DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **09 -- 006**

2. STATE: **COLORADO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
4/1/09

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | **X AMENDMENT TO BE CONSIDERED AS A NEW PLAN** | AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 U.S.C.1932(a)

7. FEDERAL BUDGET IMPACT
a. FY 09-10: $380,000 (based on 50% FMAP)
FY 10-11: $430,000 (based on 50% FMAP)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-F

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19.B, Methods and Standards for Establishing Payment Rates for Primary Care Case Managers (PCCMs) (SPA 04-015); Attachment 3.1-A (pages 12-14).

10. SUBJECT OF AMENDMENT **Methods and Standards for Voluntary Primary Care Case Management Program**

11. GOVERNOR'S REVIEW *(Check One)*

GOVERNOR'S OFFICE REPORTED NO COMMENT

X OTHER, AS SPECIFIED

Governor's letter dated 26 January 2009

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Sandeep Wadhwa, MD, MBA

14. TITLE
Medical & CHP+ Program Administration Office, Medicaid Director, Medical Director

15. DATE SUBMITTED
Original Submission on 5/4/09; Resubmitted on 7/20/09

16. RETURN TO

Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Brian Zolynas

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED 7/31/09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Richard C. Allen

22. TITLE
Associate Regional Administrator

23. REMARKS

FORM CMS-179 *(07/92)*

Instructions on Back

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

July 31, 2009

Joan Henneberry
Executive Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

RE: Colorado SPA # 09-006

Dear Ms. Henneberry:

This is your official notification that Colorado State Plan amendment 09-006, Methods and Standards for Voluntary Primary Care Case Management Program, has been approved effective April 1, 2009.

If you have any questions concerning this state plan amendment, please contact Cindy Smith at (303) 844-7041.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

State: Colorado

Citation	Condition or Requirement

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado does not enroll Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
X___ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

X___ i. fee for service;
____ ii. capitation;
X___ iii. a case management fee;
X____ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

Citation		Condition or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3.	For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). Please see an extensive discussion of incentive payments at the end of this filing, in sections N.3. and N.4. ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The initial implementation of the program was through a waiver in 1984. The program was initiated with participatory policymaking through multiple formal and informal venues soliciting input from stakeholders and community

Citation	Condition or Requirement

groups including: the Disability Medicaid Advisory Committees, Disability Working Group and the Managed Care Consumer Advisory Committee. More recently (2007-2008), the State brought together working groups of providers, clients and other stakeholders to help inform the efforts to redesign all of managed care. In 2009, the Department hosted many public forums open to the public at large to secure input and advice.

The State will continue to ensure public involvement in the program through surveys of participants and stakeholders, through a Primary Care advisory group, and through a Board and Advocacy Committee structure.

1932(a)(1)(A)

5. The state plan program will___/will not_X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary___X__ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary)_____ALL_____

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

This voluntary PCCM program is available state-wide.

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)

2. X____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

Citation		Condition or Requirement
42 CFR 438.50(c)(2) 1902(a)(23)(A)		
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	____The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met. This provision is not applicable. CFR 438.50 applies only to mandatory enrollment state plans. CFR 438.50(a). Enrollment is voluntary under this plan.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	X____The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	X____The state assures that all applicable managed care requirements of 42 CFR Part 438 for ~~MCOs and~~ PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. This provision is not applicable. The State assures that there are no at-risk PCCM contracts.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met. This provision is not applicable. The State assures that there are no non-risk prepaid capitation PCCM contracts.
45 CFR 74.40	8.	X____The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation	Condition or Requirement

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

This section D. "Eligible groups" is not applicable. Enrollment is voluntary under this plan.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
when
42 CFR 438(d)(2)

ii. ____Indians who are members of Federally recognized Tribes except

the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
Supplemental

iii. ____Children under the age of 19 years, who are eligible for

Citation	Condition or Requirement
42 CFR 438.50(d)(3)(i)	Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) out-of- 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) through a 42 CFR 438.50(3)(v)	vii. ____Children under the age of 19 years who are receiving services family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

This section E. "Identification of Mandatory Exempt Groups" is not applicable. Enrollment is voluntary under this plan.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
____iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

Citation	Condition or Requirement
	____i. yes ____ii. no
1932(a)(2) exempt 42 CFR 438.50 (d) *identification)*	4. Describe how the state identifies the following groups of children who are from mandatory enrollment: *(Examples: eligibility database, self-* i. Children under 19 years of age who are eligible for SSI under title XVI; ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; iii. Children under 19 years of age who are in foster care or other out-of-home placement; iv. Children under 19 years of age who are receiving foster care or adoption assistance.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*
1932(a)(2)	6. Describe how the state identifies the following groups who are exempt from

Citation	Condition or Requirement
42 CFR 438.50(d)	mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis The State assures that all groups with full Medicaid benefits are permitted to enroll in the PCCM program on a voluntary basis.
1932(a)(4) 42 CFR 438.50	H. Enrollment process. 1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

Citation	Condition or Requirement
	ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: This item 2. is not applicable. Enrollment is voluntary under this plan. i. the existing provider-recipient relationship (as defined in H.1.i). ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: This item 3. is not applicable. The state does not use mandatory enrollment. Enrollment is voluntary under this plan. i. The state will____/will not____ use a lock-in for managed care managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)* *Description of voluntary enrollment methods*

Citation	Condition or Requirement

1. Self-election

Medicaid recipients may join the PCCM program at any time, unless they are already enrolled under a different managed care plan and are subject to a lock-in under that other plan. Enrollment is generally effective the first day of the following month.

2. Passive enrollment

The State may enroll Medicaid recipients into the PCCM program, and may also assign Enrollees to a specific PCP in the program, through passive enrollment. The State would identify the Medicaid recipients subject to passive enrollment. Recipients would likely share a common characteristic(s) (e.g. residing in the same county or zip codes, belonging to the same eligibility category, having an existing relationship with a particular PCP or participating provider, etc.). To accommodate enrollment broker workflow and/or PCCM provider capacity, passive enrollments could be phased-in over many months.

Medicaid recipients do not have to accept the passive enrollment into the PCCM program as a condition for continued receipt of Medicaid assistance.

Medicaid recipients chosen for passive enrollment would receive 30 days advance written notice of enrollment into the PCCM program and would have 30 days to opt-out of the PCCM program by contacting the State's enrollment broker.

Recipients would be notified in the written enrollment notice:

1. of the right to disenroll from the PCCM program, without cause, during the first 90 days of their enrollment;
2. of the availability of other managed care choices to choose from (if any);
3. of the option to remain in regular fee-for-service Medicaid;
4. how to exercise the right to opt-out, to change enrollment options or provider assignment;

Citation	Condition or Requirement

5. how the failure to act timely and to contact the Enrollment broker will result in enrollment into the PCCM program and possible assignment to a specific provider; and
6. information about other available PCCM providers in the service area.

The written enrollment notice may contain or be accompanied by:

1. information about the specific provider to whom the recipient is assigned (if the provider has created such material);
2. information about the PCCM program generally (e.g. service area, benefits covered, cost sharing,) in the form of a Program Member Handbook (if the State has agreed to provide this information rather than the provider) ;
3. quality and performance indicators, including Enrollee satisfaction (if the information is available);

3. Open Enrollment Information

At the Enrollee's annual open enrollment period, the Enrollee will receive written notice of the opportunity to leave the PCCM program.

Recipients would be notified in the written open enrollment notice:

1. of the availability of other managed care choices to choose from (if any);
2. of the option to return to regular fee-for-service Medicaid;
3. how to exercise the right to opt-out, to change enrollment options or provider assignment; and
4. how the failure to act timely and to contact the Enrollment broker will result in reenrollment into the PCCM program with the same PCCM provider as the Enrollee has currently.

The written open enrollment notice may contain or be accompanied by:

1. quality and performance indicators, including Enrollee satisfaction;

Citation	Condition or Requirement

2. information about other managed care options that are available to choose from.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

This section I "State assurances on the enrollment process" are not applicable since enrollment is voluntary under this plan.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. ___The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. ____The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

X___This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

X___ This provision is not applicable to this 1932 State Plan Amendment.

5. X____ The state applies the automatic reenrollment provision in accordance

Citation	Condition or Requirement
	with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ___This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J. Disenrollment 1. The state will_X__/will not___ use lock-in for managed care. 2. The lock-in will apply for __12__ months (up to 12 months). 3. Place a check mark to affirm state compliance. __X__The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c). 4. Describe any additional circumstances of "cause" for disenrollment (if any). 1. The Enrollee's provider is relocating and the new location is not reachable within a reasonable time using available and affordable modes of transportation. 2. The Enrollee is relocating and travel to the Enrollee's provider cannot be achieved within a reasonable time using available and affordable modes of transportation 3. The Enrollee's provider is no longer participating in the PCCM program. 4. The Enrollee's provider no longer wishes to see the Enrollee for the following reasons: i. Enrollee repeatedly fails to follow medical instructions. ii. Enrollee repeatedly fails to keep appointments. iii. Enrollee repeatedly fails to show Medicaid Authorization Card. iv. Enrollee is abusive to the provider and/or provider's staff. 5. If the temporary loss of eligibility has caused the Enrollee to miss the annual disenrollment opportunity, the Enrollee may disenroll upon regaining eligibility. 6. The provider does not, because of moral or religious objections, cover the service the Enrollee needs.

Citation	Condition or Requirement

7. The Enrollee needs related services (for example, a caesarian section and a tubal ligation) to be performed at the same time; not all related services are available within the PCCM program; and the Enrollee's PCP or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.
8. Enrollment into the PCCM program, or the choice of or assignment to, the provider was in error.
9. The Enrollee has received poor quality of care from the provider.
10. There is a lack of access to covered services within the program.
11. There is a lack of access to providers experienced in dealing with the Enrollee's health care needs.
12. Any other reasons satisfactory to the State.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

____The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

42 CFR 438.10(i) does not apply, ("Special rules: States with mandatory enrollment under state plan authority") are not applicable since enrollment is voluntary under this plan.

The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CFR 438.10(f) and other applicable requirements of 42 CFR 439.10 generally.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

All services are covered in the PCCM program.

All services provided by someone other than the assigned PCCM provider will need a referral from the assigned PCCM provider, except for the following (which are available directly and without referral):

Citation	Condition or Requirement

1. Emergency care.
2. EPSDT screening examinations.
3. Emergency and non-emergent county transportation.
4. Anesthesiology services.
5. Dental and vision services including refractions.
6. Family planning services.
7. Mental health services.
8. Podiatry and foot care services.
9. Radiology services.
10. Laboratory services.
11. Home and community based services.
12. Services rendered pursuant to a child abuse diagnostic code.
13. Obstetric care.

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. X____ The selective contracting provision is not applicable to this state plan.

N. Additional Program Designs

1. All PCCM provider contracts shall set forth all payments (other than fee-for-service reimbursements) to the provider, including enhanced services descriptions, reimbursements and incentive payments.

Citation	Condition or Requirement

2. All PCCM provider contracts shall be submitted to CMS for review and approval.

3. PCCM providers offering enhanced services may receive reimbursements (administrative fees and/or fee-for-service payments and/or incentive payments) that the State does not offer to other PCCMs not providing enhanced services.

4. Incentive payments to PCCM providers offering enhanced services will have these characteristics:

a. They will not exceed 5% of the total FFS payments for those services provided or authorized by the enhanced PCCM provider for the period covered.
b. Incentives will be based upon the savings directly attributable to a reduction in utilization or costs. The State will determine the baseline from which reductions or savings are measured. The State will calculate the savings. From the total savings, the sum of all PMPM administrative payments paid to the enhanced PCCM provider for all Enrollees during the period, are subtracted. The remainder is actual savings. The enhanced PCCM provider is paid a percentage of the actual savings (subject to the cap of 5% described above). If the PCCM provider's experience does not yield actual savings, no incentive payment is made. Participating PCCM providers do not have to pay PMPM moneys back to the State for adverse results.
c. Incentives will be based upon a one year period of time.
d. Incentives will not be renewed automatically. If the State and enhanced PCCM can come to agreement on the subsequent year's measures, then the new measures will be incorporated into the contract by formal contract amendment.
e. Incentives will be made available to both public and private PCCMs who choose to provide enhanced PCCM services.
f. Incentives will not be conditioned on intergovernmental transfer agreements.

5. PCCM providers may provide one of two levels of enhanced services in exchange for PMPM administrative payments from the State.

Citation	Condition or Requirement

a. Level One services are provided to clients in State-selected eligibility categories, or population subsets, that are likely to have high costs and/or high needs.

b. Level One services include, but are not limited to, these characteristics:

1. Dedicated staff to perform care coordination and care management functions. At a minimum, the staff coordinates with the behavioral health organizations, non PCCM providers (e.g. specialists) and social services provided through community agencies and organizations.
2. Culturally and linguistically appropriate care,
3. An inter-disciplinary team-oriented delivery system,
4. Use of electronic medical records,
5. Use of population and disease registries,
6. Facilitating care transitions from inpatient and other institutional settings,
7. Performing health risk assessments,
8. Performing Enrollee satisfaction surveys,

c. Level Two services are provided to clients in State-selected eligibility categories, or population subsets, who are likely to have very high costs and/or very high needs, who are disabled, homeless, or who are considered to be "fragile" in that medical, social or financial set-backs put them at high risk for inpatient hospitalization or long-term care placement.

d. Level Two services include, but are not limited to, these characteristics:

1. Dedicated staff to perform care coordination and care management functions. At a minimum, the staff coordinates with the behavioral health organizations, non PCCM providers (e.g. specialists) and social services provided through community agencies and organizations.
2. Culturally and linguistically appropriate care,
3. An inter-disciplinary team-oriented delivery system,

Citation	Condition or Requirement

4. Use of electronic medical records,
5. Use of population and disease registries,
6. Facilitating care transitions from inpatient and other institutional settings and providing a transitions coach to encourage self-management and direct communication between the Enrollee/caregiver and the primary care provider,
7. Performing health risk assessments,
8. Performing Enrollee satisfaction surveys,
9. Assisting Enrollees to identify and to obtain home and community based services. This assistance includes completing paper-work, Prior Authorization Requests, Letters of Medical Necessity, coordinating appointments and facilitating interactions with the Single Entry Point agencies.
10. Assisting homeless Enrollees with the services provided by other agencies and organizations (e.g., 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). Assisting homeless Enrollees with the continuum of housing options in the service area, about housing advocacy, networking and resource development.
11. Assisting Enrollees who are eligible for Medicare to obtain those benefits, including "buy-in" and the steps necessary to obtain "buy-in,"
12. Providing a transportation services appraisals and assisting Enrollees with transportation needs,
13. Monitoring Enrollees for sentinel events (suicide, homicide, family harm, etc.) and taking necessary action to ameliorate and stabilize the disrupting event,
14. In home assessment and/or treatment by licensed medical professionals,
15. PCCM providers who are specialists, or who have special expertise in treating disabled populations.