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## Table of Contents

**State/Territory Name:** Colorado

**State Plan Amendment (SPA) #:** CO-16-0002

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



**Region VIII**

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August 30, 2016

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

RE: Colorado #16-0002

Dear Ms. Birch:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 16-0002. The amendment makes a technical correction to the PACE rates and payment language, as requested by CMS. Additionally, the amendment revises the frequency of payment reconciliation for PACE from quarterly to annually.

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).

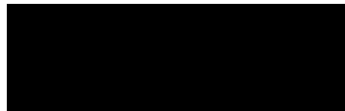
In order to track expenditures associated with this amendment, Colorado should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage report on the Form CMS-64.9 VIII 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 Line 22 – Programs Of All-Inclusive Care Elderly.



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

Sincerely,



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

cc: Gretchen Hammer      John Bartholomew  
Pat Connally              Amanda Forsythe

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  16-0002	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 ( <i>Check One</i> ):  NEW STATE PLAN                      AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION:  Section 1905(a)(26) of the Social Security Act; 42 CFR Part 460		7. FEDERAL BUDGET IMPACT a. FFY 2015-16: <u>  \$0.00  </u> b. FFY 2016-17: <u>  \$0.00  </u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Supplement 3 to Attachment 3.1-A—Program of All-Inclusive Care (PACE) (Pages 7-8 of 8)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Supplement 3 to Attachment 3.1-A—Program of All-Inclusive Care (PACE) (Pages 7-8 of 8) (TN 13-043)	
10. SUBJECT OF AMENDMENT: The amendment makes a technical correction to the PACE rates and payment language, as requested by CMS. Additionally, the amendment revises the frequency of payment reconciliation for PACE from quarterly to annually.			
11. GOVERNOR'S REVIEW ( <i>Check One</i> )  GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED  COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Governor's letter dated 15 January, 2015 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818  Attn: Barbara Prehmus	
13. TYPED NAME:  Gretchen M. Hammer			
14. TITLE:  Medicaid Director			
15. DATE SUBMITTED:  June 13, 2016			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED                      June 13, 2016		18. DATE APPROVED                      August 30, 2016	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL  April 1, 2016		 FICIAL	
21. TYPED NAME  Richard C. Allen		22. TITLE  ARA, DMCHO	
23. REMARKS			

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**PACE State Plan Amendment (Page 7 of 8)**

2. \_\_\_ Experience-based (contractors/State's cost experience or encounter data)  
(please describe)
3. \_\_\_ Adjusted Community Rate (please describe)
4. X Other (please describe)

The State uses three steps to determine PACE rates: (1) calculate the maximum per-member-per-month amount based on what it would cost to serve PACE clients through fee-for-service, (2) negotiate below the upper payment limit (UPL); and (3) adjust rates to allow for patient payment. The steps are described below.

*Calculating the Maximum Allowable Per-Member-Per-Month Rate*

The State calculates capitation rates annually for PACE based on historical fee-for-service expenses for an actuarially equivalent population of Medicaid clients who are 55 years of age and older, who require a nursing facility level of care. The State includes in this analysis only those clients who are eligible for full Medicaid benefits.

The State compiles the base data by selecting fee-for-service claims for these clients who meet the above criteria during the two most recent fiscal years of data available. The State uses all claims for all state plan service categories, because PACE rates are designed to cover all state plan services.

Only Fee-for-Service claims that were actually paid are included in the analysis to create a historical per-member-per-month rate. The State also removes from the analysis any payments made by pharmacy rebates or third party insurance, and takes into account any other payment adjustments that were made during the two fiscal years under consideration.

Using this historical rate, the State forecasts costs to create a prospective rate. The State takes into consideration both trends (consistent increases or decreases in certain service categories) and any upcoming policy changes that might change utilization and costs. The result of this analysis is a proposed maximum per-member-per-month rate. This amount is also considered the UPL.

*Negotiating Below the UPL*

To ensure that the State pays under the UPL per the CMS checklist, the State negotiates a rate below the UPL with the PACE providers. This is the rate used to pay PACE organizations.

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*Adjusting for Patient Payment*

The total PACE rate is the combination of fee-for-service claims experience paid by the State plus fee-for-service patient contributions as calculated through the Post Eligibility Treatment of Income (PETI) process. Actual final payment to the PACE provider is that rate less each PACE enrollee's payment contribution. The State makes interim estimated payments based upon expected average patient contribution but reconciles these estimated amounts based upon actual reported contributions on an annual basis, as data becomes available.

- B.   X   The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. At the Department's request, the most recent PACE rates were certified. The Department will furnish contact information for its actuaries upon request.
- C.      The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between Colorado Benefits Management System (CBMS) and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system.