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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-15-0038

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
1961 Stout Street, Room 08-148
Denver, CO 80294

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region VIII

January 21, 2016

Susan E. Birch, MBA, BSN, RN, Executive Director
Department of Health Care Policy & Financing
303 East 17th Avenue, 7th Floor
Denver, CO 80203

RE: Colorado #15-0038

Dear Ms. Birch:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 15-0038. This amendment is creating a limited benefit managed care program.

Please be informed that this State Plan Amendment was approved today with an effective date of April 1, 2016. We are enclosing the CMS-179 and the amended plan page(s).

In order to track expenditures associated with this amendment, Colorado should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage report on the Form CMS-64.9VIII and those not enrolled in the new adult group, claims should be reported on the Form CMS-64.9 Base.

This amendment would affect expenditures reported on Line18A - Medicaid Health Insurance Payments: Managed Care Organizations.

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

Sincerely,

[redacted]

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

cc: Gretchen Hammer
Tess Ellis
Pat Connally
John Bartholomew
Barb Prehmus
Amanda Forsythe

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: **15-0038**

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:
April 1, 2016

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 2015-16: **$ 0.00**
b. FFY 2016-17: **$ 0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-F – ACC: Access Kaiser
Section 5 ACC: Access Kaiser Program

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
NEW

10. SUBJECT OF AMENDMENT
Creating a limited benefit managed care program.

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

GOVERNOR'S OFFICE REPORTED NO COMMENT

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED

Governor's letter dated 15 January 2015

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Gretchen Hammer

14. TITLE
Medicaid Director

15. DATE SUBMITTED
Original Submission: 10/27/2015
Resubmitted: 01/15/2016

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

Attn: Barbara Prehmus

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED **October 27, 2015**

18. DATE APPROVED **January 21, 2016**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

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 5: ACC: ACCESS KAISER 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 mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

The State of Colorado enrolls Medicaid beneficiaries on a voluntary basis into this MCO program under section 1932(a)(1)(A) of the Act.

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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒MCO
   a. ☒Capitation

2. ☐PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. ☐PCCM (entity based)
   a. ☐ Case management fee

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

b. ☐ Bonus/incentive payments
c. ☐ Other (please explain below)

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. 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.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

☐d. Incentives will be made available to both public and private PCCMs.

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, 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.)*

Since 2012, the Department has been engaging stakeholders in conversations about payment reform initiatives to be implemented within the Accountable Care Collaborative (ACC) Program. This is the second payment initiative. Specific to this initiative, the Department engaged its ACC Program Improvement Advisory Committee (PIAC) and the Provider and Community

Citation	Condition or Requirement
	SECTION 5: ACC: ACCESS KAISER PROGRAM
	Issues sub-committee; consulted with tribal governments; and served Public Notice through the Colorado Register. Ongoing stakeholder engagement and public involvement will occur through the existing ACC PIAC stakeholder structure and also through a public committee the MCO is contractually required to develop and manage.
	D. State Assurances and Compliance with the Statute and Regulations.
	If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ☒The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 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. ☒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 Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. ☒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)	5. ☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

Citation	Condition or Requirement
SECTION 5: ACC: ACCESS KAISER PROGRAM	
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7. ☒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) CFR 447.362 42 CFR 438.50(c)(6)	8. ☐The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9. ☒The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)			X	Adams, Arapahoe, Douglas counties	
Section 1931 Adults & Related Populations1905(a)(ii)			X	Adams, Arapahoe, Douglas counties	
Low-Income Adult Group			X	Adams, Arapahoe, Douglas counties	
Former Foster Care Children under age 21			X	Adams, Arapahoe, Douglas counties	
Former Foster Care Children age 21-25			X	Adams, Arapahoe, Douglas counties	
Section 1925 Transitional Medicaid age 21 and older			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)			X	Adams, Arapahoe, Douglas counties	
Poverty Level Pregnant Women – 1905(a)(viii)			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Disabled children under age 18			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)			X	Adams, Arapahoe, Douglas counties	

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI and SSI Related Aged Populations age 65 or older-1905(a)(iii)			X	Adams, Arapahoe, Douglas counties	
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)			X	Adams, Arapahoe, Douglas counties	
Recipients Eligible for Medicare			X	Adams, Arapahoe, Douglas counties	
American Indian/Alaskan Natives			X	Adams, Arapahoe, Douglas counties	
Children under 19 who are eligible for SSI			X	Adams, Arapahoe, Douglas counties	
Children under 19 who are eligible under Section 1902(e)(3)			X	Adams, Arapahoe, Douglas counties	
Children under 19 in foster care or other in-home placement			X	Adams, Arapahoe, Douglas counties	
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)			X	Adams, Arapahoe, Douglas counties	
Other					

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

☐ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

☒Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program
Recipients enrolled in any physical health managed care program are excluded from this program. However, all recipients should simultaneously be enrolled in a BHO and this program. Enrollment with a BHO is not grounds for exclusion.

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

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

☒ Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☒ Other (Please define):
Recipients enrolled in Medicare are excluded from this program.

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. ☐ The applicant is permitted to select a health plan at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence.*)

b. ☒ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.
Clients are enrolled in the program through a passive enrollment process. The State's enrollment broker sends the Medicaid client an enrollment letter at least thirty (30) days prior to their enrollment date. The letter informs the client that they can opt-out of this program for an additional ninety (90) days after their enrollment date.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
The beneficiaries will receive a member handbook within thirty (30) days of receiving the enrollment notice. The member handbook and the enrollment letter materials cover all of the requirements in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).
Default assignment will occur for the initial enrollment for this program. This default assignment process will function as a passive enrollment process in which all beneficiaries will have the ability to opt-out for at least thirty (30) days prior to enrollment and for another sixty (60) days after enrollment. All beneficiaries currently enrolled in the Accountable Care Collaborative (ACC) program in Adams, Arapahoe, and Douglas counties that are attributed to Kaiser Permanente as their primary care medical provider will be disenrolled from that program and enrolled into the ACC: Access Kaiser

Citation | Condition or Requirement

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Program. This process will ensure existing provider-beneficiary relationships are preserved as required in 42 CFR 438.50(f).

After the one-time initial enrollment, beneficiaries will only be enrolled if they meet an appropriate eligibility category, live in a participating county, and proactively call the State contracted enrollment broker to opt-in to this program.

iv. The state's process for notifying the beneficiary of the default assignment. **The State's enrollment broker sends the Medicaid client a letter notifying them of the State's intent to enroll them into the program**

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence.*)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

1932(a)(4)
42 CFR 438.50

3. 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.

a. ☒The state assures it has an enrollment system that allows Beneficiaries 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.

b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒This provision is not applicable to this 1932 State Plan Amendment.
There are no rural counties in this program.

d. ☒ 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 438.56

G. Disenrollment.

1. The state will☒/will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for twelve months (up to 12 months).

Clients may disenroll from this program during the annual open enrollment period. The annual open enrollment period is the two months prior to the clients birth month.

3. ☒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 the state's process for notifying the Medicaid Beneficiaries 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 ninety (90) days of the client's enrollment into the program.

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

Citation	Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

a) **If the temporary loss of eligibility has caused a beneficiary to miss the annual disenrollment opportunity, the beneficiary may disenroll within sixty (60) days of regaining eligibility and enrollment into the program.**
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.**

H. Information Requirements for Beneficiaries

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

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

1932(a)(5)(D)(b)

I. List all benefits for which the MCO is responsible.
The benefits are defined at the procedure code level and are listed in the Contract between the State and MCO.

1903(m)
1905(t)(3)

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☒The state assures that each managed care organization has established an internal grievance procedure for enrollees.

1932(a)(5)(D)(b)(5)

K. Describe how the state has assured adequate capacity and services.
The State has assured adequate capacity and services by assessing the current provider network capacity in the region and the number of currently attributed beneficiaries. These will be the same beneficiaries enrolled in this program and they will stay with their current provider. Also, the State contract with the MCO requires the MCO to maintain adequate capacity and services.

42 CFR 438.206
42 CFR 438.207

1932(a)(5)(D)(c)(1)(A)
42 CFR 438.240

L. ☒The state assures that a quality assessment and improvement strategy has been developed and implemented.

Citation	Condition or Requirement
	SECTION 5: ACC: ACCESS KAISER PROGRAM
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M. ☒The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.
1932 (a)(1)(A)(ii)	N. 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.)* **The State will only contract with the Region 3 Regional Care Collaborative Organization, Colorado Access, through a Provider Services contract.** 4. ☐The selective contracting provision in not applicable to this state plan.

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SECTION 5: ACC: ACCESS KAISER PROGRAM

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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. 3/31/2014)