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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-16-0015

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

June 22, 2017

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 #16-0015

Dear Ms. Birch:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 16-0015. This Amendment would allow the Accountable Care Collaborative authority to contract with primary care case managers and pay for performance payments.

Please be informed that this State Plan Amendment was approved today with an effective date of November 11, 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.

Case management fees and incentive payments should be reported on the Form CMS-64.9 Base, Line 25 – Primary Care Case Management Service and fee-for-service payments should be reported on the appropriate service type line.

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
John Bartholomew
Amanda Forsythe
David DeNovellis

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: 16 – 0015

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: November 11, 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:
SOCIAL SECURITY ACT 1932(a) / 42 CFR 438 and 440

7. FEDERAL BUDGET IMPACT:
a. FFY 2016-17: $ 0
b. FFY 2017-18: $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F – Section 1 (ACC), Page 1-15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
- Attachment 3.1-F – Section 1 (ACC), Page 1-4 (TN 13-003)
- Attachment 3.1-F – Section 1 (ACC), Page 5-8 (TN 14-004)

10. SUBJECT OF AMENDMENT:
Accountable Care Collaborative authority to contract with primary care case managers and pay for performance payments.

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

GOVERNOR'S OFFICE REPORTED NO COMMENT | X 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: [redacted]

13. TYPED NAME: Gretchen Hammer

14. TITLE: Medicaid Director

15. DATE SUBMITTED: March 23, 2017 (update #1)
Initial: 12/29/2016 Updated: June 22, 2017 (update #2)

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 29, 2016

18. DATE APPROVED: June 22, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: November 11, 2016

[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

01932(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 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)

PCCM (individual practitioners) will receive fee-for-service payments for claims submitted.

3. ☒PCCM (entity based)
   a. ☒ Case management fee
   b. ☒ Bonus/incentive payments
   c. ☐ Other (please explain below)

Citation	Condition or Requirement

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.

The following conditions apply to incentive payments for PCCMs in the Accountable Care Collaborative program:

a. Incentives are based upon measures that are attributable to positive change in utilization or costs, improvement in health outcomes and/ or greater value to the State. The State has two types of incentive payments. One is for clinical/utilization metrics and performance and another is for activities that provide greater value to the State. The State determines the measurement areas for the fiscal year (July – June), and communicates these to the PCCMs in writing. .

b. Prior to the start of each state fiscal year, the State determines the baseline against which performance is measured, for those measures that require an established baseline.

Citation	Condition or Requirement

c. The State pays any earned incentive payments for utilization/cost metrics, referred to as Key Performance Indicators, to the PCCM on a quarterly basis within 180 days from the last day of the quarter in which the incentive payment was earned. The State calculates the incentive payment as of the end of each quarter, based off performance from the prior 12 months. . The State also pays for activities that drive greater value, this may include incentives tied to targeted program performance areas selected by the State, practice transformation activities, or alignment with other initiatives including the Comprehensive Primary Care Plus initiative (these incentive payments will not be made until after the implementation of this initiative which is January 1, 2017). These incentive payments will be made quarterly by the last day of each quarter unless the data to calculate the payment is not available. In this case the payment will be made within 180 days of receipt of data necessary to conduct analysis for payment.

d. The PCCM receives an incentive payment only for those targets the PCCM reaches during the measurement period. The PCCM does not have to pay PMPM moneys back to the State for adverse results.

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.)*

In 2009, the Department hosted public forums to obtain input and advice about the ACC program. In addition, the Department established, and continues to hold, 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.

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

Citation	Condition or Requirement
	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.

Citation		Condition or Requirement
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.
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

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	Statewide	
Section 1931 Adults & Related Populations1905(a)(ii)			x	Statewide	
Low-Income Adult Group			x	Statewide	
Former Foster Care Children under age 21			x	Statewide	
Former Foster Care Children age 21-25			x	Statewide	
Section 1925 Transitional Medicaid age 21 and older			x	Statewide	
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)			x	Statewide	
Poverty Level Pregnant Women – 1905(a)(viii)			x	Statewide	
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)			x	Statewide	
SSI and SSI related Disabled children under age 18			x	Statewide	
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)			x	Statewide	
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)			x	Statewide	

Citation Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)			x	Statewide	
Recipients Eligible for Medicare			x	Statewide	
American Indian/Alaskan Natives			x	Statewide	
Children under 19 who are eligible for SSI			x	Statewide	
Children under 19 who are eligible under Section 1902(e)(3)			x	Statewide	
Children under 19 in foster care or other in-home placement			x	Statewide	
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	Statewide	
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).

☒Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

Citation	Condition or Requirement

Individuals enrolled in any physical health managed care program, including the Program for All Inclusive Care for the Elderly (PACE) are excluded from this program. However, all individuals should simultaneously be enrolled in a Behavioral Health Organization (BHO) and this program. Enrollment in 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):

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.

Citation | Condition or Requirement

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).

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.

The State's enrollment broker sends the Medicaid client a letter notifying them of the State's intent to enroll them into the ACC program. Clients are notified of the State's intent to enroll them into a program 30 days before they are enrolled. 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.

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

The State's enrollment broker sends the Medicaid client a letter/packet notifying them of the State's intent to enroll them into the ACC program. The letter includes instructions for disenrolling within the first 90 days of the client's enrollment into the program. This letter/packet also describes other options

Citation	Condition or Requirement

available, including managed care plan, the fee-for-service option, and any other available program.

The State's enrollment broker provides a member handbook that includes other information required in 42 CFR 438.10(e). This member handbook is also available on the State's website.

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).

Enrollment to a PCCM entity 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.

The State will initially assign a PCCM (Primary Care Medical Provider) based on which provider was the main source of Medicaid care for the client during the previous year. 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 entity will request that the provider enroll.

The state monitors rates of enrollment through monthly reports generated by the enrollment broker.

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 ACC program. 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.

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

Citation	Condition or Requirement

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

Clients will be given the choice of at least two primary care medical providers (PCMPs).

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.

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.

Citation	Condition or Requirement

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).

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 ACC program also includes instructions for disenrolling within the first 90 days of the client's enrollment into the program.

5. 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.
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)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

Not applicable, this is a PCCM and not an MCO.

Citation		Condition or Requirement
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) 42 CFR 438.206 42 CFR 438.207	K.	Describe how the state has assured adequate capacity and services. **Not applicable, this is a PCCM and not an MCO.**
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. The State will assure compliance with this requirement when effective for PCCM entities.
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. The State will assure compliance with this requirement when effective for PCCM entities.
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.)*

Citation	Condition or Requirement

The State limits the number of PCCM entities that serve as Regional Care Collaborative Organizations (RCCOs). To maximize collaboration within the community, the program is designed to have one RCCO in each area of the state. RCCO selection was done as a competitive procurement. The criteria for selection are extensive, and are included in the Request for Proposals.

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

Citation	Condition or Requirement

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)