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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-14-002

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

Region VIII

July 2, 2014

Susan E. Birch, MBA, BSN, RN, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203-1818

RE: Colorado #14-002

Dear Ms. Birch:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 14-002. This amendment would add an MCO payment reform pilot program to the current PCCM structure of the ACC.

Please be informed that this State Plan Amendment was approved June 30, 2014 with an effective date of July 1, 2012. We are enclosing the CMS-179 and the amended plan page(s).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage report on the Form CMS-64.9 VIII, Line 18A-Medicaid Health Insurance Payments: Managed Care Organizations. In addition, the enhanced payments for certain primary care services furnished by particular primary care physicians should be reported on the Form CMS-64.9 VIII, Line 18A1-Medicaid MCO-Evaluation and Management and/or Line 18A2-Medicaid MCO - Vaccine codes.

Individuals not enrolled in the new adult group, claims need to be reported on the Form CMS-64, Line 18A-Medicaid Health Insurance Payments: Managed Care Organizations. Moreover, the enhanced payments for certain primary care services furnished by particular primary care physicians should be reported on the Form CMS-64, Line 18A1-Medicaid MCO-Evaluation and Management and/or Line 18A2- Medicaid MCO - Vaccine codes.

If you have any questions concerning this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

/s/

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

cc: Suzanne Brennan
Pat Connally
Barb Prehmus
John Bartholomew
Max Salazar

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**	1. TRANSMITTAL NUMBER: CO SPA 14-002	2. STATE: **COLORADO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **07/01/2014**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION **Section 1932(a) of the Social Security Act**	7. FEDERAL BUDGET IMPACT a. FFY 2014 $18,221,127.68 b. FFY 2015 $72,884,511.53
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Attachment 3.1-F (Section 3: ACC Payment Reform Program)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **NEW**

10. SUBJECT OF AMENDMENT
Adds a MCO within region one of the ACC program.

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

GOVERNOR'S OFFICE REPORTED NO COMMENT

X OTHER, AS SPECIFIED

Governor's letter dated 01 September 2011

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

12. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	16. RETURN TO
13. TYPED NAME **Suzanne Brennan**	**Colorado Department of Health Care Policy and Financing** **1570 Grant Street** **Denver, CO 80203-1818** **Attn: Barbara Prehmus**
14. TITLE **Director, Medical & CHP+ Program Administration Office**	
15. DATE SUBMITTED **April 25, 2014**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED **4/25/14**	18. DATE APPROVED **6/30/14**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL **7/1/14**	20. SIGNATURE OF REGIONAL OFFICIAL **/s/**
21. TYPED NAME **Richard C. Allen**	22. TITLE **ARA, DMCHO**

23. REMARKS

FORM CMS-179 (07/92) *Instructions on Back*

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

1932(a)(1)(A)

A. 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 ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

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

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

1. The State will contract with an

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

In the Accountable Care Collaborative (ACC) Payment Reform Program (Program), the State will contract with Rocky Mountain Health Plans (RMHP) to implement the Colorado House Bill 12-1281. The Program is comprised of a comprehensive risk-based payment for a subset of the ACC eligible population in 7 counties in RCCO region 1.

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

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

_____ i. fee for service;

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

_X_ ii. capitation;
___ iii. a case management fee;
___ iv. a bonus/incentive payment;
___ v. a supplemental payment, or
___ vi. other. (Please provide a description below).

The State will pay RMHP a comprehensive capitation payment.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

___ 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.

_X_ 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.)*

Citation	Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

In 2012, HB 12-1281 created a statute that required the Department to accept proposals for innovative ACC payment reform models designed to improve client outcomes while reducing costs. The Department went through an extensive public outreach process, which consisted of stakeholder meetings where drafts of the guidelines for proposal (GFP) were reviewed. The GFP outlined minimum requirements and selection criteria for the proposals. The Department ultimately selected the proposal of RMHP. RMHP collaborated with all of the provider types within its network to develop its payment reform proposal. RMHP has established an advisory group of stakeholders that will meet quarterly to monitor the Program. The State will also solicit feedback from the ACC Program Improvement Advisory Committee (PIAC) throughout the duration of 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__X___ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary) **Mesa, Montrose, Delta, Gunnison, Pitkin, Garfield and Rio Blanco.**

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.

Citation	Condition or Requirement
SECTION 3: ACC PAYMENT REFORM PROGRAM	
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. __X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ____ 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)	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. __X__ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. __X__ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. __X__ The 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. ____ 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	8. __X__ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. **None.**
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. __X__ 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.)* **Medicare eligible recipients who were enrolled in RMHP's PIHP and/or are in a Medicare Advantage program and reside in the ACC Payment Reform Program catchment area will be passively enrolled into the ACC Payment Reform Program. Medicare eligible recipients who opt out of the ACC Demonstration to Integrate Care for Medicare and Medicaid Eligible Beneficiaries may opt into the ACC Payment Reform Program. Beneficiaries will not be enrolled in both programs simultaneously.**
1932(a)(2)(C) when 42 CFR 438(d)(2)	ii. __X__ Indians who are members of Federally recognized Tribes except the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) Supplemental 42 CFR 438.50(d)(3)(i)	iii. __X__ Children under the age of 19 years, who are eligible for Security Income (SSI) under title XVI.

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	Only children who are in this mandatory exempt group and fall into the Aid to the Needy Disabled/Aid to the Blind (AND) eligibility group will be passively enrolled into the ACC Payment Reform Program.
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.
	Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.
1932(a)(2)(A)(v) of- 42 CFR 438.50(3)(iii)	v. _X_ Children under the age of 19 years who are in foster care or other out- the-home placement.
	Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. __X__ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
	Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.
1932(a)(2)(A)(ii) a 42 CFR 438.50(3)(v)	vii. _X_ Children under the age of 19 years who are receiving services through 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.
	Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.

Citation	Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

E. Identification of Mandatory Exempt Groups

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

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

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
_X_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.

__X_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;

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	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.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*
	i. Recipients who are also eligible for Medicare.
	Not applicable. Enrollment is not mandatory.
	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

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

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.

Not applicable. Enrollment is not mandatory.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Not applicable. Enrollment is not mandatory.

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

The following eligibility groups will be permitted to enroll on a voluntary basis within participating counties:

1) **Old Age Pension (Age 65+)**
2) **Aid to the Needy Disabled/Aid to the Blind - Supplemental Security Income without regard to age**
3) **MAGI Parents/Caretakers**
4) **MAGI Pregnant Women**
5) **MAGI Adults**
6) **Working Adults with Disabilities (Adult Buy-In)**

H. Enrollment process.

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). **Clients enrolled in the Program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider with whom they already have a relationship. If that provider is not part of the Program, RMHP will request that the provider enroll.** ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). **RMHP works with the State to recruit providers that have traditionally served Medicaid recipients to be a part of the 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.)*

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

Enrollment is voluntary, clients may choose among available MCOs and PCCMs in their geographic region, there is no cap on enrollment into any MCO or PCCM in the 7 counties so there is no need to monitor an equitable distribution. A list of the available options is included in the enrollment letter and packet sent to Medicaid clients who are passively enrolled into the 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:

   i. The state will X /will not ____ use a lock-in for managed care.

   Clients are locked into the ACC Payment Reform Program, but are not locked into specific providers within the Program network.

   ii. 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 at least 30 days before they are enrolled. After the date of effective enrollment, the client has another 90 days to disenroll. Thus, all clients have a total of 120 days to disenroll before they are locked in to the program.

   The initial lock in period starts 90 days after the effective enrollment date and lasts until the beginning of their birth month. The subsequent lock in period starts at the beginning of the client's birth month and lasts for 12 months. An open enrollment period begins 60 days prior to the clients' birth month each year. If the client disenrolls during the open enrollment period, the disenrollment will be effective at the beginning of their birth month.

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	The notification 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 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, 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 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.)*
	The Program will enroll clients with the appropriate eligibility category and who live in a participating county. The clients are currently in the ACC, in RMHP's PIHP (which is sun setting) or are receiving fee-for-service Medicaid. Enrollment in the Program will not affect clients passively enrolled into other managed care plans. Clients in the participating counties and in the applicable eligibility categories will be enrolled in the Program instead of the standard ACC.

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

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 enrollment through monthly reports generated by the enrollment broker.

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. _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.

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

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

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

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

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

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

5. _X_ 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. Disenrollment

1. The state will _X_/will not___ use lock-in for managed care.

2. The lock-in will apply for __**up to12**__ months (up to 12 months).

3. Place a check mark to affirm state compliance.

__X__The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   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 Program, or the choice of or assignment to the provider, was in error.**
   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

____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

Citation	Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

42 CFR 438.10

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)
1905(t)

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

All services and benefits including drugs covered in the state plan are included in the MCO program, either as part of the capitation payment or as wrap-around fee-for-service payments.

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 X /will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. 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 State limits the number of contracted entities based upon the competitive selection process established in State House Bill 12-1281. The criteria for selection were extensive, and were included in the GFP.

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

4. ____ The selective contracting provision in not applicable to this state plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS-10120 (exp. 01/31/2008)