the following combinations of population sizes and density parameters:***
  - ***A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 99.9 persons per square mile.***
  - ***A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.***
- ***Rural: A county in Contractor's service area with a total population of less than 100,000 people.***
- ***CEAC: Counties with a population density of less than ten people per square mile, based on U.S. Census Bureau population and density estimates.***

- ***The ACC PCCM Entity-PIHP and ACC: MCO shall ensure that its PCMP network has a sufficient number of Providers so that each Member has their choice of at least two (2) PCMPs within their zip code or within the maximum distance for their county classification. For Micro, Rural and CEAC counties, the Department may adjust this requirement based on the number and location of available providers.***
- ***In the event that there are less than two (2) practitioners that meet the PCMP standards within the defined area for a specific Member, then the ACC PCCM Entity-PIHP or ACC: MCO shall not be bound by the requirements of the prior paragraph for that Member.***
- ***GeoAccess or a comparable service will be used to measure the distance between the Members and the providers.***

2. ✓ *(Applies to the ACC: MCO)* Specialists (please describe):

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

	Large Metro County		Metro County		Micro County		Rural County		CEAC	
Required Providers	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Gynecology, OB/GYN	20	10	30	15	40	20	60	30	90	60
Specialists, Adult	30	15	45	30	80	60	90	75	120	110
Specialists, Pediatric	30	15	45	30	80	60	90	75	120	110

- ***The ACC: MCO shall ensure that its specialist network has a sufficient number of practitioners so that each Member has their choice of at least two (2) practitioners within their zip code or within the maximum distance for their county classification. For Micro, Rural and CEAC counties, the Department may adjust this requirement based on the number and location of available providers.***
- ***In the event that there are less than two (2) practitioners that meet the standards within the defined area for a specific Member, then the ACC: MCO shall not be bound by the requirements of the prior paragraph for that Member.***
- ***GeoAccess or a comparable service will be used to measure the distance between the Members and the providers.***

3.___ Ancillary providers (please describe):

4._-__ Dental (please describe):

5.✓___ *(Applies to the ACC: MCO)* Hospitals (please describe):

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

	Large Metro County		Metro County		Micro County		Rural County		CEAC	
Required Providers	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Hospital (acute care)	20	10	45	30	80	60	75	60	110	100

- ***The ACC: MCO shall ensure that its hospital network has a sufficient number of hospitals so that each Member has their choice of at least two (2) hospitals within their zip code or within the maximum distance for their county classification. For Micro, Rural and CEAC counties, the Department may adjust this requirement based on the number and location of available providers.***
- ***In the event that there are less than two (2) hospitals that meet the standards within the defined area for a specific Member, then the ACC: MCO shall not be bound by the requirements of the prior paragraph for that Member.***
- ***GeoAccess or a comparable service will be used to measure the distance between the Members and the providers.***

6 ✓ *(Applies to the ACC PCCM Entity-PIHP)* Mental Health (please describe):

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

Mental Health Network Time and Distance Standards

	Large Metro County		Metro County		Micro County		Rural County		CEAC	
Required Providers	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Acute Inpatient Hospital (Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Outpatient Clinical Mental Health (licensed, accredited, or certified professionals) - Adult	20	10	30	15	40	20	60	30	90	60
Outpatient Clinical Mental Health (licensed, accredited, or certified professionals) - Pediatric	20	10	30	15	40	20	60	30	90	60
General Pediatric Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	110	100
General Adult Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	110	100

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

In the event that there are less than two (2) practitioners that meet the behavioral health network standards within the defined area for a specific Member, then the ACC PCCM Entity-PIHP shall not be bound by the requirements of the prior paragraph for that Member.

GeoAccess or a comparable service will be used to measure the distance between the Members and the providers.

7. ✓ *(Applies to the ACC: MCO)* Pharmacies (please describe):

The ACC: MCO shall ensure that its pharmacy network meets the time and distance standards described in the table below for each practitioner type listed.

	Large Metro County		Metro County		Micro County		Rural County		CEAC	
Pharmacy	10	5	15	10	30	20	40	30	70	60

The ACC: MCO shall ensure that its pharmacy network has a sufficient number of pharmacies so that each Member has their choice of at least two (2) pharmacies within their zip code or within the maximum distance for their county classification. For Micro, Rural and CEAC counties, the Department may adjust this requirement based on the number and location of available providers.

In the event that there are less than two (2) pharmacies that meet the network standards within the defined area for a specific Member, then the ACC: MCO shall not be bound by the requirements of the prior paragraph for that Member.

GeoAccess or a comparable service will be used to measure the distance between the Members and the providers.

8, ✓ *(Applies to the ACC PCCM Entity-PIHP)* Substance Abuse Treatment Providers (please describe):

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

Substance Abuse Treatment Network Time and Distance Standards

	Large Metro County		Metro County		Micro County		Rural County		CEAC	
Required Providers	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
SUD Treatment Practitioner - Adult	20	10	30	15	40	20	60	30	90	60
SUD Treatment Practitioner - Pediatric	20	10	30	15	40	20	60	30	90	60

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

In the event that there are less than two (2) Substance Abuse Treatment Providers who meet the behavioral health provider standards within the defined area for a specific Member, then the ACC PCCM Entity-PIHP shall not be bound by the time and distance requirements of the prior table for that Member.

9.___ Other providers (please describe):

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

1.✓ PCPs (please describe):

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

- ***Well Care Visit: within 30 calendar days after the request; unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted American Academy of Pediatrics Bright Futures schedules.***

- ***Urgent Care: Within twenty-four (24) hours after the initial identification of need.***
- ***Outpatient Follow-up Appointments: within seven (7) calendar days after discharge from a hospitalization.***
- ***Routine Primary Care, Non-urgent Symptomatic Care Visit: within seven (7) business days of the request.***

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.✓ Mental Health (please describe):

The ACC-PIHP must also meet additional timeliness standards:

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

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

The ACC-PIHP must also meet additional timeliness standards:

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

7.___ Urgent care (please describe):

8. ___ Other providers (please describe):

The ACC PCCM Entity-PIHP must also meet additional timeliness standards for the Child and Youth Medicaid System of Care:

- ***High Fidelity Wraparound services for children and youth – children and youth determined eligible for Enhanced High-Fidelity Wraparound services through the Enhanced Standardized Assessment will initiate services within 30 calendar days of the ACC PCCM Entity-PIHP's***

referral of the Member to a Provider of Enhanced High-Fidelity Wraparound services.

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.

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B. Capacity Standards

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

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

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

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services.

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

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

a.___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b._-_ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

c.___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

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

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

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.✓ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

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

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

Area (City/County/Region)	***Adult PCMP-to-Enrollee Ratio***	***Adult Mid-level-to-Enrollee Ratio***	***Pediatric PCMP-to Enrollee Ratio***
Region 1	1:1,200	1:1,200	1:1,200
Region 2	1:1,200	1:1,200	1:1,200
Region 3	1:1,200	1:1,200	1:1,200
Region 4	1:1,200	1:1,200	1:1,200
Statewide Average: (e.g. 1:500 and 1:1,000	1:1,200	1:1,200	1:1,200

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.

C. Coordination and Continuity of Care Standards

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

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

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each

regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care.

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

The following items are required.

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

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

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

The State requires ACC: MCOs to implement mechanisms for identifying members requiring long-term services or having special health care needs as defined by the state in 10 C.C.R. 2505-10, §8.205.8, et seq.

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

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

and community based care, Developmental Disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates.

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

1._✓__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2._✓__Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3._✓__In accord with any applicable State quality assurance and utilization review standards.

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

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

a.___Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. ✓__ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c.✓__ Each enrollee receives **health education/promotion** information. Please explain.

Members will have access to health education/promotion information through the Department's enrollment broker and the RAE.

d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e.✓__ There is appropriate and confidential **exchange of information** among providers.

f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ✓ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

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

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

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

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

Members in the Medicaid System of Care Program (M-SOC) continue to have access to the full range of benefits covered by the ACC: PIHP-PCCM Entity. Members in the M-SOC program will receive an enhanced set of services through a comprehensive treatment plan developed and provided by the ACC: PIHP-PCCM Entity. Selective contracting for providers of these services under the M-SOC program will not negatively impact coordination and continuity of care because the M-SOC program itself is an enhanced care coordination intervention approach, and the providers involved in the program are not separate from the ACC: PIHP PCCM Entity.

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Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

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

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

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

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

2. **Assurances For PAHP program.**

NOT APPLICABLE

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

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

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

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

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

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

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

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

3.✓ Request PCCM Entity's response to identified problems;

4. ✓ Refer to program staff for further investigation;

5.✓ Send warning letters to PCCM Entities;

6. ✓ Refer to State's medical staff for investigation;

7. ✓ Institute corrective action plans and follow-up;

8. ✓ Change an enrollee's PCMP;

9. ___ Institute a restriction on the types of enrollees;

10. ✓ Further limit the number of assignments;

11. __ Ban new assignments;

12. ✓ Transfer some or all assignments to different PCMPs;

13. ✓ Suspend or terminate PCCM Entity or PCMP agreement;

14. ✓ Suspend or terminate as Medicaid providers; and

15. ✓ Other (explain):

The ACC PCCM Entity-PIHP and ACC: MCO organizations, through the Department's Commitment to Quality Program, will be required to achieve performance standards agreed to in contract. If contractors fail to meet performance standards, they will be required to contribute funding towards quality improvement initiatives, such as but not limited to, supporting the health neighborhood(s), improving member health, improving access to care, or efforts to achieve key performance indicator or shared savings goals. Performance standards are codified in the ACC PCCM Entity-PIHP and ACC: MCO contracts.

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

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

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

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

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

- ***Collaborate with patient, family, or caregiver to develop an individual care plan for Members with complex needs.***
- ***Utilize an electronic health record or are working with the RAE to share data with the Department.***

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

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ✓ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ✓ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ Other quality standards (please describe):

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

Criteria for selection of Medicaid System of Care providers: All of the services will require certification/credentialing through a state determined process.

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Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

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

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

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM Entity contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities.

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

2. **Details**

a. **Scope of Marketing**

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

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

The RAE must obtain prior approval from the Department for all proposed marketing materials. Plans can conduct outreach initiatives intended to improve member engagement, but do not indirectly market for the purposes of

encouraging enrollment in their specific plan. This is due to the nature of the ACC not being competitive for enrollment.

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

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

ACC plans do not compete for the enrollment of members and therefore do not create any marketing materials designed to influence member enrollment.

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

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs and PCCMs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State requires MCO/PIHP/PAHP and PCCM Entity to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

Spanish

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

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

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

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

ii.__ The languages comprise all languages in the MCO/PIHP/PAHP/PCCM service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

The remainder of this page is intentionally left blank.

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM Entity contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements.

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

2. **Details.**

a. **Non-English Languages**

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

Spanish

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

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

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

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

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

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

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

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

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

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

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

__ State
__ contractor (please specify)

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

c. **Enrollee Information**

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

(i) ___ the State

(ii) _✓_ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* State contractor (please specify):_Enrollment broker_____

The remainder of this page is intentionally left blank.

C. Enrollment and Disenrollment

1. **Assurances.**

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

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

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

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

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM Entity contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56. Disenrollment requirements.

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

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

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

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

- ***The Enrollment Broker will be responsible for initial outreach to members upon determination of eligibility, including informing members of their assigned PCMP or ACC: MCO and ACC PCCM Entity-PIHP Entity, choice counseling of a PCMP, and how to contact the PCMP and ACC PCCM Entity-PIHP.***

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

b. **Administration of Enrollment Process**.

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

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

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

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

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

Broker name: Maximus Health Services, Inc.

Please list the functions that the contractor will perform:

✓ choice counseling

✓ enrollment

___ other (please describe):

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

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

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

All program components of the ACC PCCM Entity-PIHP will be implemented statewide on July 1, 2025. The ACC: MCO will be implemented within the geographic regions on July 1, 2025.

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

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

i. ___ Potential enrollees will have ____ days/month(s) to choose a plan.
ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

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

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

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

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

1. ***All Medicaid Members will be mandatorily enrolled into the ACC;***
2. ***Medicaid Members will be attributed to a PCMP based on their claims history or documented choice of PCMP. Enrollees without a claims history or documented choice of PCMP will remain unattributed.***
3. ***All Members will be assigned to a RAE based upon who their PCMP is or, if they are not attributed to a PCMP, they will be assigned to a RAE based on their home address.***

Enrollment in the ACC: MCO:
Enrollment into the Program is effective on the same day that a Member's Medicaid eligibility notification is received in interChange from the CBMS. Members enrolled in Denver Health or Rocky Mountain Health Plans Prime will be automatically enrolled in the ACC: MCO for the July 1, 2025, start date. Future enrollment in the ACC: MCO will occur when the ACC: MCO enrollment drops below the contracted enrollment level in which case new Medicaid members who met the geographic and eligibility requirements will be automatically enrolled. Those individuals have a 90-day period to choose to opt out of the ACC: MCO and choose a PCMP. The members choice of a PCMP will determine the ACC: PCCM Entity-PIHP enrollment as described above.

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

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

_✓_ (*Applies to Special Connections*) The State DOES NOT automatically enroll Members into the program

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

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in a PIHP. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State **automatically re-enrolls** a beneficiary with the same PIHP/MCO if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

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

i. ✓ Enrollee submits request to State.

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

RAE Reassignment Process

Each RAE shall implement special arrangements for the reassignment of a Member from the RAE serving the Member's PCMP to the RAE serving the Member's county of residence when requested by both the Member and a care coordinator/case manager of the Member's treating Comprehensive Community Behavioral Health Providers (Comprehensive Provider).

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

- ***The Member resides in a RAE geographic region different from the RAE geographic region of the Member's PCMP.***
- ***The Member is receiving an array of mental health and community support services from a Comprehensive Provider.***
- ***The Member has a current plan of care that features the utilization of state plan services, 1915(b)(3) community-based system of care services, and other state resources to support the Member's living in the community, maintaining optimal level of functioning, and achieving recovery.***
- ***The Member requires ongoing therapeutic and community-based services in order to live stably in the community as evidenced by a history of hospitalization for a mental health condition, utilization of the Colorado Crisis Services system, involvement with the criminal justice system, or other similar indicator of the complexity of the Member's mental health condition within the past twelve (12) months.***
- ***The Member and a care coordinator/case manager from the Comprehensive Providers initiate conversation with both the RAE serving the Member's PCMP and the RAE serving the Member's county of residence***

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

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

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

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

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

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

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

_✓_ *(Applies to ACC: MCO)* The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of _12_ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause

reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

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

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

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

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

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

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

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

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

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D. Enrollee rights.

1. **Assurances.**

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

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

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

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

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

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E. Grievance System

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

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

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

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

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

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

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

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The* CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System.

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

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

✓ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

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

b. **Timeframes**

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The* State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days.

_ *The* State's timeframe within which an enrollee must file a **grievance** is 20 days (may not exceed 90).

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

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

✓ The grievance procedures are operated by:

___ the State

__ the State's contractor. Please identify: __

✓ the PCCM Entity

___ the PAHP.

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

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

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

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

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

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

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

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

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

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

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

The ACC PCCM Entity-PIHP must resolve grievances within 90 calendar days from the date a member files a grievance. ACC PCCM Entity-PIHPs may request an additional 14 calendar days to resolve grievances if they meet conditions specified in 42 CFR § 438.408

___ 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):

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F. Program Integrity

1. **Assurances.**

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

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM Entity PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM Entity's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM Entity, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM Entity's, PIHP's, or PAHP's obligations under its contract with the State.

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

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

2. **Assurances For MCO or PIHP programs**

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

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

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

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

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Section B: Monitoring Plan

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

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

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

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

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

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

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

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

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 ACC PCCM Entity-PIHP and ACC: MCO

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

Profile Utilization by Provider Caseload												
Provider Self-Report Data							✔		✔			✔
Test 24/7 PCP Availability												
Utilization Review												
Other:												

For Special Connections– BHA 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												
On-Site Review				✔			✔		✔			✔
Performance Improvement Projects												
Performance Measures							✔					

Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review												
Other: (describe) Monitoring of complaints and grievances						✔						

PART II. Monitoring Strategies

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

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

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

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

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

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

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

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

- ✓ CAHPS (please identify which one(s))

Programs: *ACC PCCM Entity-PIHP, ACC: MCO*

Personnel Responsible*: The Department*

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

The CAHPS related survey is one tool used to:

- *improve the quality of services*
- *evaluate care coordination*

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

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

Frequency: *Annual*

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

___ State-developed survey – Client Satisfaction Survey

___ Disenrollment survey

_✓__ *(Applies to the ACC PCCM Entity-PIHP, ACC: MCO)*
Consumer/beneficiary focus groups

Programs: *ACC PCCM Entity-PIHP, ACC: MCO*

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

Strategy*: The Department, ACC PCCM Entity-PIHPs, and ACC: MCOs all use Member Advisory Committees (MACs) to help identify and address potential concerns with the ACC for Members. The Department hosts one MAC, while each regional ACC PCCM Entity-PIHP is required to create at least two MACs and each ACC: MCO is required create at least one.*

Frequency: *Monthly (the Department), Quarterly (ACC PCCM Entity-PIHP, ACC: MCO)*

How it yields information about the area being monitored: *These committees discuss Member experience and the delivery of Medicaid services statewide and within their respective regions. These committees help collect qualitative data about member experience. Additionally, Members have the opportunity to advise on policy and program changes to improve the delivery of services for Members.*

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

___ Denials of referral requests
___ Disenrollment requests by enrollee
  ___ From plan
  ___ From PCP within plan
✓ Grievances and appeals data
___ PCP termination rates and reasons
✓ Other (please describe)

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

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

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

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

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

- *Monthly Grievance Report.*
    - *The Grievance Report received by the Department is reviewed by the QST which consist of the ACC PCCM Entity-PIHP Contract Manager and a representative of the Quality Health and Improvement Unit. The Grievance Report includes all quality of care concerns and grievances received by the ACC PCCM Entity-PIHP or ACC: MCO. 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.*
- *Appeals Reports*
    - *Monthly Appeals for physical health services and prescription benefit will be included in a monthly report*
    - *Behavioral health appeals will be a part of a monthly data file that is uploaded into a utilization management dashboard*
- *Quarterly Network report that includes, at a minimum, the following information:*
    - *Number of network providers by provider type and areas of expertise*
    - *Geographic location of network providers in relationship to where Medicaid members live*
    - *Physical access and accessible equipment for members with disabilities*
    - *Providers that offer telehealth services*
    - *New provider contracts and providers that left the network*
    - *The use of single case agreements by provider type and member location*
    - *Percent of network providers accepting new Medicaid Members.*
    - *Performance meeting timeliness standards.*
- *Member Assistance Statistics Report that includes the monthly call center performance such as average speed of answer, voicemails not returned in one business day, language assistance and the results of any Member surveys.*
- *Care coordination activity reporting that includes the number of unique members for whom care coordination was provided by the Contractor and narrative descriptions of how care coordination is delivered throughout the network.*
- *A quarterly Client Over-Utilization Program (COUP) Report containing information including, but not limited to, outreach*

attempts, health assessments, interventions, and primary care visits of Members meeting overutilization criteria.

- *Regular submission of all data elements necessary to support deliverable and performance standard validation.*

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

How it yields information about the area being monitored: *The reports provide discrete pieces of information that might not otherwise be available to the Department in its oversight of access, choice, program integrity and other aspects of program monitoring. For example, the grievance narrative often captures input where clients request a new provider due to dissatisfaction with their current provider selection and client satisfaction with the new Provider Selection is noted in the narrative.*

Programs: *Special Connections*

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

Strategy: *The Department reviews various non-claims reports for Special Connections, including:*

- *Timely access, monitored through the Behavioral Health Administration and/or their designee. Waitlists are monitored to ensure that pregnant people and people with dependent children enter treatment within 48 hours, or receive interim services. Waitlists document dates of first contact, dates of first appointment offered, pregnancy status, parenting status, whether interim services were offered, length of time on a waitlist, and reason for removal from a waitlist. The Special Connections program manager receives a monthly report identifying any providers who have not met the target of providing services within two days of initial contact, as well as documentation of the BHASO working with providers on a case-by-case basis to address barriers to timely service.*
- *Grievances are monitored as a part of the Behavioral Health Administration'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 perinatal people served through the Special Connections program, together with the significant amount of attention that each receives, explains the overall low number of grievances received.*

Frequency: *Monthly and ad-hoc*

How it yields information about the area being monitored: *The waitlist information allows the Behavioral Health Administration and the Department to monitor access to services and identify barriers to access. Grievances provide information with respect to compliance with federal and state standards and identify areas where improvement or corrections need to be made.*

e. _✓_ Enrollee Hotlines operated by State

Programs: *The ACC PCCM Entity-PIHP, ACC: MCO and Special Connections*

Personnel responsible: *The Department*

Strategy: *The Department has a statewide Member Call Center operated Monday through Friday to address Member questions and concerns.*

Frequency: *Monthly*

How it yields information about the area being monitored: *Member Call Center reporting includes call center statistics like the average speed of answers, the types of questions asked by members, and whether questions were resolved.*

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

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

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

Strategy: *The ACC PCCM Entity-PIHPs and ACC: MCOs perform geo-mapping to assess the adequacy of the network on a quarterly basis. Using geo-mapping data, plans report out in a standardized template, determined by the Department, and identifies counties by provider type whether metric standards are met or not met. The Department's EQRO validates geo-mapping results for Department review.*

Frequency: *Quarterly*

How it yields information about the area being monitored: *Geo-mapping activities provide whether required provider types by county meet required time and distance metric standards.*

h. ✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

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

Personnel responsible: *The Department's contracted designee*

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

Frequency: *Annually*

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

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

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

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

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

Strategy: *Each ACC PCCM Entity-PIHP is required to create and submit annually to the Department a Health Equity Plan for their respective region/service area. These plans provide robust strategies to improve quality of care in the following focus areas:*

- *Maternity and Perinatal Health*
- *Behavioral Health*
- *Prevention*

ACC PCCM Entity-PIHPs and ACC: MCOs must also submit bi-annual Health Equity Data in which they identify their own priority populations and stratify their performance on quality measures by:

- *Race/Ethnicity*
- *Member Gender*
- *Member Age*
- *Member Language*
- *Member Count*
- *Member Disability Status*

Frequency: *Annual plan and bi-annual data submissions*

How it yields information about the area being monitored: *The Department uses this information, along with other quality measures, to fully assess quality and outcomes for Members in each region.*

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

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

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

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

The ACC PCCM Entity-PIHP and ACC: MCO shall notify the Department, in writing, within five (5) Business Days of an unexpected or anticipated material

change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network. The notice shall include:

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

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

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

Programs: *Special Connections*

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

Frequency: *Monthly*

How it yields information about the area being monitored:

The Department uses this information to assess network adequacy of Special Connections services and if members have access to appropriate care for their geography.

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

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

Personnel responsible: *The Department*

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

Frequency: *Quarterly and annually.*

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

l. ✓____ *(Applies to the ACC PCCM Entity-PIHP, ACC: MCO and Special Connections)*
Virtual site review

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

Personnel responsible: *The Department's contracted designee*

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

Frequency: *Annually*

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

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

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

- *Credentialing*
- *Information provided to beneficiaries*
- *Grievances/Appeals*

- *Timely access standards*
- *Coordination/continuity of care*
- *Coverage/authorization*
- *Quality of care*
- *Program integrity processes*
- *Information systems*

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

Programs: *Special Connections*

Personnel responsible: *Behavioral Health Administration*

Strategy:
On-site reviews are done annually by Behavioral Health Administration during Behavioral Health Entity (BHE) license renewal to assure facilities and agencies are in compliance with licensing requirements to provide Women's and Maternal Behavioral Health services in a gender-responsive and trauma-informed manner. Additionally, program integrity, timely access, coordination/continuity and quality of care are monitored via on-site review.

Frequency: *Annually*

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

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

✓ Clinical

✓ Non-clinical

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

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

Strategy: *The ACC PCCM Entity-PIHPs and ACC: MCOs shall conduct Performance Improvement Projects (PIPs) that are designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that*

are expected to have a favorable effect on health outcomes and Member satisfaction. The ACC PCCM Entity-PIHPs will have a minimum of two PIPs chosen in collaboration with the Department: one that addresses physical health (may include behavioral health integration into physical health) and one that addresses behavioral health (may include physical health integration into behavioral health). The ACC: MCOs will have a minimum of two PIPs chosen in collaboration with the Department. The ACC PCCM Entity-PIHPs and ACC: MCOs will conduct PIPs on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a topic. Additionally, the ACC PCCM Entity-PIHPs and ACC: MCOs must have the capacity to conduct up to two additional PIPs upon request from the Department. The PIPs will include the following:

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

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

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

Frequency: *At completion of the three-year PIP cycle*

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

n. ✓ *(Applies to the ACC PCCM Entity-PIHP, ACC: MCO and Special Connections)*
Performance measures [**Required** for MCO/PIHP]

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

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

Personnel responsible: *The Department*

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

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

Frequency: *Annually*

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

Programs: *Special Connections*

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

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

Providers of care are evaluated to assure appropriate credentialing/ licensure is in place, such as the LAC (Licensed Addictions Counselor) credential. The CAC is

designated at three levels of clinical practice: Levels I, II and III and is under the oversight of the Department of Regulatory Agencies (DORA) for the State of Colorado.

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

Frequency: *Annually*

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

o. ____ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____ Profile utilization by provider caseload (looking for outliers)

q. ✓____ Provider Self-report data
___ Survey of providers
___ Focus groups

Programs: *The ACC PCCM Entity-PIHP*

Personnel responsible: *The Department*

Strategy: *The ACC PCCM Entity-PIHPs shall assess each PCMP in their network on chosen structural criteria using provider self-report data based on advanced primary care-focused domains. The ACC PCCM Entity-PIHPs shall submit summary details to the Department on each PCMP's rating within the structural criteria.*

Frequency: *Annually*

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

r. ____ Test 24 hours/7 days a week PCP availability

s. __ Utilization review (e.g. ER, non-authorized specialist requests)

t.____ Other: (please describe)

The remainder of this page is intentionally left blank.

Section C: Monitoring Results

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

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

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

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

✓ This is an amendment request.

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

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

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

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If

changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: ***Lawrence Tam***

c. Telephone Number: ***(303) 866-4053***

d. E-mail: ***lawrence.tam@state.co.us***

e. The State is choosing to report waiver expenditures based on

X_ 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. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

**** CMS requested one quarter for a sixth year be included in the cost effectiveness. The P6 period reflects a quarter for Appendix D1. Annual per capita projections included in Appendix D5, D6, and D7 have been developed on an annual basis, consistent with prior Projection Year development.***

The Section D Excel Cost-Effectiveness workbook has been updated to include P6. The following Appendices within the Excel worksheet have been updated:

- ***Appendix D1 – One quarter of P6 member months projections***
- ***Appendix D5 – Annual P6 per capita projections***
- ***Appendix D6 – Includes one quarter of Member Months from Appendix D1 and the Annual per capita from Appendix D5.***
- ***Appendix D7 – Includes Member Months from Appendix D1 and the Annual per capita from Appendix D5.***
- ***Appendix D1 – This amendment #1 reflects revisions to prior projections. These updates are necessary to reflect impacts associated with the ending of the public health emergency (PHE) including enrollment redeterminations and are based on more recent data. Data that was unavailable when the original renewal cost effectiveness was submitted.***
- ***Appendix D5***
  - ***Updated service costs for acuity changes related to the PHE, approved 1115 demonstration costs, projected lawsuit settlement costs, and trends.***
  - ***Updated PCCME costs for ACC 3.0 implementation***
  - ***Updated administrative costs for approved 1115 non-service expenditures.***

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

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

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

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

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

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

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

1. _X_ First Year: ***$16.76*** per member per month fee
2. _X_ Second Year: ***$17.53*** per member per month fee
3. _X_ Third Year: ***$19.53*** per member per month fee
4. _X_ Fourth Year: ***$20.59*** per member per month fee
5. _X_ Fifth: ***$21.70*** per member per month fee
6. _X_ Sixth Year: ***$22.87*** per member per month fee*

**** CMS requested a sixth year be included. The cost effectiveness includes a Projection Year 6.***

The Base Year, (7/1/2021 – 6/30/2022), PCCM-E amount in Appendix D3 (column I) reflects two components:

- ***PCCM-E monthly fee (less incentive withhold paid to Regional Accountable Entities).***
- ***The amount the PCCM-E earned of the incentive withhold.***

These components are included in Appendix D3 in (columns S, T and U).

The P1 projection reflects the first-year target of $16.76, which includes a $4.34 withhold amount subject to earned incentives. The inflation factor in Appendix D5 column U is calculated as the annualized difference between the base period PMPM (PCCM-E paid and incentive earned and the SFY24 PCCM-E PMPM.

For the P2-P6 is trended based on the wage growth of 5.4% for president's budget trends plus the applicable 1115 approved non-service costs in each year.

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.

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

The Base Year (BY) utilized is retrospective year (R2) July 1, 2021 – June 30, 2022. Only one year was selected due to the availability of 1915(b)(3) service utilization and earned PCCM-E withholds. Utilization for the 1915(b)(3) services was not available for the July 1, 2022 – June 30, 2023 period (R1).

Within Appendix D1 and Appendix D3 we have included supplemental information for the R1 period, (July 1, 2022 – June 30, 2023). Note the supplemental expenditures for R1 (July 1, 2022 – June 30, 2023) do not include 1915(b)(3) service break-out or earned PCCM-E withhold amounts since they are not available to provide.

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

All formulas in Appendix D1, Appendix D5 and Appendix D7 have been updated to reflect the annualized application and calculation of trends from the BY to P1.

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

The change in the member months between the retrospective periods occurred due to the COVID-19 public health emergency (PHE) and moratorium on disenrollment. Projected membership reflects the impact of the PHE unwinding. The re-determination process is expected to continue over a twelve-month period.

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

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

The Base Year BY is SFY22 (July 1, 2021 – June 30, 2022)

E. 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._X_ [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**:

There are no changes or differences in the covered services between the retrospective and prospective periods.

b._X_ [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:

The following populations and services are outside of the waiver and cost-effectiveness, consistent with the prior waiver cost-effectiveness:

- ***Home and community-based waiver services expenditures***
- ***PACE program expenditures***
- ***Expenditures for members without full Title XIX Medicaid benefits***

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

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

For Initial Waivers:

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

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

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

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c._X_ Other (Please explain).

The administrative costs detailed in D2.A. of the cost effectiveness spreadsheet reflect the administrative costs allocated by the State and reported on CMS 64.10 forms for behavioral health, PCCM-E, physical health managed care and FFS administration for R1 and R2.

Administrative expenditures for R2 (July 1, 2021 – June 30, 2022) are included in Appendix D2.A and D5 (column X) were trended for each projection period.

G. Appendix D3 – Actual Waiver Cost

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

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

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*

1915(b)(3) service expenditures reported in Appendix D3 (column H) and Appendix D5 (column P) for R2 (July 1, 2021 – June 30, 2022) are outlined in the following table:

	R2 (SFY22) Expenditures		
1915(b)(3) Service Description	**MEG 1**	**MEG 2**	**MEG 3**
Prevention/Early Intervention Services	$3,210,424	$4,045,959	$34,544
Respite Care	$705,707	$1,078,389	$25,647
Intensive Case Management	$4,484,082	$2,183,638	$290
Vocational Services	$491,230	$477,897	$10,825
Recovery Services	$4,411,907	$6,916,593	$11,012
Clubhouses/Drop-in Center Services	$2,032,416	$823,176	$0
Assertive Community Treatment	$6,100,803	$1,892,591	$158
Residential Services	$7,172,832	$11,508,657	$0
Total	**$28,609,401**	**$28,926,900**	**$82,476**

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. X 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. _X_ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. ____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.
   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

Behavioral Health Quality Incentive program:
The State will allow the ACC: PIHP to receive incentive payments for the improvement of key performance indicators. The implementation of the Pay for Performance Program is contingent on the availability of funds as well as state and federal approval. Under the Pay for Performance Program, the overall incentive funds available to the ACC: PIHP's are proportionally contingent on the ACC: PIHP's performance participation performance requirements established each contract year:

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

each incentive performance measure is defined as the ACC: PIHP "closing their performance gap by 10%" from a goal established by the state and fiscal year performance. The table below lists the intended initial behavioral health performance measures; the actual measures will be included in the contracts to be reviewed by CMS annually. The Department will work with the ACC: PIHP to negotiate what the appropriate baselines will be.

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

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

Incentive payments may only be available for a fixed period of time and incentive performance must be measured during the rating period under the contract in which the performance incentive program is applied, in accordance with 42 CFR 438.6(b)(2)(i). The Department must remit qualifying incentive payments earned during the performance period by State Fiscal Year (July 1, 20XX - June 30, 20XX to the Contractor between the following State Fiscal Year.

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

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

2. _X_ 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)**

The PCCM-E and earned incentive is itemized at a separate component on Appendix D3 (column I) and Appendix D5 (columns T:U).

Annually, the State determines the proportion of funds associated with the key performance indicators (KPI) Program and the Performance Pool so that the total incentive payment. For P1 the Contractor may earn equals four dollars and thirty-four cents ($4.34) PMPM, effective July 1, 2023. The Contract can earn sixty-four and seven-tenths percent (64.7%) of this funding on Key Performance Indicators and thirty-five and three- tenths percent (35.3%) on

Performance Pool measures. Any unearned KPI dollars will be added to the Performance Pool.

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

- ***The state determines the proportion of funds associated with each individual KPI so that the total incentive payment the ACC:***
- ***The state will pay an incentive payment to the ACC: PCCM Entity for each individual KPI that the ACC: PCCM Entity meets or exceeds the established performance goal.***
- ***The state will remit all payments on KPIs to the ACC: PCCM Entity within 180 days from the last day of the quarter in which the KPI incentive payments were earned. The state calculates the KPI incentive payment as of the end of each quarter based off the ACC: PCCM Entity's performance from the prior 12 months.***

Current Initial Waiver Adjustments in the preprint

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

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

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

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

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

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

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

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

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

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

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

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

Others:

- Additional State Plan Services (+)

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

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

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____Other (please describe):

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

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

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

D.____Other (please describe):

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

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

2.___ An administrative adjustment was made.

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

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

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

C.____Other (please describe):

ii.___ FFS cost increases were accounted for.

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

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

C.____Other (please describe):

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

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

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

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

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

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

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

i. State Plan Service trend

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

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

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

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

3. Explain any differences:

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

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

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

3.___ Other (please describe):

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

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

Method:

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

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

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

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

Basis and Method:

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

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

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

Method:

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

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

Basis and method:

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

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

Basis and Method:

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

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

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

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
   1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
   2.___ This adjustment was made:
      a. ___Potential Selection bias was measured in the following manner:
      b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
   1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
   2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
   3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
   4.___ Other (please describe):

Special Note section:

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

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

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

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

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

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

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

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

  1.___ No adjustment was made.

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

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. _X_ [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: ***See Appendix D5 (Column J).*** Please document how that trend was calculated:

   The Base Year reflected in Appendix D5 is a one-year period (July 1, 2021 – June 30, 2022) referred to as R2.

   We have included R1 (July 1, 2022 – June 30, 2023) as supplemental information in Appendix D3; however, due to timing of data availability, 1915(b)(3) expenditures for this period are not readily available.

   Prospective Year (P1) is a three-month period (April 1, 2024 – June 30, 2024). This period was selected because the waiver expired June 30, 2023 and the State

wants to continue to operate the waiver projection periods aligned with state fiscal year (SFY).

All period beginning with March 2020 were impacted by the COVID-19 pandemic and Public Health Emergency. This includes R1 and R2 period. These impacts include federal and state interventions that steadily increased Medicaid program membership that resulted in decreases in health care service utilization and per capita figures.

The Base Year (BY/R2) period is projected to P1 based on capitation rates effective for P1 plus projected fee-for-service expenditures. The state plan adjustment reflected in Appendix D5 reflects the annualized rate of change between (BY/R2) base period and the six-month P1 period described below.

<u>Developing P1 Projections and State Plan Trend</u>
As noted above, P1 period represents a six-month period and is made up of SFY24 (July 1, 2023 to June 30, 2024) capitation rates and FFS expenditures. The process to incorporate capitation and FFS expenditures by MEG is illustrated in figure 2 below:

Figure 2: Cost Effectiveness Population and Services Background

	Health First Colorado									
	RAE Region (MEG 1 & MEG 2)									MEG 3
	1		2	3	4	5		6	7	M-CHIP
BH Capitation	RAE		RAE	RAE	RAE	RAE		RAE	RAE	RAE
Physical Health Capitation		Rocky Mountain					Denver Health			See note 2
Physical Health FFS	X		X	X	X	X		X	X	X
Dental	FFS (ASO)	FFS (ASO)	FFS (ASO)	FFS (ASO)	FFS (ASO)	FFS (ASO)	FFS (ASO)	FFS (ASO)	FFS (ASO)	FFS(ASO)

Health First Colorado Overview

1. For MEG 1 and MEG 2, the State of Colorado, Health Care Policy and Finance (HCPF) contracts with Regional Accountable Entities in seven regions across the state.
2. The RAE is responsible for coordinating the care of Health First Colorado members in their region to ensure that care is delivered efficiently and duplication of services is minimized as well as developing plans to address the needs of sub-populations such as children or adults.
3. The RAE is responsible for building networks of primary care and behavioral health care providers so that Health First Colorado members have access to these services.
4. The RAE received capitation rates for behavioral health services for all Health First Colorado members.
5. Monitoring data and metrics to ensure RAEs and their provider networks meet their goals to provide quality care.

MEG 1 and MEG 2 Notes

1. All individuals in MEG 1 and MEG 2 are enrolled in behavioral health managed care for each region.
2. Rocky Mountain and Denver Health operate voluntary physical health managed care within specific service areas within Regions 1 and 5.
3. Individuals who do not enroll in Rocky Mountain or Denver Health in Region 1 and 5, receive their physical health services via fee-for-service.
4. Individuals in MEG 1 and MEG 2 receive dental services through an administrative services arrangement.

MEG 3 Notes

1. MEG 3 includes M-CHIP children. Behavioral health services are provided through capitated payments to the RAEs.
2. Physical health and dental services are provided through FFS. A portion of MEG 3 members may receive services through Denver Health capitation.

P1 Projection (MEG 1, MEG 2, and MEG 3)

P1 projections were developed for MEG 1 and MEG 2 utilizing members from State Fiscal Year 2023 (July 1, 2022 – June 30, 2023), who were enrolled in the behavioral health capitated program. These unique members behavioral health capitation expenditures, physical health capitated expenditures and fee-for-service (including dental services) were aggregated for MEG 1 and MEG 2 to develop P1 projections.

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

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

- ***The population in MEG 3 are Medicaid CHIP children.***

P1 inflation factors presented in Appendix D5 are the annualized difference between the (BY/R2) and the P1 projected per capita values for each MEG. P1 per capita projections were developed based on prospective capitation rates and evaluation of historical FFS expenditures for each MEG as described below.

Data for MEG 1 was organized at the rate cohort level (e.g., children, adults, disabled) to ensure that the demographic proportions that influence the weighted average per capita could be evaluated and adjusted for the projection periods. Adjustments for P1 through P6 may include changing proportion of populations as the PHE enrollment unwind evolves or program changes isolated to one population within the MEG.

The data for MEG 1 and MEG 2 and P1 adjustments are outlined below:

- ***The capitated portion of the expenditures are based on SFY24 prospective capitation rates by rate cohort that inherently reflect:***
    - ***Incurred but not paid (IBNP) factors***
    - ***Pharmacy rebates***
    - ***Prospective trend factors***
    - ***Program changes that became effective after July 1, 2023***
    - ***End of PHE acuity adjustment***

- ***The FFS portion of the expenditures were adjusted for the following:***
    - ***Incurred but not paid (IBNP) factors***
    - ***Pharmacy rebates***
    - ***Prospective trend factors***
    - ***Program changes that became effective after July 1, 2023***
    - ***End of PHE acuity adjustment***

P1 Projection (MEG 3)
MEG 3 represents the M-CHIP children. The following adjustments inherent or applicable to the expenditures are outlined below:

- ***The capitated portion of the expenditures are based on SFY24 prospective capitation rates by rate cohort that inherently reflect:***
    - ***Incurred but not paid (IBNP) factors***
    - ***Pharmacy rebates***
    - ***Prospective trend factors***
    - ***Program changes that became effective after July 1, 2023.***
    - ***End of PHE acuity adjustment***

- ***The FFS expenditures adjustments include:***
    - ***Incurred but not paid (IBNP) factors***
    - ***Pharmacy rebates***

- ***Prospective trend factors***
- ***Program changes that became effective after July 1, 2023.***
- ***End of PHE acuity adjustment***

Adjustments related to the ending of the COVID-19 public health emergency and enrollment unwinding have been itemized seperately as program change adjustments in Appendix D5.

PCCM-E Projection
The P1 PCCM-E payment is $16.76, which includes a $4.34 withhold amount subject to incentives. The inflation factor for the (BY/R2) to P1 is calculated as the annualized difference between the base period PMPM and the SFY24 PCCM-E PMPM.

P2-P6 Projections (MEG 1, MEG 2 and MEG 3)
The P2 projections utilize the projected P1 per capita amounts plus prospective trend. The source of the trend factor varies based on the underlying data for each MEG. The capitated expenditures portion of the MEG per capita are trended utilizing the upper bound trend factor for the corresponding SFY24 capitated rates. For the FFS portion of the data trend factors were developed is based on historical utilization, unit cost and per capita expenditures by major service category. Additionally, the FFS portion of the data has been adjusted for the projected demonstration costs under the approved 1115 waiver and projected settlements from the systems of care step-down lawsuit.

The PCCM-E PMPM component for P2 was trended using P1 and applying wages growth of 4.6% for Private Industry workers as published by the Bureau of Labor Statistics. For P3, the state's new behavioral health incentive program, ACC 3.0, will be effective; the P3 projection reflects the projected UB ACC 3.0 PMPM. The P3 trend factor is backed into based on the P3 and P2 projected PMPMs. PCCM-E PMPMs for P4-P6 were trended using the president's budget trend of 5.4%.

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Note: CMS requested a one quarter for the sixth year, the Appendix D5 has been update to project an additional year, P6.

2. _X_ [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 ratesetting regulations) *(i.e., trending from present into the future)*.
   i. _X__ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.).

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

Described in the prior section, the trend factors reflected in Appendix D5 for P1 reflects the annualized percentage change between the R2 period (July 1, 2021 – September 30, 2022) and P1 (April 1, 2024 – June 30, 2024) period.

<u>P1 Trend Adjustments</u>

State Plan Trend
The state plan services annual trend rate reflected for P1 is the annualized difference between projected cost for P1 by MEG. As described in the prior sections.

MEG	Annual State Plan Trend BY to P1 Appendix D5 Column J
MEG 1	9.5%
MEG 2	6.5%
MEG 3	7.3%

PCCM-E Projection
The P1 PCCM-E payment is $16.76, which includes a $4.34 withhold amount subject to incentives. The inflation factor for the BY/R2 to P1 is calculated as the annualized difference between the base period PMPM and the SFY24 PCCM-E PMPM.

1915(b)(3) Trend
The trend factor for the 1915(b)(3) services is equal to the state plan trend.

<u>P2 Trend Adjustments</u>

State Plan Trend
The state plan trend adjustment for P1 to P6 reflected in Appendix D (column J) represents the following.

	Annualized State Plan Trend Factors				
MEG	P1 to P2	P2 to P3	P3 to P4	P4 to P5	P5 to P6
MEG 1	3.4%	6.4%	6.1%	6.0%	8.6%

MEG 2	5.6%	5.9%	5.6%	5.6%	5.6%
MEG 3	3.7%	3.6%	3.6%	3.6%	3.6%

Trend factors reflect a mix of capitated rate and FFS data. These data were trended for the capitated portion of MEG 1, MEG 2 and MEG 3 expenditures using upper bound trend factors from the SFY24 capitation rate development. FFS data were trended based on historical data, adjusted for programmatic and reimbursement changes described above to ensure that the impact of these changes was not duplicated as both a program change impact and as trend.

The underlying trend factors for the capitation and FFS is based on historical evaluation of data by major service category, and month of service. The data to support the trends for each source was evaluated on 3-month, 6-month, and 12-month moving averages.

A combination of these metrics was used to determine prospective trends. However, there is not a pre-determined algorithm in place and trend assumptions vary based on nuances with a MEG or COS; given that prospective trend is a projection of future experience, it is necessary to make adjustments considering that historical trend experience may differ from what will materialize in the future.

Throughout the effective waiver period, the state may need to amend the cost-effectiveness trend and program change factors based on emerging information (e.g., newly implemented program changes).

PCCM-E Projection
The PCCM-E PMPM component for P2 was trended using P1 and applying wages growth of 4.6% for Private Industry workers as published by the Bureau of Labor Statistics. For P3, the state's new behavioral health incentive program, ACC 3.0, will be effective; the P3 projection reflects the projected UB ACC 3.0 PMPM. The P3 trend factor is backed into based on the P3 and P2 projected PMPMs. PCCM-E PMPMs for P4-P6 were trended using the president's budget trend of 5.4%.

Link to Press Release: https://www.bls.gov/news.release/pdf/eci.pdf

1915(b)(3) Trend
The trend factor for the 1915(b)(3) services is equal to the state plan trend.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____.

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

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

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

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

b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program. Others:

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

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

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____Other (please describe):

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

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

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

vi.X Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

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

D.__X__Other (please describe):

P1 Program Change Adjustment

The program change adjustment for P1 and P2 in Appendix 5 (column L) reflects anticipated acuity increase associated with the anticipated disenrollment of members as part of the PHE unwind associated with fee-for-service expenditures within the MEG.

Through the State's monitoring efforts, it was deemed necessary to amend the P1 and future projection periods based on significant deviations between the prior projection and actual experiential data. At the time of this amendment, P1 and P2 acuity adjustments for FFS based on actual historical data are available and have been utilized in this amendment. Additionally, actual managed care rates for P1 and P2 reflecting more accurate adjustments for acuity are also available and have been utilized in this amendment. Lastly, additional actual enrollment data covering the post-PHE disenrollment period has been used to update the membership projections.

P2–P6 Program Change Adjustments

At the time of the cost-effectiveness development, there are two program changes known at this time (1115 demonstrations and the systems of care step-down lawsuit settlement) that will impact P2–P6. The adjustments for P1 and P2 are related to acuity changes due to the unwinding of enrollment accumulated during the PHE. The P2-P6 projections currently account for the projected approved 1115 waiver demonstration costs and the systems of care step-down lawsuit settlement costs.

Throughout the waiver period, the state may need to amend the cost-effectiveness projections for P2–P6 to reflect emerging impacts of unwinding or new legislative appropriations or other benefit and reimbursement changes implemented by the State.

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._X_ 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._X_ Cost increases were accounted for.

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

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

C.____ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.__X__ Other (please describe):

State administrative costs are based on allocated costs including contract labor. The President's budget trend rate of 5.4% was used to project BY administrative costs to P1–P6.

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. _X_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: ***See Appendix D5, Column Q, the trend for the 1915(b)(3) services is equivalent to the state plan trend for each projection period.*** Please provide documentation.
2. _X_ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
    i. State historical 1915(b)(3) trend rates
        1. Please indicate the years on which the rates are based: base years ***See Appendix D5, Column Q, the trend for the 1915(b)(3) services is equivalent to the state plan trend for each projection period.***
        2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
    ii. State Plan Service Trend
        1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

           The trend used the same as the state plan service trend from the BY to to P1.

           For P2-P6, the state plan service trend utilized.

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 ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

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

3.___ Other (please describe):

1.___ No adjustment was made.

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

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**:

   The caseload, (member month), changes between the BY and P1 are associated with enrollment decreases that occured beginning July 2023 through June 2024.

   As previously discussed, the State has amended the P1-P6 projections utilizing actual historical data and updated managed care rates to reflect actual changes in acuity and membership mix.

   Throughout the waiver period, the state may need to amend the cost-effectiveness projections for P2–P6 to reflect emerging impacts of new legislative appropriations or other benefit and reimbursement changes implemented by the State.

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**:

   The rate of change between BY and P1 reflects an annualized rate of change inclusive of behavioral health capitation, physical health managed care capitation, state plan trend, program changes and impacts associated with the Public Health Emergency (COVID-19) as well as impacts on utilization and cost and acuity associated with the moratorium on Medicaid beneficiaries' disenrollment).

   Annualized rates of change reflect the state plan trend factors reflected in Appendix 5.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

   The rate of change between BY and P1 reflects an annualized rate of change inclusive of behavioral health capitation, physical health managed care capitation, state plan trend, program changes and impacts associated with the Public Health Emergency (COVID-19) as well as impacts on utilization and

cost and acuity associated with the moratorium on Medicaid beneficiaries' disenrollment).

Annualized rates of change reflect the state plan trend factors reflected in Appendix 5.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

Appendix D:
[CO 1915b - Consolidated Waiver Cost Effectiveness (Exhibits)_2025.03.06.xlsx]