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ATTACHMENT 3.1-F Section 1 (ACC), Page 1 OMB No.:0938-0933

Citation		Condition or Requirement		
SECTION 1: ACCOU	NTAB	LE CARE COLLABORATIVE PROGRAM		
1932(a)(1)(A)	Α.	Section 1932(a)(1)(A) of the Social Security Act.		
		The State of Colorado enrolls Medicaid beneficiaries on a voluntary 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 <i>not</i> be used to mandate enrollment in Prepaid Inpatient Health Plans (P1HPs), 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)		
	В.	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)		1. The State will contract with an		
1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)		i. MCO <u>x</u> ii. PCCM (including capitated PCCMs that qualify as PAHPs) iii. Both		
42 CFR 438.50(b)(2)		2. The payment method to the contracting entity will be:		
42 CFR 438.50(b)(3)		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).		

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Citation		Condition	or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3.	payments case mana If applica	that pay a PCCM on a fee-for-service basis, incentive are permitted as an enhancement to the PCCM's agement fee, if certain conditions are met. ble to this state plan, place a check mark to affirm the state has met
			following conditions (which are identical to the risk incentive rules ged care contracts published in 42 CFR 438.6(c)(5)(iv)).
		<u>x</u> 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.
		<u>x</u> _ii.	Incentives will be based upon specific activities and targets.
		<u>x_</u> iii.	Incentives will be based upon a fixed period of time.
		<u>x</u> iv.	Incentives will not be renewed automatically.
		<u>x</u> v.	Incentives will be made available to both public and private PCCMs.
		<u>x_</u> vi.	Incentives will not be conditioned on intergovernmental transfer agreements.
		vii.	Not applicable to this 1932 state plan amendment.
		The follo Accounts	wing conditions apply to incentive payments for PCCMs in the able Care Collaborative program:
		reduction specific p measure fiscal yea	entives are based upon measures that are attributable to a n in utilization or costs, or improvement in health outcomes. The performance targets change each year. The State determines the ment areas, performance targets, and incentive amounts for the ur (July-June), and communicates these to the PCCMs, no later rch 1 of each year.
			or to the start of each state fiscal year, the State determines the against which performance is measured.
			State pays any earned incentive payment to the PCCM on a ybasis within 120 days from the last day of the quarter in which
TN No. 11-010			Approval Date1

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Effective Date April 1, 2011

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State: COLORADO

ATTACHMENT 3.1-F Section 1 (ACC), Page 3 OMB No.:0938-0933

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Citation			Condition or Requirement
			the incentive payments was earned. The State calculates the incentive payment separately for each month in a quarter, and the PCCM may receive different amounts for each month within a quarter based on the specific performance targets the PCCM was able to meet during each specific month.
			d. The PCCM receives an incentive payment only for those targets the PCCM reaches in a given month. The PCCM does not have to pay PMPM moneys back to the State for adverse results.
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.)
			In 2009, the Department hosted public forums to obtain input and advice about the ACC program. In addition, the Department established four ACC program advisory groups, including one that has representation from ACC members, families, advocates, PCCM providers, other Medicaid providers, the behavioral health community, and community organizations.
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 enrollment will be implemented in the following county/area(s):
			i. county/counties (mandatory)
			ii. county/counties (voluntary)
			iii. area/areas (mandatory)
			iv. area/areas (voluntary)
	C.	<u>Stat</u>	e Assurances and Compliance with the Statute and Regulations.
			pplicable to the state plan, place a check mark to affirm that compliance with the owing statutes and regulations will be met.
1932(a)(1)(A)(i)(1)		1.	The state assures that all of the applicable requirements of
			Approval Date 11 3/11
Supersedes TN No. 09-000	6	-	Effective Date April 1, 2011

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Citation	Condition or Requirement
1903(m) 42 CFR 438.50(c)(1)	section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(1) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. <u>x</u> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	 x 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.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. <u>x</u> 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)	 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)	6The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <u>x</u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	 <u>x</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u> :
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.
	None.

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ATTACHMENT 3.1-F Section I (ACC), Page 5 OMB No.:0938-0933

Citation	Co	Condition or Requirement		
	Us	andatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. e a check mark to affirm if there is voluntary enrollment in any of the lowing mandatory exempt groups.		
1932(a)(2)(B) 42 CFR 438(d)(1)	i.	<u>x</u> 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) 42 CFR 438(d)(2)	ii.	<u>x</u> 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.		
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	<u>x</u> Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.		
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	<u>x</u> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.		
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v.	<u>x</u> Children under the age of 19 years who are in foster care or other out-of- the-home placement.		
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	<u>x</u> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.		
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii	. <u>x</u> Children under the age of 19 years who are receiving services through a 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

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State: COLORADO

ATTACHMENT 3.1-F Section I (ACC), Page 6 OMB No.:0938-0933

Citation		Condition or Requirement
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.)
		Children who receive services through Colorado's Health Care Program for Children with Special Needs.
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 <u>x</u> 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.
		<u>x</u> i. yes ii. no
1932(a)(2) 42 CFR 438.50 (d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (Examples: eligibility database, self- identification)
		i. Children under 19 years of age who are eligible for SSI under title XVI;
		Eligibility database.
		 ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;
		Eligibility database.
		iii. Children under 19 years of age who are in foster care or other out- of-home placement;
		Eligibility database.

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Condition or Requirement Citation Children under 19 years of age who are receiving foster care or iv. adoption assistance. Eligibility database. Describe the state's process for allowing children to request an exemption from 5. 1932(a)(2) mandatory enrollment based on the special needs criteria as defined in the state 42 CFR 438.50(d) plan if they are not initially identified as exempt. (Example: self-identification) Not applicable. Enrollment is not mandatory. Describe how the state identifies the following groups who are exempt from 6: 1932(a)(2) 42 CFR 438.50(d) mandatory enrollment into managed care: (Examples: usage of aid codes in the eligibility system, self-identification) Not applicable. Enrollment is not mandatory. Recipients who are also eligible for Medicare. i. Indians who are members of Federally recognized Tribes except when јй. 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. F. List other eligible groups (not previously mentioned) who will be exempt from 42 CFR 438.50 mandatory enrollment Not applicable. Enrollment is not mandatory. 11 TN No. 11-010 Approval Date Supersedes TN No. 09-006 Effective Date April 1, 2011

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ATTACHMENT 3.1-F Section I (ACC), Page 8 OMB No.:0938-0933

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Citation			Condi	tion or Requirement
42 CFR 438.50	G.	List all other eligible groups who will be permitted to enroll on a voluntary basis All eligibility groups are permitted to enroll in the ACC program on a voluntary basis.		
	H.	Enro	ollment	process.
1932(a)(4)		1.	Defin	itions
42 CFR 438.50			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.
			ii.	A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4)		2.	State	process for enrollment by default.
42 CFR 438.50			Descr	ibe how the state's default enrollment process will preserve:
			i.	the existing provider-recipient relationship (as defined in H.1.i).
				Clients enrolled in the ACC program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider they already have a relationship with. If that provider is not part of the ACC program, the PCCM (Regional Care Coordination Organization) will request that the provider enroll. The State will initially assign a PCMP based on which provider was the main source of Medicaid care for the client during the previous year.
			ii.	the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
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Citation	Condition or Requirement		
		The Regional Care Collaborative Organizations work with the State to recruit providers that have traditionally served Medicaid recipients to be a part of the ACC program. These providers have been involved as stakeholders since program planning began.	
	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.)	
		The State's enrollment process does not preserve the equitable distribution of Medicaid recipients among PCCMs because enrollment is voluntary. Clients may choose from among available MCOs and PCCMs in their geographic areas. A list of the available options is included in the enrollment letter and packet sent to Medicaid clients who are passively enrolled into the ACC program.	
1932(a)(4) 42 CFR 438.50		rt of the state's discussion on the default enrollment process, include llowing information:	
	i.	The state will_x_/will not use a lock-in for managed care.	
	й.	The time frame for recipients to choose a health plan before being auto-assigned will be:	
		Clients are notified of the State's intent to enroll them into the program 30 days before they are enrolled. This letter also describes other options available, including managed care plans, the fee-for-service option, and any other available program.	
	iii .	Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)	
		The State's enrollment broker sends the Medicaid client a letter notifying them of the State's intent to enroll them into the ACC	

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ATTACHMENT 3.1-F Section 1 (ACC), Page 10 OMB No.:0938-0933

Citation		Condition or Requirement			
		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.)		
			The letter sent by the State's enrollment broker to notify a client of the State's intent to enroll the client in the ACC program also includes instructions for disenrolling within the first 90 days of the client's enrollment into the program.		
		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.)		
			Enrollment is based on geographic service areas. The ACC program enrolls clients receiving fee-for-service Medicaid and will not affect the number of clients passively enrolled into other managed care plans.		
		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)		
			The state monitors rates of enroliment through monthly reports generated by the enroliment broker.		
1932(a)(4) 42 CFR 438.50	1.	State assur	ances on the enrollment process		
			eck mark to affirm the state has met all of the applicable requirements of collment, and re-enrollment.		
		alread	he state assures it has an enrollment system that allows recipients who are dy enrolled to be given priority to continue that enrollment if the MCO or M does not have capacity to accept all who are seeking enrollment under the am.		

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ATTACHMENT 3.1-F Section I (ACC), Page 11 OMB No.:0938-0933

State: <u>COLOR</u>	ADO	
Citation		Condition or Requirement
	2.	<u>x</u> 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.
	-	<u>x</u> 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.)
		<u>x</u> This provision is not applicable to this 1932 State Plan Amendment.
	5.	<u>x</u> The state applies the automatic reenrollment provision in accordance 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. <u>C</u>	Disenrollment
42 CFR 438.30	I.	The state will \underline{x} /will not use lock-in for managed care.
	2.	The lock-in will apply for <u>12</u> months (up to 12 months).
	3.	Place a check mark to affirm state compliance.
		\underline{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).
		 a. If the temporary loss of eligibility has caused a client to miss the annual disenrollment opportunity, the client may disenroll upon regaining eligibility. b. Enrollment into the PCCM program, or the choice of or assignment to the provider, was in error.

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Citation	Condition or Requirement
	 c. There is a lack of access to covered services within the program. d. There is a lack of access to providers experienced in dealing with the client's health care needs. e. 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") because enrollment is voluntary under this plan.
	The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.
1932(a)(5)(D)	L. List all services that are excluded for each model (MCO & PCCM)
1905(t)	 All Medicaid services are included in the ACC 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): Emergency care. EPSDT screening examinations. Emergency and non-emergent county transportation. Anesthesiology services. Dental and vision services including refractions. Family planning services. Behavioral health services. Home and community based services. Services rendered pursuant to a child abuse diagnostic code. Obstetric care. Hospice.

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ATTACHMENT 3.1-F Section 1 (ACC), Page 13 OMB No.:0938-0933

State: COLORADO

Citation		Condition or Requirement
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. <u>x</u> The selective contracting provision in not applicable to this state plan.
	N.	PCCM Contracts
		1. PCCM contracts for Regional Care Collaborative Organizations and Primary Care Medical Providers set forth all payments (except for fee-for-service reimbursements) to these PCCMs, including the per-member-per-month fee and any incentive payments. These contracts also describe the services rendered in exchange for the payments.
		2. The State shall submit all PCCM provider contracts to CMS for review and approval.
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TN No.<u>11-010</u> Supersedes TN No. <u>09-006</u> Approval Date (1/**3**/1) Effective Date April 1, 2011

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State: COLORADO

ATTACHMENT 3.1-F Section 2 (PCPP), Page 1 OMB No.:0938-0933

Citation		Condition or Requirement		
SECTION 2: PRIMARY CARE PHYSICIAN PROGRAM (PCPP)				
1932(a)(1)(A)	Α.	Section 1932(a)(1)(A) of the Social Security Act.		
		The State of Colorado enrolls Medicaid beneficiaries on a voluntary 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 <i>not</i> 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)		1. The State will contract with an		
1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)		 MCO <u>x</u>ii. PCCM (including capitated PCCMs that qualify as PAHPs) iii. Both 		
42 CFR 438.50(b)(2)		2. The payment method to the contracting entity will be:		
42 CFR 438.50(b)(3)		 <u>x</u>_i. fee for service; <u>ii.</u> capitation; <u>iii.</u> a case management fee; <u>iv.</u> a bonus/incentive payment; <u>v.</u> a supplemental payment, or <u>vi.</u> other. (Please provide a description below). 		

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State: COLORADO

ATTACHMENT 3.1-F Section 2 (PCPP), Page 2 OMB No.:0938-0933

Condition or Requirement Citation For states that pay a PCCM on a fee-for-service basis, incentive 1905(t) 3 payments are permitted as an enhancement to the PCCM's 42 CFR 440.168 case management fee, if certain conditions are met. 42 CFR 438.6(c)(5)(iii)(iv) 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)). Incentive payments to the PCCM will not exceed 5% of the total **i**. FFS payments for those services provided or authorized by the PCCM for the period covered. Incentives will be based upon specific activities and targets. ii. Incentives will be based upon a fixed period of time. iii. Incentives will not be renewed automatically. iv. Incentives will be made available to both public and private ٧. PCCMs. Incentives will not be conditioned on intergovernmental transfer vi. agreements. x vii. Not applicable to this 1932 state plan amendment. Describe the public process utilized for both the design of the program and its CFR 438.50(b)(4) 4. 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 groups including: the Disability Medicaid Advisory Committees, Disability Working Group and the Managed Care Consumer Advisory Committee. In 2007-08, the State brought together working groups of providers, clients and other stakeholders to help redesign all of managed care.

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State: COLORADO

ATTACHMENT 3.1-F Section 2 (PCPP), Page 3 OMB No.:0938-0933

Condition or Requirement Citation The state plan program will ___/will not _x_ implement mandatory 1932(a)(1)(A) 5. enrollment into managed care on a statewide basis. If not statewide, /voluntary_____ enrollment will be implemented in the mandatory following county/area(s): county/counties (mandatory) ______ i. ii. county/counties (voluntary)_____ area/areas (mandatory)_____ iii. area/areas (voluntary)_____ iv. State Assurances and Compliance with the Statute and Regulations. C. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met. The state assures that all of the applicable requirements of 1. 1932(a)(1)(A)(i)(1) section 1903(m) of the Act, for MCOs and MCO contracts will be met. 1903(m) 42 CFR 438.50(c)(1) x The state assures that all the applicable requirements of section 1905(t) 2. 1932(a)(1)(A)(i)(1) of the Act for PCCMs and PCCM contracts will be met. 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A) x The state assures that all the applicable requirements of section 1932 1932(a)(1)(A) 3. (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom 42 CFR 438.50(c)(3) of choice by requiring recipients to receive their benefits through managed care entities will be met. x The state assures that all the applicable requirements of 42 CFR 431.51 1932(a)(1)(A 4. regarding freedom of choice for family planning services and supplies as 42 CFR 431.51 defined in section 1905(a)(4)(C) will be met. 1905(a)(4)(C) x The state assures that all applicable managed care requirements of 1932(a)(1)(A) 5. 42 CFR Part 438 for MCOs and PCCMs will be met. 42 CFR 438 42 CFR 438.50(c)(4)

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	-	•
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6The state assures that all applicable requirements of 42 CFR 438.6(c for payments under any risk contracts will be met.	:)
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	 <u>x</u> The state assures that all applicable requirements of 42 CFR 447.36 payments under any nonrisk contracts will be met. 	2 for
45 CFR 74.40	 x The state assures that all applicable requirements of 45 CFR 92.36 f procurement of contracts will be met. 	òr
	Eligible groups	
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.	
	The Primary Care Physician Program is voluntary. No eligible groups will enrolled on a mandatory basis.	l be
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438	8.50.
	Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.	
1932(a)(2)(B)	i. <u>x</u> Recipients who are also eligible for Medicare.	
42 CFR 438(d)(1)	If enfollment is voluntary, describe the circumstances of enrollment (Example: Recipients who become Medicare eligible during, enrollment, remain eligible for managed care and are not disenrolle fee-for-service.)	mid
1932(a)(2)(C) . 42 CFR 438(d)(2)	ii. <u>x</u> Indians who are members of Federally recognized Tribes except the MCO or PCCM is operated by the Indian Health Service or an 1	
TN No. <u>11-010</u>	Approval Date <u>11/3/11</u>	
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State: COLORADO

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Citation	, C	Condition or Requirement		
		Health program operating under a contract, grant or cooperative agreemen with the Indian Health Service pursuant to the Indian Self Determinatio Act; or an Urban Indian program operating under a contract or grant wit the Indian Health Service pursuant to title V of the Indian Health Car Improvement Act.		
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	HI	 <u>x</u> Children under the age of 19 years, who are eligible for Supplementa Security Income (SSI) under title XVI. 		
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv	 x Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. 		
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v.	\underline{x} Children under the age of 19 years who are in foster care or other out-of the-home placement.		
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi	 <u>x</u> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. 		
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vi	ii. <u>x</u> Children under the age of 19 years who are receiving services through family-centered, community based, coordinated care system that receive grant funds under section 501(a)(1)(D) of title V, and is defined by the statin terms of either program participation or special health care needs.		
Е. [.] <u>І</u> с	dentification	n of Mandatory Exempt Groups		
1932(a)(2) 42 CFR 438.50(d)	មា	Describe how the state defines children who receive services that are funded nder section 501(a)(1)(D) of title V. (Examples: children receiving services t a specific clinic or enrolled in a particular program.)		
		Children who receive services through Colorado's Health Care Program fo Children with Special Needs.		
1932(a)(2) 42 CFR 438.50(d)		lace a check mark to affirm if the state's definition of title V children determined by:		
		i. program participation, ii. special health care needs, or <u>x</u> iii. both		
1932(a)(2) 42 CFR 438.50(d)		lace a check mark to affirm if the scope of these title V services received through a family-centered, community-based, coordinated		
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State: COLORADO

Citation		Condition or Requirement
		care system.
		<u>x</u> i. yes ii. no
1932(a)(2) 42 CFR 438.50 (d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (Examples: eligibility database, self-identification)
		i. Children under 19 years of age who are eligible for SSI under title XVI;
		Eligibility database.
		 ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;
		Eligibility database.
		iii. Children under 19 years of age who are in foster care or other out- of-home placement;
		Eligibility database.
		iv. Children under 19 years of age who are receiving foster care or adoption assistance.
		Eligibility database.
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)
		Not applicable. Enrollment is not mandatory.

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ATTACHMENT 3.1-F Section 2 (PCPP), Page 7 OMB No.:0938-0933

Condition or Requirement Citation Describe how the state identifies the following groups who are exempt from 6. 1932(a)(2) mandatory enrollment into managed care: (Examples: usage of aid codes in the 42 CFR 438.50(d) eligibility system. self-identification) Not applicable. Enrollment is not mandatory. Recipients who are also eligible for Medicare. i. Indians who are members of Federally recognized Tribes except when ii. 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. List other eligible groups (not previously mentioned) who will be exempt from F. 42 CFR 438.50 mandatory enrollment List all other eligible groups who will be permitted to enroll on a voluntary basis G. 42 CFR 438.50 All eligibility groups are permitted to enroll in the Primary Care Physician Program on a voluntary basis. I. Enrollment process. Definitions 1. 1932(a)(4) 42 CFR 438.50 An existing provider-recipient relationship is one in which the i. 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. A provider is considered to have "traditionally served" Medicaid ii. recipients if it has experience in serving the Medicaid population.

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ATTACHMENT 3.1-F Section 2 (PCPP), Page 8 OMB No.:0938-0933

Citation		Condition or Requirement
1932(a)(4)	2.	State process for enroliment by default.
42 CFR 438.50		Describe how the state's default enrollment process will preserve:
		i. the existing provider-recipient relationship (as defined in H.I.i).
		There is no passive or default enrollment for the Primary Care Physician Program. A client must actively choose to participate in the program, and selects a primary care provider upon enrollment into the program.
		ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
		Not applicable. There is no passive or default enrollment into the Primary Care Physician Program.
		 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.)
		Not applicable. There is no passive or default enrollment into the Primary Care Physician Program.
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 section is not applicable. There is no default enrollment into the Primary Care Physician Program.
		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:

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Citation	Condition or Requirement
	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)
1932(a)(4)	I. State assurances on the enrollment process
42 CFR 438.50	Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.
	 x_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.
	 <u>x</u> 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).
	 The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.
	<u>x</u> This provision is not applicable to this 1932 State Plan Amendment.
	4The 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

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Citation			Condition or Requirement
			the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)
			<u>x</u> This provision is not applicable to this 1932 State Plan Amendment.
		5.	<u>x</u> The state applies the automatic reenrollment provision in accordance 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)	J.	Dis	senrollment
42 CFR 438.50		1.	The state will x_/will not use lock-in for managed care.
		2.	The lock-in will apply for <u>12</u> months (up to 12 months).
		3.	Place a check mark to affirm state compliance.
			<u>x</u> 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).
			 a. The Enrollee's provider is relocating and the new location is not reachable within a reasonable time using available and affordable modes of transportation. b. 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 c. The Enrollee's provider is no longer participating in the PCCM program. d. The Enrollee's provider no longer wishes to see the Enrollee for the following reasons: Enrollee repeatedly fails to follow medical instructions. Enrollee repeatedly fails to show Medicaid Authorization Card. Enrollee is abusive to the provider and/or provider's staff.

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ATTACHMENT 3.1-F Section 2 (PCPP), Page 11 OMB No.:0938-0933

State: COLORADO

Citation	Condition or Requirement
	 a. If the temporary loss of eligibility has caused the Enrollee to miss the annual disenrollment opportunity, the Enrollee may disenroll upon regaining eligibility. b. The provider does not, because of moral or religious objections, cover the service the Enrollee needs. c. 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. d. Enrollment into the PCCM program, or the choice of or assignment to, the provider was in error. e. The Enrollee has received poor quality of care from the provider. f. There is a lack of access to providers experienced in dealing with the Enrollee's health care needs. h. 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") because enrollment is voluntary under this plan.
	The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.
1932(a)(5)(D)	L. List all services that are excluded for each model (MCO & PCCM)
1905(t)	All Medicaid services are included in the PCPP. 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):
<u> </u>	
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State: COLORADO

ATTACHMENT 3.1-F Section 2 (PCPP), Page 12 OMB No.:0938-0933

Condition or Requirement Citation 1. Emergency care. 2. EPSDT'screening examinations. Emergency and non-emergent county transportation. 3. 4. 'Anesthesiology services. 5. .Dental and vision services including refractions. Family planning services. 6. 7. Béhavioral health services. Home and community based services. 8. Services rendered pursuant to a child abuse diagnostic code. 9. 10. Obstetric care. 11. Hospice. Selective contracting under a 1932 state plan option 1932 (a)(1)(A)(ii) М. To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. intentionally limit the number of entities it 1. The state will /will not contracts under a 1932 state plan option. The state assures that if it limits the number of contracting entities, this 2. 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. <u>x</u> The selective contracting provision in not applicable to this state plan. PCCM Contracts N 1. PCCM contracts for providers in the Primary Care Physician Program set forth all payments (except for fee-for-service reimbursements) to these PCCMs. These contracts also describe the services rendered in exchange for the payments. 2. The State shall submit all PCCM provider contracts to CMS for review and approval. TN No. 11-010 Approval Date_

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State: COLORADO

ATTACHMENT 3.1-F Section 3 (CAHI), Page 1 OMB No.:0938-0933

Citation		Condition or Requirement				
SECTION 3: COLOR	SECTION 3: COLORADO ALLIANCE FOR HEALTH AND INDEPENDENCE (CAHI)					
1932(a)(1)(A)	Α.	Section 1932(a)(1)(A) of the Social Security Act.				
		The State of Colorado enrolls Medicaid beneficiaries on a voluntary 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 <i>not</i> 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)				
	В.	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)		1. The State will contract with an				
1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)		i. MCO <u>x</u> 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: <u>x</u>i. fee for service; ii. capitation; <u>x</u>iii. a case management fee; iv. a bonus/incentive payment; v. a supplemental payment, or vi. other. (Please provide a description below). 				

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ATTACHMENT 3.1-F Section 3 (CAHI), Page 2 OMB No.:0938-0933

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 <i>all</i> 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)).			
		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.			
		<u>x</u> 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.)			
		This program was established through legislation and the public process that accompanies the legislative process. The Board of Directors at the Colorado Alliance for Health and Independence is made up of stakeholders from the disability community, who continues to give feedback about the program.			
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 enrollment will be implemented in the following county/area(s):			
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State: COLORADO

Citation	Condition or Requirement				
	i. county/counties (mandatory)				
	ii. county/counties (voluntary)				
	iii. area/areas (mandatory)				
	iv. area/areas (voluntary)				
	C. <u>State Assurances and Compliance with the Statute and Regulations.</u>				
	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)	 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)(1) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	 x The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met. 				
1932(a)(1)(A) 42 CFR 438.50(c)(3)	 x 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. 				
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. <u>x</u> 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)	 <u>x</u> 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)	6The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.				

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ATTACHMENT 3.1-F Section 3 (CAHI), Page 4 OMB No.:0938-0933

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42 CFR 447.362 payments under any nonrisk contracts will be met. 42 CFR 438.50(c)(6) 8:	Citation		Condition or Requirement			
42 CFR 447.362 payments under any nonrisk contracts will be met. 42 CFR 438.50(c)(6) 45 CFR 74.40 8:	42 CFR 438.50(c)(6)					
procurement of contracts will be met. D. Eligible groups 1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis. The Colorado Alliance for Health and Independence program is voluntary. No eligible groups will be enrolled on a mandatory basis 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 4 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	42 CFR 447.362	7.	<u>x</u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.			
 List all eligible groups that will be enrolled on a mandatory basis. The Colorado Alliance for Health and Independence program is voluntary. No eligible groups will be enrolled on a mandatory basis Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 4 Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. Mandatory exempt groups. ListRecipients who are also eligible for Medicare. CFR 438(d)(1) X_Recipients who are also eligible for Medicare. If enrollment, remain eligible for managed care and are not disenroit fee-for-service.) Indians who are members of Federally recognized Tribes excee the MCO or PCCM is operated by the Indian Health Service or an Health program operating under a contract or grat the Indian Health Service pursuant to the Indian Self Determ Act; or an Urban Indian program operating under a contract or grat the Indian Health Service pursuant to title V of the Indian Health Improvement Act. [1932(a)(2)(A)(i) Children under the age of 19 years, who are eligible for Suppl Security Income (SSI) under title XVI. 	45 CFR 74.40	8:	<u>x</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.			
The Colorado Alliance for Health and Independence program is voluntary. No eligible groups will be enrolled on a mandatory basis 2: Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 4 Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. 1932(a)(2)(B) ixRecipients who are also eligible for Medicare. 1932(a)(2)(B) ixRecipients who are also eligible for Medicare. 1932(a)(2)(C) iixIndians who are members of Federally recognized Tribes excee the MCO or PCCM is operated by the Indian Health Service or an Health program operating under a contract, grant or cooperative agwith the Indian Health Service pursuant to the Indian Self Determ Act; or an Urban Indian program operating under a contract or grather Indian Health Service pursuant to title V of the Indian Health Improvement Act. 1932(a)(2)(A)(i) iiiChildren under the age of 19 years, who are eligible for Suppl Security Income (SSI) under title XVI.		D. <u>Eli</u> g	zible groups			
 voluntary. No eligible groups will be enrolled on a mandatory basis 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 4 Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. 1932(a)(2)(B) i. <u>x</u> Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment (<i>Example: Recipients who become Medicare eligible durin enrollment, remain eligible for managed care and are not disenrol fee-for-service.</i>) 1932(a)(2)(C) ii. <u>x</u> Indians who are members of Federally recognized Tribes excet the MCO or PCCM is operated by the Indian Health Service or an Health program operating under a contract, grant or cooperative agg with the Indian Health Service pursuant to the Indian Self Detern Act; or an Urban Indian program operating under a contract or grather Indian Health Service pursuant to title V of the Indian Health Improvement Act. 1932(a)(2)(A)(i) iii. <u>Children under the age of 19 years, who are eligible for Supple Security Income (SSI) under title XVI.</u> 	1932(a)(1)(A)(i)	1.	List all eligible groups that will be enrolled on a mandatory basis.			
Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. 1932(a)(2)(B) iRecipients who are also eligible for Medicare. 42 CFR 438(d)(1) iRecipients who are also eligible for Medicare. 1932(a)(2)(C) If enrollment is voluntary, describe the circumstances of enrollment enrollment, remain eligible for managed care and are.not disenrol fee-for-service.) 1932(a)(2)(C) iiIndians who are members of Federally recognized Tribes exce the MCO or PCCM is operated by the Indian Health Service or an Health program operating under a contract, grant or cooperative agi with the Indian Health Service pursuant to the Indian Self Determ Act; or an Urban Indian program operating under a contract or grat the Indian Health Service pursuant to title V of the Indian Healt Improvement Act. 1932(a)(2)(A)(i) iiiChildren under the age of 19 years, who are eligible for Suppl Security Income (SSI) under title XVI.			The Colorado Alliance for Health and Independence program is voluntary. No eligible groups will be enrolled on a mandatory basis.			
following mandatory exempt groups. 1932(a)(2)(B) 42 CFR 438(d)(1) i		2:	Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.			
 42 CFR 438(d)(1) 42 CFR 438(d)(1) 42 CFR 438(d)(1) 14 f enrollment is voluntary, describe the circumstances of enrollment (<i>Example: Recipients who become Medicare eligible durin enrollment, remain eligible for managed care and are.not disenrol fee-for-service.</i>) 1932(a)(2)(C) 1932(a)(2)(C) 10. x Indians who are members of Federally recognized Tribes excee the MCO or PCCM is operated by the Indian Health Service or an Health program operating under a contract, grant or cooperative agg with the Indian Health Service pursuant to the Indian Self Determ Act; or an Urban Indian program operating under a contract or grat the Indian Health Service pursuant to title V of the Indian Health Improvement Act. 1932(a)(2)(A)(i) 10. Children under the age of 19 years, who are eligible for Suppl Security Income (SSI) under title XVI. 						
If enrollment is voluntary, describe the circumstances of enrollment (Example: Recipients who become Medicare eligible durin enrollment, remain eligible for managed care and are not disenrol fee-for-service.) 1932(a)(2)(C) ii			i. <u>x</u> Recipients who are also eligible for Medicare.			
42 CFR 438(d)(2) the MCO or PCCM is operated by the Indian Health Service or an Health program operating under a contract, grant or cooperative agg with the Indian Health Service pursuant to the Indian Self Determ Act; or an Urban Indian program operating under a contract or grat the Indian Health Service pursuant to title V of the Indian Health Improvement Act. 1932(a)(2)(A)(i) iiiChildren under the age of 19 years, who are eligible for Suppl Security Income (SSI) under title XVI.	42 CFR 438(d)(1)		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.)			
42 CFR 438.50(d)(3)(i) Security Income (SSI) under title XVI.			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			
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Citation		Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)		ivChildren under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)		vChildren under the age of 19 years who are in foster care or other out-of- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)		viChildren under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)		vii. Children under the age of 19 years who are receiving services through a 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.	<u>Identificati</u>	ion of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)		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.)
		Children who receive services through Colorado's Health Care Program for Children with Special Needs.
1932(a)(2) 42 CFR 438.50(d)		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 <u>x</u> iii. both
1932(a)(2) 42 CFR 438.50(d)		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.
		_x_i. yes ii. no
1932(a)(2) 42 CFR 438.50 (d)		Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (Examples: eligibility database, self- identification)

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Citation		Condition or Requirement				
		i.	Children under 19 years of age who are eligible for SSI under title XVI;			
			Eligibility database.			
			Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;			
			Eligibility database.			
			Children under 19 years of age who are in foster care or other out- of-home placement;			
			Eligibility database.			
		iv.	Children under 19 years of age who are receiving foster care or adoption assistance.			
			Eligibility database.			
1932(a)(2) 42 CFR 438.50(d)	5.	mandato	e the state's process for allowing children to request an exemption from ory enrollment based on the special needs criteria as defined in the state ney are not initially identified as exempt. (Example: self-identification)			
		Not app	licable. Enrollment is not mandatory.			
1932(a)(2) 42 CFR 438.50(d)	6.	mandato	e how the state identifies the following groups who are exempt from ory enrollment into managed care: (Examples: usage of aid codes in the by system, self- identification)			
		Not app	licable. Enrollment is not mandatory.			
		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			

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Citation		(Condition or Requirement
			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.	<u>List of</u> manda	her eligible groups (not previously mentioned) who will be exempt from tory enrollment
		Not aj	pplicable. Enrollment is not mandatory.
42 CFR 438.50	G.	<u>List al</u>	other eligible groups who will be permitted to enroll on a voluntary basis
		Any a Based progra	fult client aged 21 and over who is eligible to receive Home and Community Services may enroll in the Colorado Alliance for Health and Independence im.
	H.	<u>Enrolli</u>	nent_process.
1932(a)(4) 42 CFR 438.50		1. C	efinitions
		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.
		ii	A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 12 CFR 438.50		2. S	ate process for enrollment by default.
2 CI K 490.90		D	escribe how the state's default enrollment process will preserve:
		i.	the existing provider-recipient relationship (as defined in H.I.i).
			Enrollment into the Colorado Alliance for Health and Independence does not replace any existing relationship between a provider and client. As a Primary Care Case Manager, the Colorado Alliance for Health and Independence works with

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	Condition or Requirement			
		primary care providers and other providers to manage the care of the clients in the program. Clients enrolled in this program are also enrolled in the Primary Care Physician Program for primary care case management; please see Section 2 of this State Plan Amendment for information on how that program preserves the provider-client relationship.		
	ii.	the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).		
		Not applicable. The program does not assign clients to providers.		
	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.)		
		There is no default enrollment into the Colorado Alliance for Health and Independence program; participation is voluntary.		
3.		t of the state's discussion on the default enrollment process, include lowing information:		
	This s Color	ection is not applicable. There is no default enrollment into the ado Alliance for Health and Independence program.		
	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		
	i ii .	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		
	3.	iii. 3. As par the fol This s Color i. i.		

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Condition or Requirement Citation first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets etc.) Describe the default assignment algorithm used for auto-assignment. ٧. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.) Describe how the state will monitor any changes in the rate of default vi. assignment. (Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker) State assurances on the enrollment process 1932(a)(4) I. 42 CFR 438.50 Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment. x The state assures it has an enrollment system that allows recipients who are 1. 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. _x_The state assures that, per the choice requirements in 42 CFR 438.52, 2. 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). The state plan program applies the rural exception to choice requirements of 3. 42 CFR 438.52(a) for MCOs and PCCMs. x This provision is not applicable to this 1932 State Plan Amendment. The state limits enrollment into a single Health Insuring Organization (HIO), 4. 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.)

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Condition or Requirement Citation <u>x</u> This provision is not applicable to this 1932 State Plan Amendment. x The state applies the automatic reenrollment provision in accordance 5. 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) J. **Disenrollment** 42 CFR 438.50 The state will __/will not _x _ use lock-in for managed care. 1. The lock-in will apply for __ months (up to 12 months). 2. 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). Describe any additional circumstances of "cause" for disenrollment (if any). 4. a. If the temporary loss of eligibility has caused a client to miss the annual disenrollment opportunity, the client may disenroll upon regaining eligibility. b. Enrollment into the PCCM program was in error. There is a lack of access to covered services within the program. c. There is a lack of access to providers experienced in dealing with the d. client's health care needs. e. Any other reasons satisfactory to the State. K. Information requirements for beneficiaries Place a check mark to affirm state compliance. The state assures that its state plan program is in compliance with 42 CFR 1932(a)(5) 438.10(i) for information requirements specific to MCOs and PCCM programs 42 CFR 438.50 operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check 42 CFR 438.10 mark to affirm state compliance.)

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Citation	Condition or Requirement	
	42 CFR 438.10(i) does not apply("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary this plan.	
	The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.	
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM)	
	All Medicaid services are included for clients in the Colorado Alliance for Health and Independence program.	
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. \underline{x} The selective contracting provision in not applicable to this state plan.	
	N. PCCM Contracts	
	 The PCCM contract for the Colorado Alliance for Health and Independence sets forth all payments (except for fee-for-service reimbursements). This contract also describes the services rendered in exchange for the payments. 	
	2. The State shall submit all PCCM provider contracts to CMS for review and approval.	
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ATTACHMENT 3.1-F Section 4 (CRICC), Page 1 OMB No.:0938-0933

Citation	Condition or Requirement		
SECTION 4: COLOR	ADO R	REGIONAL INTEGRATED CARE COLLABORATIVE (CRICC)	
1932(a)(1)(A)	Α.	Section 1932(a)(1)(A) of the Social Security Act.	
		The State of Colorado enrolls Medicaid beneficiaries on a voluntary 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 <i>not</i> 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)	
	В.	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)		I. The State will contract with an	
1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)		i. MCO <u>x</u> 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: <u>x</u>_i. fee for service; <u>ii.</u> capitation; <u>x</u>_iii. a case management fee; <u>iv.</u> a bonus/incentive payment; <u>v.</u> a supplemental payment, or <u>vi.</u> other. (Please provide a description below). 	

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ATTACHMENT 3.1-F Section 4 (CRICC), Page 2 OMB No.:0938-0933

Condition or Requirement Citation For states that pay a PCCM on a fee-for-service basis, incentive 1905(t) 3 42 CFR 440.168 payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. 42 CFR 438.6(c)(5)(iii)(iv) 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)). Not applicable to the CRICC program. Incentive payments to the PCCM will not exceed 5% of the total i. FFS payments for those services provided or authorized by the PCCM for the period covered. Incentives will be based upon specific activities and targets. ii. Incentives will be based upon a fixed period of time. iii. Incentives will not be renewed automatically. iv. Incentives will be made available to both public and private _**v**. PCCMs. Incentives will not be conditioned on intergovernmental transfer vi. agreements. vii. Not applicable to this 1932 state plan amendment. Describe the public process utilized for both the design of the program and its 4. CFR 438.50(b)(4) 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.) CRICC is a partnership between the Department and the Center for Health Care Strategies. There were public stakeholder meetings prior to the start of the program and during initial implementation. The state plan program will__/will not_x_ implement mandatory 5. 1932(a)(1)(A) enrollment into managed care on a statewide basis. If not statewide. _/ voluntary_____ enrollment will be implemented in the mandatory following county/area(s):

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Citation	Condition or Requirement	
	i. county/counties (mandatory)	
	iii. area/areas (mandatory)	
	iv. area/areas (voluntary)	
	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)(1) 1903(m) 42 CFR 438.50(c)(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)(1) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	 x The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met. 	
1932(a)(1)(A) 42 CFR 438.50(c)(3)	 x 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. 	
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. <u>x</u> 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)	 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)	 6The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. 	

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Condition or Requirement Citation x The state assures that all applicable requirements of 42 CFR 447.362 for 7. 1932(a)(1)(A) payments under any nonrisk contracts will be met. 42 CFR 447.362 42 CFR 438.50(c)(6) x The state assures that all applicable requirements of 45 CFR 92.36 for 8. 45 CFR 74.40 procurement of contracts will be met. Eligible groups D. List all eligible groups that will be enrolled on a mandatory basis. 1932(a)(1)(A)(i) 1. The Colorado Regional Integrated Care Collaborative program is voluntary. No eligible groups will be enrolled on a mandatory basis. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. 2. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. <u>x</u> Recipients who are also eligible for Medicare. 1932(a)(2)(B) i. 42 CFR 438(d)(1) If enrollment is voluntary, describe the circumstances of enrollment. (Example: Recipients who become Medicare eligible during midenrollment, remain eligible for managed care and are not disenrolled into fee-for-service.) Clients who become Medicare eligible during the program remain eligible for CRICC. x Indians who are members of Federally recognized Tribes except when 1932(a)(2)(C) ii. the MCO or PCCM is operated by the Indian Health Service or an Indian 42 CFR 438(d)(2) 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. Children under the age of 19 years, who are eligible for Supplemental 1932(a)(2)(A)(i) iii. Approval Date TN No._11-010 Effective Date April 1, 2011 Supersedes TN No. 09-006

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ATTACHMENT 3.1-F Section 4 (CRICC), Page 5 OMB No.:0938-0933

Condition or Requirement Citation Security Income (SSI) under title XVI. 42 CFR 438.50(d)(3)(i) Children under the age of 19 years who are eligible under 1932(a)(2)(A)(iii) iv. 1902(e)(3) of the Act. 42 CFR 438.50(d)(3)(ii) Children under the age of 19 years who are in foster care or other out-of-1932(a)(2)(A)(v)٧. the-home placement. 42 CFR 438.50(3)(iii) Children under the age of 19 years who are receiving foster care or 1932(a)(2)(A)(iv) vi. adoption assistance under title IV-E. 42 CFR 438.50(3)(iv) Children under the age of 19 years who are receiving services through a vii. 1932(a)(2)(A)(ii) family-centered, community based, coordinated care system that receives 42 CFR 438.50(3)(v) 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. Identification of Mandatory Exempt Groups Ε. Describe how the state defines children who receive services that are funded 1932(a)(2) 1. under section 501(a)(1)(D) of title V. (Examples: children receiving services 42 CFR 438.50(d) at a specific clinic or enrolled in a particular program.) Children who receive services through Colorado's Health Care Program for Children with Special Needs. Place a check mark to affirm if the state's definition of title V children 1932(a)(2) 2. is determined by: 42 CFR 438.50(d) program participation, i. special health care needs, or ii. iti. both 3. Place a check mark to affirm if the scope of these title V services 1932(a)(2) 42 CFR 438.50(d) is received through a family-centered, community-based, coordinated care system. i. yes ij. пo TN No. 11-010 Approval Date Effective Date April 1, 2011 Supersedes TN No. 09-006

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ATTACHMENT 3.1-F Section 4 (CRICC), Page 6 OMB No.:0938-0933

Condition or Requirement Citation Describe how the state identifies the following groups of children who are exempt 4. 1932(a)(2) from mandatory enrollment: (Examples: eligibility database, self-identification) 42 CFR 438.50 (d) Children under 19 years of age who are eligible for SSI under title XVI; i. Eligibility database. Children under 19 years of age who are eligible under section 1902 ii. (e)(3) of the Act; Eligibility database. Children under 19 years of age who are in foster care or other outiii. of-home placement; Eligibility database. Children under 19 years of age who are receiving foster care or iv. adoption assistance. Eligibility database. Describe the state's process for allowing children to request an exemption from 5. 1932(a)(2) mandatory enrollment based on the special needs criteria as defined in the state 42 CFR 438.50(d) plan if they are not initially identified as exempt. (Example: self-identification) Not applicable to the CRICC program. Enrollment is not mandatory, and children are not enrolled into this program. Describe how the state identifies the following groups who are exempt from 6. 1932(a)(2) mandatory enrollment into managed care: (Examples: usage of aid codes in the 42 CFR 438.50(d) eligibility system, self- identification) Not applicable. Enrollment is not mandatory. i. Recipients who are also eligible for Medicare. TN No. 11-010 Approval Date Effective Date April 1, 2011 Supersedes TN No. 09-006

ATTACHMENT 3.1-F Section 4 (CRICC), Page 7 OMB No.:0938-0933

State: COLORADO **Condition or Requirement** Citation Indians who are members of Federally recognized Tribes except when ii. 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. F. List other eligible groups (not previously mentioned) who will be exempt from 42 CFR 438.50 mandatory enrollment Not applicable. Enrollment is not mandatory. List all other eligible groups who will be permitted to enroll on a voluntary basis 42 CFR 438.50 G. Groups eligible for the CRICC program include: Aid to the Needy Disabled/Aid to the Blind (AND/AB-SSI), aged 21 and over Old Age Pensioners, aged 60-64 (OAP-B) Н. Enrollment process. Definitions 1932(a)(4) 1. 42 CFR 438.50 An existing provider-recipient relationship is one in which the .**i.** * 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. A provider is considered to have "traditionally served" Medicaid ii. recipients if it has experience in serving the Medicaid population. 2. State process for enrollment by default. 1932(a)(4) 42 CFR 438.50 Approval Date TN No. 11-010 Effective Date April 1, 2011 Supersedes TN No. 09-006

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Citation	Condition or Requirement	
	Describ	be how the state's default enrollment process will preserve:
	i.	the existing provider-recipient relationship (as defined in H.1.i).
		Clients with an existing relationship with a provider outside of the CRICC program would opt out of the program.
	ii.	the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
		Providers in the CRICC program have traditionally served Medicaid clients.
	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.)
		The Enrollment process does not preserve the equitable distribution of Medicaid recipients among PCCMs because enrollment is voluntary, and because the providers and recipients are constrained by the study design of the program.
1932(a)(4) 42 CFR 438.50		of the state's discussion on the default enrollment process, include owing information:
	i.	The state will_x_/will not use a lock-in for managed care managed care.
	й.	The time frame for recipients to choose a health plan before being auto-assigned will be:
		Clients are notified of the State's intent to enroll them into the program 30 days before they are enrolled.

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Citation	Condition or Requirement
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)
	The State's enrollment broker sends Medicaid clients a letter notifying them of the State's intent to enroll them into the CRICC program.
	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, IMO enrollment packets etc.)
	The letter sent by the State's enrollment broker to notify clients of the State's intent to enroll them into the program also includes instructions for disenrolling within the first 90 days of their enrollment.
	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.)
	The program is active in a limited geographic service area; clients are drawn from those areas.
	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)
	The State monitors rates of enroliment through monthly reports.
1932(a)(4) 42 CFR 438.50	I. State assurances on the enrollment process
	Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.
	1. <u>x</u> 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
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Citation			Condition or Requirement
			PCCM does not have capacity to accept all who are seeking enrollment under the program.
		2.	<u>x</u> 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.
			<u>x</u> 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.)
			<u>x</u> This provision is not applicable to this 1932 State Plan Amendment.
		5.	<u>x</u> The state applies the automatic reenrollment provision in accordance 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)	J.	Di	senrollment
42 CFR 438.50		1.	The state will <u>x</u> /will not use lock-in for managed care.
		2.	The lock-in will apply for <u>12</u> months (up to 12 months).
		3.	Place a check mark to affirm state compliance.
			<u>x</u> 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).

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Condition or Requirement Citation a. The Enrollee's provider is relocating and the new location is not reachable within a reasonable time using available and affordable modes of transportation. The Enrollee is relocating and travel to the Enrollee's provider b. cannot be achieved within a reasonable time using available and affordable modes of transportation The Enrollee's provider is no longer participating in the PCCM c. program. d. 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. i. If the temporary loss of eligibility has caused the Enrollee to miss the annual disenrollment opportunity, the Enrollee may disenroll upon regaining eligibility. i. The provider does not, because of moral or religious objections, cover • the service the Enrollee needs. k. 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. I. Enrollment into the PCCM program, or the choice of or assignment to, the provider was in error. m. The Enrollee has received poor quality of care from the provider. n. There is a lack of access to covered services within the program. o. There is a lack of access to providers experienced in dealing with the Enrollee's health care needs. p. Any other reasons satisfactory to the State. K. Information requirements for beneficiaries Place a check mark to affirm state compliance. The state assures that its state plan program is in compliance with 42 CFR 1932(a)(5) 438.10(i) for information requirements specific to MCOs and PCCM programs 42 CFR 438.50 operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check 42 CFR 438.10 mark to affirm state compliance.) 3 11

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Citation		Condition or Requirement		
		42 CFR 438.10(i) does not apply("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan. The State is in compliance with the informational requirements of 42 CFR		
		438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.		
1932(a)(5)(D) 1905(t)	L.	List all services that are excluded for each model (MCO & PCCM)		
		All Medicaid services are included in the CRICC program.		
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.		
		 The state will <u>x</u> /will not intentionally limit the number of entities it contracts under a 1932 state plan option. 		
		2. \underline{x} 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.)		
		The CRICC program was designed to test the efficacy of a specific model of primary care case management. It was necessary to limit the providers in order to maintain the integrity of the study design.		
		4 The selective contracting provision in not applicable to this state plan.		
	N.	PCCM Contracts		
		1. PCCM contracts for providers in the Primary Care Physician Program set forth all payments (except for fee-for-service reimbursements) to these		

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Citation

Condition or Requirement

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- PCCMs. These contracts also describe the services rendered in exchange for the payments.
- 2. The State shall submit all PCCM provider contracts to CMS for review and approval.

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