REQUEST FOR INFORMATION

Accountable Care Collaborative

DRAFT RFP Release - Appendices

Released: November 4, 2016

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY.
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Appendices List

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Appendices List

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Appendix F
Client Enrollment and Attribution

To ensure that clients can quickly benefit from the ACC and that Regional Accountable Entities (RAEs) and Health Neighborhood providers can more seamlessly connect with clients, the Department is making several significant changes to how Medicaid clients are enrolled into the ACC, attributed to Primary Care Medical Providers (PCMPs), and assigned to RAEs. There are three main components of the Department's enrollment plan:

1. All Medicaid enrollees will be mandatorily enrolled into the ACC;
2. All ACC members will be immediately attributed or assigned to a PCMP; and
3. All clients will be assigned to a RAE based upon who their PCMP is.

1. Mandatory ACC Enrollment

- The Department will mandatorily enroll all full-benefit Medicaid beneficiaries into the ACC at the time of Medicaid enrollment.
- Enrollment into the ACC will occur daily and will be effective on the day in which the enrollee becomes eligible for Medicaid.
- Clients will be automatically reenrolled in the ACC when they lose and regain Medicaid eligibility.

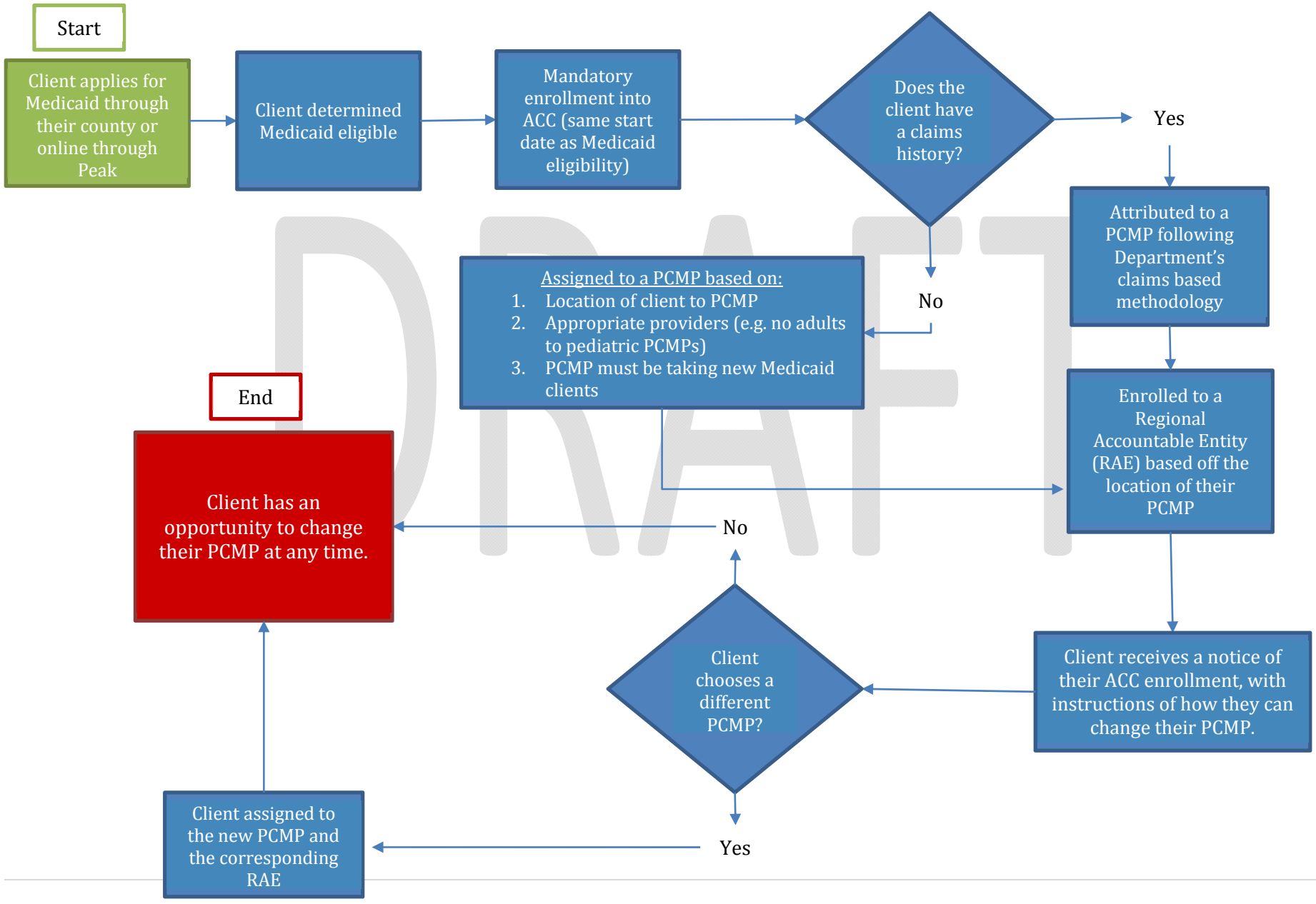
2. PCMP Attribution and Assignment

- All ACC clients will be immediately be attributed or assigned to a PCMP, upon being determined eligible for the ACC. The Department will attribute or assign clients using the following three methods:
    1) Claims-based attribution methodology – the Department will use historical claims data to identify the PCMP that the client has seen the most often during the past 12 months.
    2) System Assignment methodology - In the absence of any claims history for the client or family member, the Department will assign the client to a PCMP based on three factors: 1) proximity of the PCMP to the client's residence; 2) PCMP appropriateness; and 3) PCMP performance.
    3) Client choice – all clients will receive notice of their enrollment into the ACC and have the opportunity to change their PCMP at any time.

3. RAE Assignment

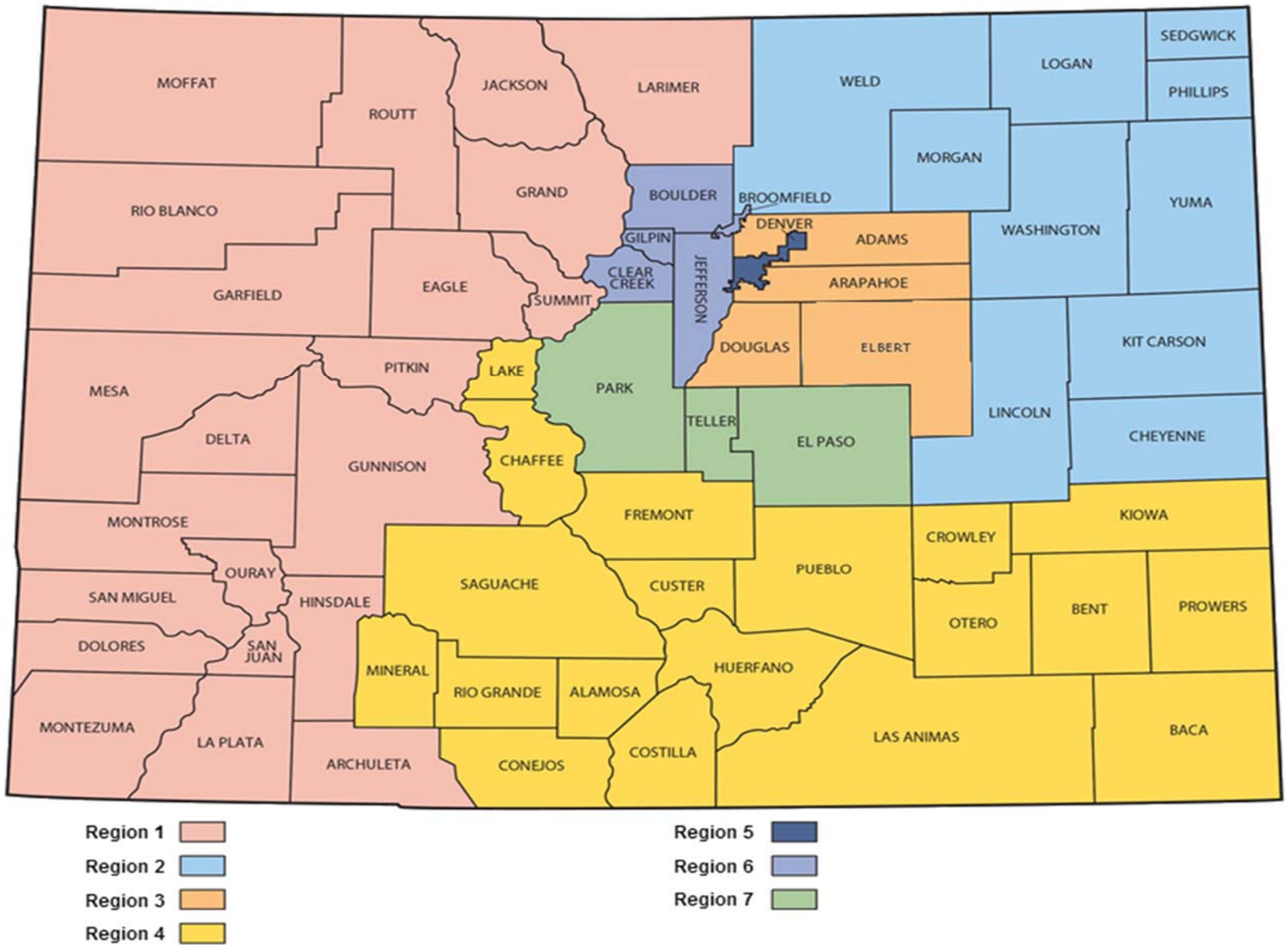
- All clients will be automatically assigned to a RAE based upon who the client's PCMP is.
- A PCMP's RAE will be determined by the geographic location of the practice. Each practice location will be treated as a single PCMP.
    - For example, if client resides in Denver County, but is attributed to a PCMP in Adams County, he/she will be attributed to the RAE whose catchment area includes Adams County.
- All PCMPs will be contracted with only one RAE.

ACC Enrollment Flowchart



APPENDIX G

Regional Map and Enrollment Assessment



APPENDIX G

Regional Map and Enrollment Assessment

Enrollment Estimates by RAE

RCCO or RAE	Count of current ACC enrolled clients by RCCO	Count ACC enrolled clients attributed to a PCMP by RCCO	Count of current PCMPs by RAE (based on provider location county)	Count of current PCMP attributed clients by PCMP's RAE (clients assigned to a RAE based on their PCMP's county)	Count clients not currently ACC enrolled by future RAE	Count of ACC eligible clients by future RAE (using future ACC enrollment criteria)
1	133,587	101,469	140	108,044	63,897	198,140
2	76,281	62,882	43	54,598	16,902	92,378
3	232,335	170,752	105	145,006	80,741	314,711
4	113,383	95,804	90	95,232	19,337	132,828
5	104,909	81,988	69	123,378	96,409	210,673
6	128,993	98,662	85	83,418	29,290	149,942
7	164,123	129,814	78	132,571	26,760	188,235
Total	**953,611**	**741,371**	**610**	**742,247**	**333,336**	**1,286,907**

A client would be counted in RAE 1 for the following reasons:

- If the client requested their current PCMP (and are RCCO enrolled), and the PCMP is assigned to RAE 1 based on the PCMPs location
- If the client did not request their current PCMP (and are RCCO enrolled), and live in RAE 1
- If the client does not have a current PCMP (and are RCCO enrolled), and live in RAE 1
- Any Medicaid eligible client that is not RCCO enrolled, has full Medicaid eligibility, are not enrolled in PACE, and live in RAE 1

Clients currently enrolled in a managed care program other than PACE are included in the future RAE enrollment numbers

APPENDIX H
Health Needs Survey Questions

These questions would be asked of each client at the time of Medicaid enrollment
Some questions would be optional, based on the client's response to previous questions in their Medicaid application.

1) **Have you ever been told that you have one of the following health conditions?**
- Asthma
- Diabetes
- Heart Disease
- High Blood Pressure
- Mental or Behavioral Health Condition
- Other

2) **Do you need help managing your health condition? OR IF NO CONDITIONS ARE SELECTED, do you need help managing your health?**
- Yes
- No

    a. **IF YES, What kind of help?**
    - Information/education
    - Finding a provider
    - Medication management
    - Transportation
    - Other

3) **In the past 12 months how many times have you been hospitalized or gone to the emergency department?**
- None
- 1-3
- 4 or more

4) **Are you pregnant? (OPTIONAL)**
- Yes
- No

5) **Would you like help with family planning (education on number of children and spacing, birth control, treatment for sexually transmitted diseases)?**
- Yes
- No

6) **Do you need or want help with other resources?**
- Housing resources
- Food Assistance
- Other

APPENDIX H
Health Needs Survey Questions

7) Do you have a child with special health care needs?
- Yes
- No

8) Do you have any concerns about your child?
- Growth/Development
- Learning
- Behavior
- Self-care/Doing things for themselves
- Weight (underweight or overweight)

9) What are your top health goals this year (choose up to 3)?
- Eat better
- Exercise more
- Quit smoking
- Learn how to stay healthy
- Reduce stress or depression
- Avoid alcohol and other drugs

Following 3 questions asked for each goal chosen:

10) How important is [eating better, exercising more, etc.] to you right now?
- Not important
- Important
- Very important

11) How confident are you about [eating better, exercising more, etc.] this year?
- Not confident
- Confident
- Very confident

12) Would you like help meeting this goal?
- Yes
- No

APPENDIX I
Population Health Management Plan

RAE Name:
Region:
Date Submitted:

PEDIATRIC

Stratification Methodology – Please describe the steps you will take to stratify your population.

1.
2.
3.
4.
5.

Please answer the following questions about the Stratification Methodology:

a) What is the schedule to run the stratification?

b) What event or condition would prompt re-stratification?

c) What method will be used to identify individuals who change from one stratification level to another?

APPENDIX I
Population Health Management Plan

Pediatric Interventions

Stratification Level	**INSTRUCTIONS** for completing the table below: 1) List each population group identified as part of your Stratification Methodology in the Stratification Level column; e.g., healthy, non-users; members with special health care needs, etc. 2) Identify each Intervention that is part of the Contractor's Population Health Management Plan in the column headers (see example below). 3) Place a checkmark in the cell indicating which interventions will be used for each stratification level.											
	Wellness Mailing	HRA	Birth Control Text Reminder	Diabetes Prevention Mailing	Care Coordination							
Healthy, non-user	✓	✓										
Members aged 15-20	✓	✓	✓									
Members with Special Health Care Needs	✓	✓			✓							

APPENDIX I
Population Health Management Plan

Description of Interventions: (Please fill out one box for each Intervention)

Name of Intervention:

Description:

Please check one of the following three options

- ☐ Evidence-Based:
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined:

How the method of delivering the intervention will be determined:

Potential outcomes:

APPENDIX I
Population Health Management Plan

RAE Name:
Region:
Date Submitted:

ADULT

Stratification Methodology – Please describe the steps you will take to stratify your population.

1.
2.
3.
4.
5.

Please answer the following questions about the Stratification Methodology:

a) What is the schedule to run the stratification?

b) What event or condition would prompt re-stratification?

c) What method will be used to identify individuals who change from one stratification level to another?

APPENDIX I
Population Health Management Plan

Adult Interventions

Stratification Level	**INSTRUCTIONS** for completing the table below: 1) List each population group identified as part of your Stratification Methodology in the Stratification Level column; e.g., healthy, non-users; members with special health care needs, etc. 2) Identify each Intervention that is part of the Contractor's Population Health Management Plan in the column headers (see example below). 3) Place a checkmark in the cell indicating which interventions will be used for each stratification level.											
	Wellness Mailing	HRA	Birth Control Text Reminder	Diabetes Prevention Mailing	Care Coordination							
Healthy, non-user	✓	✓										
Members with Special Health Care Needs	✓	✓			✓							

APPENDIX I
Population Health Management Plan

Description of Interventions: (Please fill out one box for each Intervention)

Name of Intervention:

Description:

Please check one of the following three options

- ☐ Evidence-Based:
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined:

How the method of delivering the intervention will be determined:

Potential outcomes:

APPENDIX J
Stratification Report

RAE Name:

Region:

Date Run:

	Q1		Q2		Q3		Q4	
Stratification Level	Number of Members	% of Total Members	Number of Members	% of Total Members	Number of Members	% of Total Members	Number of Members	% of Total Members
Total								

Describe Changes in overall population Stratification:

APPENDIX K
Practice Support Tools and Resources

The Contractor shall make available a range of tools and resources to provide ongoing support and development for their Network Providers. The following lists are examples of the types of tools and resources that the Department expects the Contractor to provide to its Network Providers, but this is not an exhaustive list.

Example Medical Management Techniques:

Coordination with the Department's utilization management contractor to detect inappropriate utilization of services.

Integrating disease management into the care of Members with multiple chronic conditions.

Catastrophic case management.

Coordination of medical services for Members with serious, life-changing, and possibly life-threatening, illnesses and injuries.

Technologically enhanced communication, such as cell phone messages, email communication and text messaging.

Providing PCMPs with tools and resources to support informed medical decision-making with Members.

Alternate formats for delivering care.

Methods for diversion to the most appropriate care setting.

Clinical and Operational Tools:

Clinical care guidelines and best practices.

Clinical screening tools, such as depression screening tools and substance use screening tools.

Health and functioning questionnaires.

Chronic care templates.

Registries.

Shared decision making tools.

Member reminders.

Self-management tools.

Educational materials about specific conditions.

Member action plans.

Behavioral health surveys and other self-screening tools.

APPENDIX K
Practice Support Tools and Resources

Guidance and education on the principles of the Medical Home.

Training on providing culturally competent care.

Training to enhance the health care skills and knowledge of supporting staff.

Training to enhance delivery of team-based care.

Training for delivering integrated care.

Guidelines for motivational interviewing.

Guidelines for health coaching.

Tools and resources for phone call and appointment tracking.

Tools and resources for tracking labs, referrals and similar items.

Referral and transitions of care checklists.

Visit agendas or templates.

Standing pharmacy order templates.

Practice redesign.

Operational efficiency enhancements

Expanded provider network directory.

Comprehensive directory of community resources.

Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line.

Link from the Contractor's website of centrally located tools and resources to the Colorado Medicaid website.

APPENDIX L
Colorado Client Assessment Record

The Contractor's provider network shall comply with the current Colorado Client Assessment Record (CCAR) policy which is as follows:

An "admission" CCAR must be completed upon a Member receiving:

Six (6) or more brief integrated mental and physical health service encounters during any continuous six-month period.

Four (4) or more mental health service encounters during any continuous six-month period in a non-integrated care setting.

The exempt procedure codes listed below do not count toward the total number of services received within a six-month period.

Providers may voluntarily administer CCARs to Members who receive fewer than four (4) service encounters.

The Contractor shall submit an electronic file of all completed CCAR tools to the Department and/or designee (e.g., Office of Behavioral Health) in a format determined by the Department or its designee. If changes to the CCAR are made, the Contractor shall implement all changes. At the Department's request, the Contractor shall participate and collect the Drug/Alcohol Coordinated Data System (DACODS) for Members with a substance use disorder diagnosis.

Procedure Codes Exempt from the CCAR

97535	Self-care management training
97537	Community/work reintegration
H0002	Behavioral health screening
H0023	Alcohol and/or drug outreach
H0025	Alcohol and/or drug prevention
H0038	Self-help/peer svc per 15mm
H 2015	Comp comm supp svc, 15 mm
H 2016	Comp comm supp svc, per diem
H2027	Psycho-ed svc, per 15 mm (non clinician only)
H2030	MI-I clubhouse svc, per 15 mm
H2031	MH clubhouse svc, per diem
S9453	Smoking cessation class
S9454	Stress mgmt class

Appendix M
Primary Care APM

As part of the Department of Health Care Policy & Financing's (Department) efforts to shift providers from volume to value, the Department is developing a structure to make differential fee-for-service payments to give providers greater flexibility, reward performance while maintaining transparency and accountability, and create alignment across the delivery system. Under the proposed model, providers can earn higher reimbursement (when designated as meeting specific criteria) as they implement and achieve more Advanced criteria. Movement along this framework not only encourages higher organizational performance but also helps the Accountable Care Collaborative (ACC) achieve its respective programmatic goals.

In developing the proposed framework, the Department cross-referenced with Departmental initiatives, such as CPC, CPC+, EPCMP, and SIM, as well as with National Committee for Quality Assurance (NCQA) standards for Patient-Centered Medical Homes (PCMHs). Please note this is a proposed framework intended for discussion. Also note that additional work is being done to align with CPC+ Track 2 – the framework described does not apply to that methodology.

Primary Care Alternative Payment Framework

Care Delivery Domain	**Payment Category**			**Outcomes/ Areas of Impact**
	Basic	*Enhanced*	*Advanced*	
Access to and Continuity of Care	1. 24 hour phone access 2. Primary care focus 3. Extended hours 4. Same day appts	1. Provider Empanelment (75%) 2. Accept new patients 3. 24 hour EHR access	1. Asynchronous communication 2. Provider Empanelment (95%)	1. Well child care 2. Depression screening 3. ER utilization 4. Other preventive screenings
Care Management	1. Preventive health screening 2. Medication management 3. Release of previous records	1. Population stratification: methods 2. Population stratification: care protocols 3. Registries 4. Shared care plan: patient 5. E-prescribing	1. Self-management goals	1. Appropriate asthma medications 2. HbA1c testing 3. Well child care 4. Depression screening 5. SUD screening
Team Based Care	1. Care team roles 2. Care team structure 3. Standing orders	1. Care team empanelment (75%)	1. Care team empanelment (95%) 2. QI trainings	1. HbA1c testing 2. Well child care

		2. Patient engagement trainings 3. Population health management trainings 4. Care team huddling	3. Shared care plans: provider	3. Depression screening 4. SUD screening 5. ED Visits for ambulatory care-sensitive conditions 6. CAHPS survey 7. ECHO survey 8. National Core Indicators survey
Health Neighborhood Care Coordination	1. Care compact: medical providers	1. Referral tracking 2. eConsult	1. Hospital F/U 2. ER F/U 3. Care compact: community partners	1. ED Visits for ambulatory care-sensitive conditions 2. Total cost of care
Behavioral Health Integration	1. BH preventive health screening 2. BH referrals	1. BH registry 2. BH share care plan: patient 3. BH shared decision making tool 4. Care compact: behavioral health providers 5. BH agency strategic measures 6. BH referral tracking	1. BH co-location 2. BH providers	1. Well child care 2. Depression screening 3. SUD screening
Patient Engagement and Experience	1. Process for soliciting patient feedback	1. Shared decision making tools 2. Patient satisfaction survey	3. Patient advisory group	1. CAHPS survey 2. ECHO survey 3. National Core Indicators Survey

Quality Improvement	1. Performs practice improvement activities	1. Agency strategic measures 2. Agency QI plan	1. Agency QI projects 2. Family and patient engagement in QI projects 3. QI project progress and communication	

Primary Care Alternative Payment Criteria

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Access and Continuity	24 hour phone access	Practices will provide patients with 24 hour, 7 day a week access to a provider or clinician.	Basic	Well Child Care; Depression Screening	CPC, CPC+, SIM	1B2
Access and Continuity	Primary care focus	Practices will focus their care models on wellness and prevention and will provide their patients access to primary care providers from the following specialties: Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn.	Basic	Well Child Care; Depression Screening	ACC 1.0	
Access and Continuity	Extended hours	Practices will provide patients with access to care and their provider/care teams outside of the standard working hours. At least one alternatively scheduled day a week.	Basic	Well Child Care; Depression Screening	CPC+, ACC 1.0	1A2
Access and Continuity	Provider empanelment (75%)	Practices will assign 75% patients to a provider who will serve as their primary point of care.	Enhanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2
Access and Continuity	Same day appointments	Practices will ensure timely access to care through integration and use of same day appointments.	Basic	Well Child Care; Depression Screening		1A1

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Access and Continuity	24 hour EHR access	Practices will provide patients with 24 hour, 7 day a week access to a provider or clinician who has real-time access to their medical records.	Enhanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	1B3
Access and Continuity	Provider empanelment (95%)	Practices will assign 95% patients to a provider who will serve as their primary point of care.	Advanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2
Access and Continuity	Accept new patients	Practices will take on new Medicaid patients as their care team capacity permits.	Enhanced	Well Child Care; Depression Screening	ACC 1.0	
Access and Continuity	Asynchronous communication	Practices will implement at least one form of asynchronous communication (patient portal, email, text messaging, etc.) and will set appropriate and timely follow-up standards.	Advanced	Well Child Care; Depression Screening	CPC, SIM	1A3, 1B3, 1C5
Care Management	Preventive health screening	Practices will regular screen patients for preventive health issues.	Basic	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	ACC 1.0	

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Care Management	Medication management	Practices will proactively manage and review each patient's respective medications.	Basic	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC, CPC+, SIM	4C
Care Management	Release of previous records	Practices will develop protocols and processes whereby they can request, receive, and send patient records from previous providers.	Basic	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening		5C
Care Management	Population stratification: methods	Practices will employ data-driven methods and tools (including BDIM) to risk stratify all empaneled patients.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC, CPC+, SIM, ACC 1.0	3D; 4A1
Care Management	Population stratification: care protocols	Practices will develop and implement care protocols for the specific risk pools within their population.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care;	CPC, CPC+, SIM, ACC 1.0	4A

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
				Depression Screening; SUD Screening		
Care Management	Registries	Practices will develop and implement patient registries to manage the care and outcomes of at least three specific patient populations.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	SIM, ACC 1.0	4A
Care Management	Shared care plan: patient	Practices will develop and monitor care plans with each patient that address relevant needs and that are shared across each patient's care team members.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC, CPC+, SIM, ACC 1.0	4B5
Care Management	E-prescribing	Practices will develop and implement technologies and partnerships that allow for electronic transmission of patients' prescriptions.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC	4D

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Care Management	Self-management goals	Practices will develop and monitor self-management goals with their respective patients.	Advanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	SIM	4B
Team Based Care	Care team roles	Practices will define the specific roles for care teams and integrate patient engagement, population health management, and quality improvement responsibilities in each role. These roles will ensure that all members are working to the top of their licenses.	Basic		SIM	2D
Team Based Care	Care team structure	Practices will define the composition of their agency's care teams. Care team members can include but are not limited to a provider, medical assistant, care coordinator, nurse, social worker, or behavioral health consultant.	Basic		SIM	2D
Team Based Care	Care team huddling	Practices will create spaces for care teams to meet and perform pre-visit planning. Meetings will include the care team	Enhanced	Well Child Care; Depression Screening; SUD Screening; HbA1c	SIM	2D

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
		members and any relevant staff, will discuss anticipated needs for the day or patient, and will occur on a consistent basis.		testing; ED Visits for Ambulatory Care Sensitive Conditions		
Team Based Care	Standing orders	Practices will develop and implement written protocols approved by an authorized practitioner that allow qualified clinicians to assess and administer certain clinical services, including vaccines, laboratory tests, and screenings.	Basic	Well Child Care; Depression Screening; SUD Screening; HbA1c testing	SIM	2D
Team Based Care	Care team empanelment (75%)	Practices will assign 75% patients to an interdisciplinary care team who will serve as their primary point of care. Care team members must include but are not limited to: medical provider, care coordinator, and behavioral health provider.	Enhanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2
Team Based Care	Patient engagement trainings	Practices will employ a common patient engagement curriculum across their agencies and provide consistent trainings for all staff in said curriculum. Curriculums must include topics on shared care plan development, motivational	Enhanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	SIM	2D

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
		interviewing, patient feedback surveys, etc.				
Team Based Care	Population health management trainings	Practices will employ a common population health curriculum across their agencies and provide consistent trainings for all staff in said curriculum. Curriculums must include topics on tools (registries, dashboards, etc), delivery systems (integrated care teams, care coordination, etc), and systems integration (community partnerships, integrated care models with external providers, etc).	Enhanced	Well Child Care; Depression Screening; SUD Screening; HbA1c testing; ED Visits for Ambulatory Care Sensitive Conditions	SIM	2D
Team Based Care	Care team empanelment (95%)	Practices will assign 95% patients to an interdisciplinary care team who will serve as their primary point of care. Care team members must include but are not limited to: medical provider, care coordinator, and behavioral health provider.	Advanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Team Based Care	QI trainings	Practices will employ a common performance improvement methodology across their agencies and provide consistent opportunities to train all staff in said methodology. Methodologies can be based on PDSAs, Lean/Six Sigma, Microsystems, etc.	Advanced		SIM	2D
Team Based Care	Shared care plans: provider	Practices will enact compacts with relevant partner practices, including one behavioral health practice, to grant access to their respective EHRs and their patients' respective medical records and care plans.	Advanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	SIM	2A4; 4B2/3
Health Neighborhood Care Coordination	Care compact: medical providers	Practices will enact care compacts with 1-3 relevant partner providers to track and coordinate care.	Basic	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	CPC, CPC+, SIM	4C; 5B
Health Neighborhood Care Coordination	Referral tracking	Practices will monitor the status of patient referrals between the practice and its respective partners.	Enhanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	SIM, ACC 1.0	5B2

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Health Neighborhood Care Coordination	Hospital F/U	Practices will follow up with 75% of hospitalized patients within 72 hours of discharge.	Advanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	CPC, CPC+, SIM	5C
Health Neighborhood Care Coordination	ER F/U	Practices will follow up with 75% of emergency room patients within one week of discharge.	Advanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	CPC, CPC+, SIM	5C
Health Neighborhood Care Coordination	Care compact: community partners	Practices will enact care compacts with 1-3 relevant community partners to refer and coordinate care.	Advanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	ACC 1.0?	4E
Behavioral Health Integration	BH preventive health screening	Practices will regular screen patients for behavioral health issues using a nationally recognized screening tool.	Basic	Well Child Care; Depression Screening; SUD Screening	SIM	3C
Behavioral Health Integration	BH referrals	Practices will provide access to behavioral health services through referrals to partner providers or internal services.	Basic	Well Child Care; Depression Screening; SUD Screening	SIM	5B/C
Behavioral Health Integration	BH registry	Practices will develop and implement patient registries to manage the care and outcomes of patients with behavioral health needs.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4A

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Behavioral Health Integration	BH shared care plan: patient	Practices will develop and monitor care plans with each patient that address behavioral health needs and that are shared across each patient's care team members.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4B5
Behavioral Health Integration	BH shared decision making tool	Practices will employ shared decision making tools for patients with behavioral health needs.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4E
Behavioral Health Integration	Care compact: behavioral health providers	Practices will enact care compacts with relevant behavioral health providers to track and coordinate care.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4C; 5B
Behavioral Health Integration	BH agency strategic measures	Practices will identify and monitor at least one clinical quality measure relevant to behavioral health.	Enhanced	Well Child Care; Depression Screening; SUD Screening		6A
Behavioral Health Integration	BH referral tracking	Practices will monitor the status of patient referrals between the practice and its respective behavioral health partners.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	5B
Behavioral Health Integration	BH co-location	Practices will provide on-site behavioral health services through a contracted or in-house provider.	Advanced	Well Child Care; Depression Screening; SUD Screening	SIM	2

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Behavioral Health Integration	BH providers	Practices will employ behavioral health providers as part of their service portfolio.	Advanced	Well Child Care; Depression Screening; SUD Screening	SIM?	2
Patient Engagement and Experience	Solicit patient input	Practices will gather feedback from their patients using a post-visit question or brief set of questions.	Basic	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, SIM	
Patient Engagement and Experience	Patient satisfaction survey	Practices will enact and publish results from a patient satisfaction survey on a bi-annual basis.	Enhanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, SIM	6C
Patient Engagement and Experience	Shared decision making tools	Practices will employ shared decision making tools for at least two primary care conditions.	Enhanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, CPC+, SIM	4E
Patient Engagement and Experience	Patient advisory group	Practices will convene a patient and family advisory council and publish relevant minutes on a quarterly basis.	Advanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, CPC+, SIM	6C4
Quality Improvement	Performs practice improvement activities	Practices will identify a change area and work on specific activities that will advance progress in that area.	Basic			6
Quality Improvement	Agency QI plan	Practices will develop and implement an agency quality improvement plan that is reviewed annually and linked to	Enhanced		ACC 1.0	6

Appendix M
Primary Care APM

Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
		the strategic and operational direction of the practice.				
Quality Improvement	Agency strategic measures	Practices will identify and monitor at least three clinical quality measures relevant to their specific patient populations or the RAE's strategic initiatives and goals or the State's designated key performance indicators.	Enhanced		CPC, CPC+	6A
Quality Improvement	Agency QI projects	Practices will implement 1-3 performance improvement projects, using relevant performance improvement tactics and clinical and operational data, to improve their respective clinical quality measures.	Advanced		CPC, CPC+, SIM	6D
Quality Improvement	Family and patient engagement in QI projects	Practices will solicit and include feedback from patients and families regarding the development and implementation of QI projects.	Advanced		CPC, CPC+, SIM	6C
Quality Improvement	QI project progress and communication	Practices will publicly publish their progress and outcomes from their respective quality improvement initiatives.	Advanced		CPC, CPC+, SIM	6E/F

APPENDIX N
Capitated Behavioral Health Benefit Covered Services

Covered Services

Low Acuity Behavioral Health Service Procedure Codes- Always covered by the behavioral health capitation when billed by a Behavioral Health Specialty Provider or when billed for more than six sessions by a primary care provider, regardless of diagnosis.	
90791 Diagnostic Eval without Medical Services	90839 Psychotherapy for crisis-60 minutes
90792 Diagnostic Eval with Medical Services	90840 Psychotherapy for crisis-ea addl 30 min
90832 Psychotherapy-30 minutes	90853 Group psychotherapy
90834 Psychotherapy-45 minutes	90846 Family psychotherapy (w/o patient)
90837 Psychotherapy-60 minutes	90847 Family psychotherapy (with patient)
Evaluation & Management Codes- Will require a diagnosis and are covered under the behavioral health capitation when the service is provided by a behavioral health specialty provider for a behavioral health diagnosis.	
90833 Psytx pt &/or family w/e&m 30 mins	99254 Inpatient consultation
90836 Psytx pt &/or family w/e&m 45 mins	99255 Inpatient consultation
90838 Psytx pt &/or family w/e&m 60 mins	99281 ED services
99201 Office or OP – New, 10m	99282 ED services
99202 Office or OP – New, 20m	99283 ED services
99203 Office or OP – New, 30m	99284 ED services
99204 Office or OP – New, 45m	99285 ED services
99205 Office or OP – New, 60m	99304 Initial nursing facility, 25m
99212 Office or OP – Est, 10m	99305 Initial nursing facility, 35m
99213 Office or OP – Est, 15m	99306 Initial nursing facility, 45m
99214 Office of OP – Est, 25m	99307 Subseq nursing facility, 10m
99215 Office or OP – Est, 40m	99308 Subseq nursing facility, 15m
99211 Office or OP – other	99309 Subseq nursing facility, 25m
99217 Observ Care discharge day mgmt.	99310 Subseq nursing facility, 35m
99218 Initial Observ Care, 30m	99315 Nursing facility discharge, 30m
99219 Initial Observ Care, 50m	99316 Nursing facility discharge, 30+m
99220 Initial Observ Caer, 70m	99318 Annual nursing facility assmt
99221 Initial hospital care	99324 Dom, Rest, Custodial – New, 20m
99222 Initial hospital care	99325 Dom, Rest, Custodial – New, 30m
99223 Initial hospital care	99326 Dom, Rest, Custodial – New, 45m
99224 Subseq Hospital Care, 15m	99327 Dom, Rest, Custodial – New, 60m
99225 Subseq Hospital Care, 25m	99328 Dom, Rest, Custodial – New, 75m
99226 Subseq Hospital Care, 35m	99334 Dom, Rest, Custodial – Est, 15m
99231 Subsequent hospital care	99335 Dom, Rest, Custodial – Est, 25m
99232 Subsequent hospital care	99336 Dom, Rest, Custodial – Est, 40m
99233 Subsequent hospital care	99337 Dom, Rest, Custodial – Est, 60m
99234 Same day admit/DC, 40m	99341 Home care – New, 20m
99235 Same day admit/DC, 50m	99342 Home care – New, 30m

APPENDIX N
Capitated Behavioral Health Benefit Covered Services

99236 Same day admit/DC, 55m	99343 Home care – New, 45m
99238 Hospital discharge day	99344 Home care – New, 60m
99239 Hospital discharge-manage	99345 Home care – New, 75m
99242 Inpatient Consultation, 30m	99347 Home care – Est, 15m
99243 Inpatient Consultation, 40m	99348 Home care – Est, 25m
99244 Inpatient Consultation, 60m	99349 Home care – Est, 40m
99245 Inpatient Consultation, 80m	99350 Home care – Est, 60m
99251 Inpatient consultation	99366 Team conf w/patient by hc pro
99252 Inpatient consultation	99367 Team conf w/o patient by phys
99253 Inpatient consultation	99368 Team conf w/patient by hc pro
Behavioral health codes- always covered by the behavioral health capitation, regardless of diagnosis	
H0005 Alcohol and/or drug services	96116 Neurobehavioral status exam
H0004 Alcohol and/or drug services	96102 Psycho testing by technician
H0002 Alcohol and/or drug screening	96101 Psycho testing by psych/phys
H0001 Alcohol and/or drug assessment	90849 Multiple family group psytx
96119 Neuropsych testing by tech	96120 Neuropsych test admin w/comp
96118 Neuropsych testing by psych/phys	
Specialty Behavioral Health Codes- always covered under the behavioral health capitation for behavioral health diagnoses.	
H2001 Rehab program 1/2 day	H2018 Psysoc rehab svc, per diem
96120 Neuropsych test admin w/comp	H2021 Com wrap-around sv, 15 min
96372 Ther/proph/diag inj, sc/im	H2022 Com wrap-around sv, per diem
97535 Self care mngment training	H2023 Supported employ, per 15 min
97537 Community/work reintegration	H2024 Supported employ, per diem
98966 Hc pro phone call 5-10 min	H2025 Supp maint employ, 15 min
98967 Hc pro phone call 11-20 min	H2026 Supp maint employ, per diem
98968 Hc pro phone call 21-30 min	H2033 Multisys ther/juvenile 15 min
H0043 Supported housing, per diem	S5150 Unskilled respite care, per 15m
H0044 Supported housing, per month	S5151 Unskilled respite care, per diem
H0045 Respite not-in-home per diem	T1005 Respite care service 15 min
H2014 Skills train and dev, 15 min	T1016 Case management
H2017 Psysoc rehab svc, per 15 min	T1017 Targeted case management

In ACC II, the integrated care codes can be performed, in any combination, in a primary care setting for up to 6 total sessions per State fiscal year, and regardless of diagnosis before a prior authorization request is required.
The processing of prior authorizations requests for additional services beyond the 6 will be an administrative function covered under the capitation; integrated care services authorized beyond the 6 sessions will also be funded under the capitation.

APPENDIX N
Capitated Behavioral Health Benefit Covered Services

Covered Behavioral Health Diagnoses

Part I- Mental Health Covered Diagnosis Ranges

Start Value	End Value
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F60.0	F63.9
F68.10	F69
F90.0	F99
R45.1	R45.2
R45.5	R45.82

Part II- Substance Use Disorder Covered Diagnosis Ranges

Start Value	End Value
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96
F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99

Part III – Other Diagnoses

R69
Z03.89

Wrap Around Services

Wrap Around services are services not paid for by the HMO. Wrap Around services are paid for by the State of Colorado Medicaid program on a fee for service basis upon determination of medical necessity. Wrap Around Services include, but are not limited to, the following:

Home and Community Based Services Waiver Programs

Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD). See 10 CCR 2505-10, Section 8. 485.

Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA). See 10 CCR 2505-10, Section 8. 496.

Home and Community Based Services for the Developmentally Disabled (HCB-DD) Waiver. See 10 CCR 2505-10, Section 8. 500.

Supported Living Services Waiver. See 10 CCR 2505-10, Section 8. 500.90.

Children's Extensive Support Waiver Program (CES). See 10 CCR 2505-10, Section 8. 503.

Home and Community Based Services Pediatric Hospice Waiver. See 10 CCR 2505-10, Section 8. 504.

Children's Home and Community Based Services Waiver Program. See 10 CCR 2505-10, Section 8. 506.

Children's Habilitation Residential Program. See 10 CCR 2505-10, Section 8. 508.

Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS). See 10 CCR 2505-10, Section 8. 509.

Consumer Directed Attendant Support Services. See 10 CCR 2505-10, Section 8. 510.

Home and Community Based Services for People with Brain Injury (HCBS-BI). See 10 CCR 2505-10, Section 8. 515.

Consumer Directed Care for the Elderly. See 10 CCR 2505-10, Section 8. 518.

Home and Community Based Services for Children with Autism Waiver. See 10 CCR 2505-10, Section 8. 519

Consumer Directed Attendant Support. See 10 CCR 2505-10, Section 8. 551. Services include skilled nursing services and home health aide services, personal care services and homemaker services.

In-Home Support Services. See 10 CCR 2505-10, Section 8. 552.

Community Transition Services. See 10 CCR 2505-10, Section 8. 553. This is a Single Entry Point agency program.

Hospice

Hospice entities retain professional, financial, and administrative responsibility for core hospice services.

Skilled Nursing Facility (Long Term)

Skilled nursing facilities retain professional, financial, and administrative responsibility for core Skilled Nursing Facility Services provided to Members in custodial care.

Home Health Services (Long Term)

Includes skilled nursing services, home health aide services, occupational therapy services, physical therapy services, and speech/language pathology services for chronic conditions. See 10 CCR 2505-10, Section 8.520.

Alternative Care Facility Services

See 10 CCR 2505-10, Section 8. 495.

Non-emergency transportation to medical appointments

Services are provided through the Member's county of residence.

Food and Lodging to Obtain Out-of-State Medical Services

Private duty nursing

See 10 CCR 2505-10, Section 8. 540.

Environmental Modifications

Home modifications and other items listed in 10 CCR 2505-10, Section 8. 516.

Non-medical Transportation

See 10 CCR 2505-10, Section 8.516.20 and Section 8.494.

Transitional Living

See 10 CCR 2505-10, Section 8. 516.30.

Behavioral Programming

See 10 CCR 2505-10, Section 8. 516.40

Electronic monitoring

See 10 CCR 2505-10, Section 8.488.10.

Personal Care Services

See 10 CCR 2505-10, Section 8. 489

Homemaker Services

Homemaker Services are available to clients in the Home and Community Based Services waivers for Elderly Blind and Disabled, Persons Living with Aids and Persons with Mental Illness.

Homemaker Services are available to clients in the Home and Community Based Services waiver for Persons with Brain Injury when the client is also receiving personal care services.

Adult Day Care Services

See 10 CCR 2505-10, Section 8. 491.

Respite Care

See 10 CCR 2505-10, Section 8. 492.

Home Modifications

See 10 CCR 2505-10, Section 8.493.

Targeted Case Management Services for Persons with Developmental Disabilities

See 10 CCR 2505-10, Section 8.760

"Targeted Case Management services for persons with developmental disabilities" consist of at least one activity every other month, by the community centered board which is providing targeted case management services to the individual, for one or more of the following purposes:

Coordinating the completion of assessments for the determination of the need for services;

Facilitating the development of the Individual Habilitation Plan (IMP) and ensuring the development of related Individual Program Plans (IPP);

Monitoring and reviewing the goals and services identified in the Individual Habilitation Plan and individual program plans developed in response to the IHP;

Coordinating the services being provided as identified in the IHP to ensure continuity of service provision;

Advocating for the entry of persons receiving services into the services and/or programs identified in the IHP;

Providing counsel and support to the person receiving services and other appropriate parties as necessary to prepare them for entry, transfer or termination from a program;

Providing notification and documentation of intended actions, transfers or terminations; or,

For persons who no longer require services from the developmental disabilities system or whose needs would be better served in alternative services options, terminating services or transferring to other necessary services.

Nurse Home Visitor Program

Nurse Home Visitor Program (NHVP) means a program established pursuant to Section 25-31-101,C.R.S. et seq., including the provision of targeted case management services to first-time pregnant women or whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level. Services are offered through the child's second birthday plus one month.

Prenatal Plus Program

Prenatal Plus Program Services address the psychosocial behaviors that impact pregnancy outcome and are in addition to medical prenatal care. They are limited to:

Risk Assessment: Identification and documentation of client medical, psychosocial, nutritional and behavioral strengths and risk factors that could negatively impact pregnancy outcome.

Prenatal Care Coordination: Services provided by a Prenatal Plus provider that includes service planning and coordination, referral, follow-up and monitoring.

Home visitation: A 30-90 minute face-to-face contact with a client at the client's residence or alternative non-provider site by the Prenatal Plus provider to address issues identified through the Risk Assessment.

Nutrition counseling: Nutrition intervention services provided by a registered dietitian including ongoing nutrition assessment, client counseling and referral to other health professionals as needed.

Psychosocial counseling: Services provided by a mental health professional including ongoing assessment of the client's psychological and social situation, brief psychotherapy, crisis intervention and referral to additional mental health treatment as needed.

Outpatient Substance Abuse Treatment

See 10 CCR 2505-10, Section 8.746, unless the Department exercises its option to include these services in the Program.

Drug/Alcohol Treatment for pregnant women

Drug/Alcohol Treatment for pregnant women is available through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. See 10 CCR 2505-10, Section 8.745.

Teen Pregnancy Prevention Services

Teen Pregnancy Prevention Services are a package of support services developed to reduce teen pregnancy including:

Intensive individual or group counseling, which includes a component on delayed parenting.
Guidance promoting self-sufficiency, self-reliance and the ability to make appropriate family planning decisions.
Home visits or visiting nurse services.

APPENDIX N
Capitated Behavioral Health Benefit Covered Services

Eligible individuals up to nineteen years of age who reside in a neighborhood in which there is a preponderance of poverty, unemployment and underemployment, substance abuse, crime, school dropouts, a significant public assistance population, teen pregnancies and teen parents or other conditions that put families at risk.

APPENDIX O

Low-acuity Behavioral Health Services in a Primary Care Setting

In order to support the availability of a full continuum of behavioral health services, the Department is promoting the provision of behavioral health services within primary care settings for low-acuity and brief episodic conditions.

Behavioral health practitioners in a primary care setting may provide up to six (6) sessions of the low-acuity behavioral health services listed in this appendix, in any combination, per episode of care without prior authorization from the Contractor. These sessions will not require a covered behavioral health diagnosis.

Low-acuity Behavioral Health Service Procedure Codes

90791	Diagnostic Evaluation without Medical Services
90792	Diagnostic Evaluation with Medical Services
90832	Psychotherapy-30 minutes
90834	Psychotherapy-45 minutes
90837	Psychotherapy-60 minutes
90839	Psychotherapy for crisis-60 minutes
90840	Psychotherapy for crisis-each additional 30 min
90853	Group Psychotherapy
90846	Family Psychotherapy (w/o patient)
90847	Family Psychotherapy (with patient)

The services listed above are reimbursed fee-for-service when they are billed in a primary care place of service. Practitioners must request authorization from the Contractor to continue to provide more than six (6) low-acuity behavioral health services in a primary care setting.

Instruction of the CASH based Alternative Service quarterly report

Contract Exhibit R2, Section I.A.2.: Contractor shall submit, quarterly, reports in electronic format to the Department and/or designee detailing the previous quarters expenditures for 1915(b)(3) Waiver (Alternative) services.
I.A.2.a. Expenditure reports shall detail the specific type of service and the expenditure amount associated with that service for the given quarter.
Contract II.I.2.j Due Dates for Quarterly Reporting:
In the absence of an alternative reporting time line, all quarterly reports are due thirty (30) calendar days following the end of the reporting quarter.

The CASH based Alternative Service quarterly report is a cost report based on the service adjudication date during a quarter of a fiscal year. The steps to fill out the report are listed as below:

1. The total cost of each service class adjudicated during a quarter should be filled in the column D of a corresponding quarterly tab (xxxQ_brkdwn).

2. Each of the costs from step one above then should be broken down into two columns, the cost for the service date of prior fiscal year and the cost for the service date of current fiscal year. The prior year's cost is in the column B and the current year's cost is in the column C.

For example, one BHO has $100,000 of residential services adjudicated (paid) during the second quarter of FY05-06 (Oct.-Dec. of 2005). $20,000 of the $100,000 is for the service date of prior FY (before July 1, 2005). And $80,000 is for the current FY. In this case, $100,000 goes to column D20 in tab '2ndQ_Brkdwn', $20,000 to column B20 and $80,000 to column C20.

3. Other 'filled-out' fields include the date submitted in all of the quarterly tabs, the BHO name and the fiscal year in the 1stQ_Brkdwn tab.

4. The 'SumByPayDate' tab with a title of 'Cash Based Alternative service expenditure report for FYxxxx' is an auto-populated tab. The information is automatically transferred from the quarterly tabs.

Please note: All services provided to children, with the exception of respite and vocational rehab, are considered state plan services under EPSDT. With the exception of respite and vocational rehab, please report the cost of B(3) services for adults, only. For respite and vocational rehab, please report the cost of B(3) services for children and adults.

A	B	C	D
Amount adjudicated in 1st Qtr of FY broken down by Date of Service			
BHO:		Fiscal Year:	
Date Submitted:		Quarter:	July - September
ALTERNATIVE SERVICE	**Date of Service**		**Total Amount Paid**
	Prior FY	**Current FY**	
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			0
Residential Services			0
TOTAL EXPENDITURE	0	0	0

A	B	C	D
Amount adjudicated in 2nd Qtr of FY broken down by Date of Service			
BHO:	0	Fiscal Year:	**0**
Date Submitted:		Quarter:	October - December
	Date of Service		
ALTERNATIVE SERVICE	**Prior FY**	**Current FY**	**Total Amount Paid**
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			
Residential Services			0
TOTAL EXPENDITURE	0	0	0

A	B	C	D
Amount adjudicated in 3rd Qtr of FY broken down by Date of Service			
BHO:	0	Fiscal Year:	**0**
Date Submitted:		Quarter:	January - March
	Date of Service		
ALTERNATIVE SERVICE	**Prior FY**	**Current FY**	**Total Amount Paid**
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			0
Residential Services			0
TOTAL EXPENDITURE	0	0	0

A	B	C	D
Amount adjudicated in 4th Qtr of FY broken down by Date of Service			
BHO:	0	Fiscal Year:	**0**
Date Submitted:		Quarter:	April - June
	Date of Service		
ALTERNATIVE SERVICE	**Prior FY**	**Current FY**	**Total Amount Paid**
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			0
Residential Services			0
TOTAL EXPENDITURE	0	0	0

A	B	C	D
Amount adjudicated in 1st Qtr of FY broken down by Date of Service			
BHO:		Fiscal Year:	
Date Submitted:		Quarter:	July - September
ALTERNATIVE SERVICE	**Date of Service**		**Total Amount Paid**
	Prior FY	**Current FY**	
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			0
Residential Services			0
TOTAL EXPENDITURE	0	0	0

A	B	C	D
Amount adjudicated in 2nd Qtr of FY broken down by Date of Service			
BHO:	0	Fiscal Year:	**0**
Date Submitted:		Quarter:	October - December
	Date of Service		
ALTERNATIVE SERVICE	**Prior FY**	**Current FY**	**Total Amount Paid**
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			
Residential Services			0
TOTAL EXPENDITURE	0	0	0

A	B	C	D
Amount adjudicated in 3rd Qtr of FY broken down by Date of Service			
BHO:	0	Fiscal Year:	**0**
Date Submitted:		Quarter:	January - March
	Date of Service		
ALTERNATIVE SERVICE	**Prior FY**	**Current FY**	**Total Amount Paid**
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			0
Residential Services			0
TOTAL EXPENDITURE	0	0	0

Cash Based Alternative Service Expenditure Report for FY					
BHO:	0			Fiscal Year:	**0**
Date Submitted:				Quarter:	
	Paid Amount				
ALTERNATIVE SERVICE	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Total Year to Date**
Intensive Case Management	0	0	0	0	0
Vocational Services	0	0	0	0	0
Other:					
Assertive Community Treatment	0	0	0	0	0
Respite Care	0	0	0	0	0
Clubhouse/Drop-in Center	0	0	0	0	0
Recovery Services	0	0	0	0	0
Prevention/Early Intervention	0	0	0	0	0
REQUIRED SERVICE					
Residential Services	0	0	0	0	0
TOTAL EXPENDITURE	0	0	0	0	0

A	B	C	D
Amount adjudicated in 4th Qtr of FY broken down by Date of Service			
BHO:	0	Fiscal Year:	**0**
Date Submitted:		Quarter:	April - June
	Date of Service		
ALTERNATIVE SERVICE	**Prior FY**	**Current FY**	**Total Amount Paid**
Intensive Case Management			0
Vocational Services			0
Other:			0
Assertive Community Treatment			0
Respite Care			0
Clubhouse/Drop-in Center			0
Recovery Services			0
Prevention/Early Intervention			0
REQUIRED SERVICE			0
Residential Services			0
TOTAL EXPENDITURE	0	0	0

APPENDIX Q

Proposed Performance Measures

In addition to the Key Performance indicators, the Department will track several other measures to monitor the performance of the program and RAE efforts in each region. These measures will be publicly reported and tracked throughout the life of the contract. The following measures are still under development.

MEASURE	ALIGNMENT WITH OTHER INITIATIVES
Use of appropriate medications for asthma	Adult and Child Core Sets
HbA1c Screening	Adult core set, SIM
Well-visits 3 domains--all Children, Children in Child Welfare, LTSS	Current ACC
Clinical depression screening	SIM, Adult core set
Maternal Health Depression Screening	MIH Grant
SUD Screening	SIM, Adult core set
Total cost of care	
ED Visits for Ambulatory Care-sensitive Conditions	Adult core set, child core set, MMP
CAHPS - Physical Health (Rating of all Health Care, Rating of Personal Doctor, Rating of specialist seen most often, Getting needed care)	Adult core set, child core set, Triple Aim
ECHO - Behavioral Health (Rating of all Counseling or Treatment, Getting Treatment Quickly, How Well Clinicians Communicate, Perceived Improvement)	Triple Aim, BH Indicator 6
National Core Indicators Survey	Triple Aim
Percent of 1st time mothers connect to NFP	
Percent of Medicaid clients with a dental visit	CHIPRA Core measure set
Number of Behavioral Health visits in primary care settings	
Percent of Clients Who Were Recently Released from Corrections with an office visit within 30 days of release	Performance Improvement Projects
Risky behavior screening for adolescents (11-20)	MIH Grant

APPENDIX Q

Proposed Performance Measures

Prenatal Care and Postpartum Care (HEDIS)	
Screening for Fall Risks	
Child and adolescent major depressive disorder (MDD): Suicide risk assessment	NQF 1365, BH Indicator 1
Adult major depressive disorder (MDD): suicide risk assessment	NQF 0104, BH Indicator 2
BH Hospital Readmissions: 7,30,90,180 days	1768/SIM, BH Indicator 3
Percent of members prescribed redundant or duplicated atypical antipsychotic medication	BH Indicator 4
Adherence to antipsychotics for individuals with schizophrenia	CMS Core, NQF 1879, BH Indicator 5
Penetration Rates	BH Indicator 6
Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication	1932 NQF, BH Indicator 8
BH Inpatient Utilization	BH Indicator 9
ED Utilization for mental health conditions	BH Indicator 10
Follow up after ED visit for Mental health or Alcohol or Drug Dependence	2605 NQF, BH Indicator 11
Mental Health Engagement	BHO Incentive measure, indicator 12
Initiation and Engagement of Alcohol and other drug dependence program	BHO Incentive measure, indicator 13, CMS 0004
Follow up appointments within 7 and 30 days after hospital discharge for a mental health condition - adult and child/adolescent	BHO Incentive measure, indicator 14, CMS Core 0576
Depression Remission at 12 months using standard PHQ-9	BHO Stretch Measure, Indicator 15, NQF 0710
Substance Use Screening Composite: Screening and Intervention	BHO Stretch Measure, Indicator 16, SIM 2597
Adolescent Health Risk Screening and Referral/coordination of care	BHO Stretch Measure, Indicator 17, MIH Grant

APPENDIX Q

Proposed Performance Measures

Develop a person/Family Centered Advisory Council	BHO Stretch Measure, Indicator 18
Children involved with child welfare with a behavioral health claim (0-21 years)	CCBHC
Low Birth Weight	MIH
Developmental Screens	
Percent of Clients with an E&M Claim with their assigned PCP	
ED Utilization	
Readmissions	
30 Day Post-discharge Follow-up	
High Cost Imaging	
Breast Cancer Screening Rate	
Cervical Cancer Screening Rate	
Fall-related Hospitalizations	
Asthma Related ED Visits	
Asthma Related Admissions	
Teen Pregnancy Rate	
Number of PCMPs participating in Alternative Payment Methodologies	
Percentage of administrative PMPM funding passed-through to PCMPs	
Care Coordination Measure	
Member engagement measure	
Children with a positive BH screening in primary care with a follow up visit to a BH provider	CCBHC
Percent of clients who have completed the Health Needs Survey or other health risk assessment (HRA)	
Percent of practices in the ACC with connection to CORHIO/QHN and actively working on sharing data for care coordination	SIM
Percent of clients with access to their Patient Health Record	
Quality of Life	

APPENDIX Q

Proposed Performance Measures

Weight Assessment and physical activity and nutrition counseling	
Client/Caregiver Experience of Care	
BMI Documented	
Percent of pregnant women/new mothers connected to SNAP and WIC	
Immunizations	
Living Independently in the Community	
Access to Care measure	
LTSS Transition measure	
Individuals with special health care needs with a well-visit	
Member Decision Tool or Patient Activation measure	

Appendix R

Proposed Key Performance Indicators (KPIs)

Cost

1) Total Cost of Care - Risk adjusted measure of average per member per month costs for both physical and behavioral health

2) ED Visits for Ambulatory Sensitive Conditions - Number of ED visits per thousand members within a rolling twelve (12) month period, using the SIM ambulatory sensitive conditions criteria

Prevention/Care/Health and Wellness

1) Behavioral Health Engagement – Members engaged in behavioral health services delivered either in primary care settings or under the Capitated Behavioral Health Benefit within a twelve (12) month rolling period.

2) Well Visits – Members of all ages and populations with at least 90 days of continuous program enrollment that have had a well visit within a rolling twelve (12) month period

3) Prenatal Care – Members with a prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of program enrollment and the gaps in enrollment during the pregnancy. The data source for the measure is claims.

4) Dental Visit - Percentage of Members with a dental visit within a rolling twelve (12) month period

Public Health

1) Obesity – Rates of overweight and obesity as measured through the BRFSS OR by CDPHE as part of Colorado's 10 Winnable Battles

Health Neighborhood

1) Health Neighborhood – Hybrid measure of utilization of Colorado Medical Society's Primary Care-Specialty Care Compact (Appendix S CMS Care Compact) and number of electronic consultations made within a twelve (12) month period

APPENDIX S
DISPROPORTIONATE SHARE AND
GRADUATE MEDICAL EDUCATION HOSPITAL REPORTING
By Calendar Year Quarter

Managed Care Contractor Name: _____

Quarter No.: _____ Calendar Year: _____

HOSPITAL	Medicaid Provider ID Or NPI	TOTAL MEDICAID DAYS (See Note Below)	TOTAL MEDICAID OUTPATIENT CHARGES (See Note Below)	# of Discharges
TOTAL				

NOTE: Medicaid needs hospital days and outpatient hospital charges for determining which hospitals are disproportionate share hospitals and to calculate the graduate medical education reimbursement rate per day. This form should be itemized by hospital and the days should include newborns as defined in Medicaid HEDIS, December 1995, National Committee for Quality Assurance, page 60. Outpatient hospital charges should include the charges for all services covered by your managed care organization for dates of service during the applicable quarter. The Department will consult with Contractors to develop any other specifications and formats required to appropriately calculate disproportionate share and graduate medical education payments.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DUE:	July 31, _____	October 31, _____	January 31, _____	April 30, _____

SEND TO: Facility Rates Section, Colorado Department of Health Care Policy & Financing
1570 Grant Street, 1st Floor, Denver, Colorado 80203

Primary Care – Specialist Physician Collaborative Guidelines

I. Purpose

- *To provide optimal health care for our patients.*
- *To provide a framework for better communication and safe transition of care between primary care and specialty care providers.*

II. Principles

- *Safe, effective and timely patient care is our central goal.*
- *Effective communication between primary care and specialty care is key to providing optimal patient care and to eliminate the waste and excess costs of health care .*
- *Mutual respect is essential to building and sustaining a professional relationship and working collaboration.*
- *A high functioning medical system of care provides patients with access to the 'right care at the right time in the right place'.*

III. Definitions

- *Primary Care Physician (PCP) – a generalist whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients.*
- *Specialist – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of diseases or type of patient.*
- *Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision making and self-management.*
- *Transition of Care – an event that occurs when the medical care of a patient is assumed by another medical provider or facility such as a consultation or hospitalization.*
- *Technical Procedure – transfer of care to obtain a clinical procedure for diagnostic, therapeutic, or palliative purposes.*

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• *Patient-Centered Medical Home –a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.*

• *Patient Goals – health goals determined by the patient after thorough discussion of the diagnosis, prognosis, treatment options, and expectations taking into consideration the patient's psychosocial and personal needs.*

• *Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.*

Types of Care Management Transition

• *Pre-consultation exchange – communication between the generalist and specialist to:*

1. *Answer a clinical question and/or determine the necessity of a formal consultation.*

2. *Facilitate timely access and determine the urgency of referral to specialty care.*

3. *Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.*

• *Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCP after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.*

• *Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient's health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources as outlined by the "Joint Principles" and meeting the requirements of NCQA PPC-PCMH recognition.*

• *Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.*

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- *<u>Co-management with Shared management for the disease</u> -- the specialist shares long-term management with the primary care physician for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the PCMH and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.*
- *<u>Co-management with Principal care for the disease (Referral)</u> – the specialist assumes responsibility for the long-term, comprehensive management of a patient's referred medical/surgical condition. The PCMH continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The generalist continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.*
- *<u>Co-management with Principal care for the patient (Consuming illness)</u> – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The PCMH remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.*

- *<u>Emergency care</u> – medical or surgical care obtained on an urgent or emergent basis.*

IV. Mutual Agreement for Care Management

- Review tables and determine which services you can provide.
- The *Mutual Agreement* section of the tables reflect the core elements of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.
- The *Expectations* section of the tables provide flexibility to choose what services can be provided depending in the nature of your practice and working arrangement with PCP or specialist.
- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to specialty care, processes should be in place to determine the patient's overall needs and reintegrate further care with the PCMH, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient.

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- Upon signing this agreement, each provider should agree to an open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, the format and venue of this discussion.
- Optimally, this agreement should be reviewed every 2 years.

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Transition of Care

Mutual Agreement

- Maintain accurate and up-to-date clinical record.
- When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD]
- Ensure safe and timely transfer of care of a prepared patient

Expectations

Primary Care	Specialty Care
☐ PCP maintains complete and up-to-date clinical record including demographics. ☐ Transfers information as outlined in Patient Transition Record. ☐ Orders appropriate studies that would facilitate the specialty visit. ☐ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit ☐ Provides patient with specialist contact information and expected timeframe for appointment.	☐ Determines and/or confirms insurance eligibility ☐ Identifies a specific referral contact person to communicate with the PCMH ☐ When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up

Additional agreements/edits: _____

_____

_____

_____

_

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Access

Mutual Agreement

- Be readily available for urgent help to both the physician and patient via phone or e-mail.
- Provide visit availability according to patient needs.
- Be prepared to respond to urgencies.
- Offer reasonably convenient office facilities and hours of operation.
- Provide alternate back-up when unavailable for urgent matters.

Expectations

Primary Care	Specialty Care
☐ Communicate with patients who "no-show" to specialists. ☐ Determines reasonable time frame for specialist appointment. ☐ Provide a secure email option for communication with patient and specialist.	☐ Notifies PCP of first visit 'no-shows' or other actions that place patient in jeopardy. ☐ Provides visit availability according to patient needs. ☐ Be available to the patient for questions to discuss the consultation. ☐ Schedule patient's first appointment with requested physician. ☐ Be available to PCP for pre-consultation exchange by phone and/or secure email. ☐ When available and clinically practical, provide a secure email option for communication with established patients and/or provider. ☐ Provides PCP with list of practice physicians who agree to compact principles.

Additional agreements/edits: _____

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_____

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Collaborative Care Management

Mutual Agreement

- Define responsibilities between PCP, specialist and patient.
- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
- Maintain competency and skills within scope of work and standard of care.
- Give and accept respectful feedback when expectations, guidelines or standard of care are not met
- Agree on type of specialty care that best fits the patient's needs.

Expectations

Primary Care	Specialty Care
☐ Follows the principles of the Patient Centered Medical Home or Medical Home Index. ☐ Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills. ☐ Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. ☐ Reviews and acts on care plan developed by specialist. ☐ Resumes care of patient when patient returns from specialist care. ☐ Explains and clarifies results of consultation, as needed, with the patient. Makes agreement with patient on long-term treatment plan and follow-up.	☐ Reviews information sent by PCP ☐ Addresses referring provider and patient concerns. ☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. ☐ Confers with PCP before refers to secondary/tertiary specialists for problems within the PCP scope of care and uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization when needed. ☐ Sends timely reports to PCP to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions. ☐ Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations. ☐ Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs. ☐ Provides useful and necessary education/guidelines/protocols to PCP, as needed

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Additional agreements/edits: _____

Patient Communication

Mutual Agreement

- Engage and utilize a secure electronic communications platform for high risk patients such as ReachMyDoctor or CORHIO.
- Prepare the patient for transition of care.
- Consider patient/family choices in care management, diagnostic testing and treatment plan.
- Provide to and obtain informed consent from patient according to community standards.
- Explores patient issues on quality of life in regards to their specific medical condition and shares this information with the care team.

Expectations

Primary Care	Specialty Care
☐ Explains specialist results and treatment plan to patient, as necessary. ☐ Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in their care team.	☐ Informs patient of diagnosis, prognosis and follow-up recommendations. ☐ Provides educational material and resources to patient. ☐ Recommends appropriate follow-up with PCP. ☐ Will be accountable to address patient phone calls/concerns regarding their management. ☐ Participates with patient care team.

Additional agreements/edits: _____

_____

_____

_____

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V. Appendix

- ## PCP Patient Transition Record

1. Practice details – PCP, PCMH level, contact numbers (regular, emergency)

2. Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation and contact information.

3. Diagnosis -- ICD-9 code

4. Query/Request – a clear clinical reason for patient transfer and anticipated goals of care and interventions.

5. Clinical Data --

- problem list
- medical and surgical history
- current medication
- immunizations
- allergy/contraindication list
- care plan
- relevant notes
- pertinent labs and diagnostics tests
- patient cognitive status
- caregiver status
- advanced directives
- list of other providers

6. Type of transition of care.

- Consultation
- Co-management
  - Principal care
  - Consuming illness
  - Shared care
- Specialty Medical Home Network (complete transition of care to specialist practice)
- Technical procedure

7. Visit status -- routine, urgent, emergent (specify time frame).

8. Communication and follow-up preference – phone, letter, fax or e-mail

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- **Specialist Patient Transition Record**

1. Practice details – Specialist name, contact numbers (regular, emergency)
2. Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation.
3. Communication preference – phone, letter, fax or e-mail
4. Diagnoses (ICD-9 codes)
5. Clinical Data – problem list, medical/surgical history, current medication, labs and diagnostic tests, list of other providers.
6. Recommendations – communicate opinion and recommendations for further diagnostic testing/imaging, additional referrals and/or treatment. Develop an evidence-based care plan with responsibilities and expectations of the specialist and primary care physician that clearly outline:
    1. new or changed diagnoses
    2. medication or medical equipment changes, refill and monitoring responsibility.
    3. recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
    4. secondary diagnoses.
    5. patient goals, input and education provided on disease state and management .
    6. care teams and community resources.
7. Technical Procedure – summarize the need for procedure, risks/benefits, the informed consent and procedure details with timely communication of findings and recommendations.
8. Follow-up status – Specify time frame for next appointment to PCP and specialist. Define collaborative relationship and individual responsibilities.
    1. Consultation
    2. Co-management
        - Principal care
        - Shared care
        - Consuming illness
    3. Specialty Medical Home Network (complete transition of care to specialist practice)
    4. Technical procedure

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References

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- Forrest, CB, A Typology of Specialists' Clinical Roles. Arch Intern Med. 2009;169:1062-1006
- Primary Care – Specialty Care Master Service Agreement CPMG - Kaiser Permanente. June 2008
- Care Coordination and Care Collaboration between PCP and Specialty Care template from TransforMed Delta Exchange
- Coordination Model: PCP to Specialist process map– from Johns Hopkins Bloomberg School of Medicine. The development and testing of EHR-based care coordination performance measures in ambulatory care (current study).
- Direct Referrals Model - Quality Health Network communication
- Principles of Service Agreements for PCMH and PCMH-N, American College of Physicians internal document 10-09.
- Dropping the Baton: Exploring what can go wrong during patient handoffs and reducing the risk. COPIC Insurance Company. Sept 2009 (151)

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Primary Care-Specialty Care Collaborative Guidelines
Level 1 Medical Neighbor

Transition of Care

Mutual Agreement

Maintain accurate and up-to-date clinical record.

Expectations

Primary Care	Specialty Care
☐ Transfers information as outlined in Patient Transition Record. ☐ Provides patient with specialist contact information	☐ Provide single source contact person to coordinate services with specialist or primary care practice. ☐ When PCP uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up

Access

Mutual Agreement

Be readily available for urgent help to both the physician and patient via phone.
Be prepared to respond to urgencies.
Provide alternate back-up when unavailable for urgent matters.

Expectations

Primary Care	Specialty Care
☐ Determines reasonable time frame for specialist appointment.	☐ Have timely consultation appointments available to meet patient and referral source requests. Discuss special arrangements, as needed.

Collaborative Care Management

Mutual Agreement

Define responsibilities between PCP, specialist and patient.
Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
Give and accept respectful feedback when expectations, guidelines or standard of care are not met

Expectations

Primary Care	Specialty Care
☐ Suggests type of transition of care ☐ Resumes care of patient when patient returns from specialist care and acts on care plan developed by specialist.	☐ Reviews information sent by PCP ☐ Sends timely reports to PCP to include a care plan, follow-up and test results as outlined in Specialist Transition Record.

Patient Communication

Mutual Agreement

Consider patient/family choices in care management, diagnostic testing and treatment plan.
Provide to and obtain informed consent from patient according to community standards.

Expectations

Primary Care	Specialty Care
☐ Explains specialist results and treatment plan to patient, as necessary. ☐ Identifies whom the patient wishes to be included in their care team.	☐ Informs patient of diagnosis, prognosis and follow-up recommendations. ☐ Recommends appropriate follow-up with specialist and PCP.

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State of Colorado - MLR Reporting Template

General:

This report will be used to assess the MLR for the various Colorado Medicaid Managed Care programs.
Each plan is requested to complete each report within the template to the best of its ability.
An overview of this template and instructions on how to complete each report is contained within the remainder of this sheet.
Please note that any cells shaded in light orange are to be completed by the MCO.

Reporting Entity and Time Period:

MCO Name:	MCO Name
Service Incurral Period:	July 1, 2018 - June 30, 2019
Paid Through:	September 30, 2019

Report Instructions:

Report 1 -- MLR Template
Non-Claim Medical Payments: Any settlement amounts paid outside of the claims/encounter system, such as Critical Access Hospital settlements.
Medical Incentive Bonuses: Payments made by a MCO to providers and other unrelated risk sharing entities to share savings.
Reinsurance Premiums Less Recoveries: Reinsurance premiums should be based on date of payment. Reinsurance recoveries should be based on service date of the claim for which the recovery is made.
Less Related-Party Medical Margin: Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization. Please enter the Related-Party Medical Margin as a negative.
If line items are not able to be filled out at cohort level please fill in 'Totals' section where applicable.
For non-applicable line items, please leave blank.

Report 2 -- Submission Certification (by MCO CEO)
Please provide certification by the MCO's CEO or CFO that the figures in this reporting template are accurate and representative of MCO experience for the given time period.

MCO Scratch Sheet
Please use this worksheet to provide any additional information.

MCO: MCO Name
Report: MLR
COA: Non-expansion Parent
Time Period: July 1, 2018 - June 30, 2019

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	
b	Taxes, licensing, and regulatory fees (Including HIPF)	
c	Contractor Hold back ((a - b) * Holdback %)	
d	Earned Hold back	
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	
k	Estimated IBNR	
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	
m	Medical Incentive Bonus	
n	Reinsurance Premiums Less Recoveries	
o	Activities that Improve Health Care Quality	
p	Less Related-Party Medical Margin	
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i)	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: MCO Name
Report: MLR
COA: Children
Time Period: July 1, 2018 - June 30, 2019

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	
b	Taxes, licensing, and regulatory fees (Including HIPF)	
c	Contractor Hold back ((a - b) * Holdback %)	
d	Earned Hold back	
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	
k	Estimated IBNR	
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	
m	Medical Incentive Bonus	
n	Reinsurance Premiums Less Recoveries	
o	Activities that Improve Health Care Quality	
p	Less Related-Party Medical Margin	
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: **MCO Name**
Report: **MLR**
COA: **MAGI Adults**
Time Period: **July 1, 2018 - June 30, 2019**

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	
b	Taxes, licensing, and regulatory fees (Including HIPF)	
c	Contractor Hold back ((a - b) * Holdback %)	
d	Earned Hold back	
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	
k	Estimated IBNR	
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	
m	Medical Incentive Bonus	
n	Reinsurance Premiums Less Recoveries	
o	Activities that Improve Health Care Quality	
p	Less Related-Party Medical Margin	
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i)	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: **MCO Name**
Report: **MLR**
COA: **Expansion Parent**
Time Period: **July 1, 2018 - June 30, 2019**

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	
b	Taxes, licensing, and regulatory fees (Including HIPF)	
c	Contractor Hold back ((a - b) * Holdback %)	
d	Earned Hold back	
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	
k	Estimated IBNR	
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	
m	Medical Incentive Bonus	
n	Reinsurance Premiums Less Recoveries	
o	Activities that Improve Health Care Quality	
p	Less Related-Party Medical Margin	
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: MCO Name
Report: MLR
COA: Foster Care
Time Period: July 1, 2018 - June 30, 2019

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	
b	Taxes, licensing, and regulatory fees (Including HIPF)	
c	Contractor Hold back ((a - b) * Holdback %)	
d	Earned Hold back	
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	
k	Estimated IBNR	
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	
m	Medical Incentive Bonus	
n	Reinsurance Premiums Less Recoveries	
o	Activities that Improve Health Care Quality	
p	Less Related-Party Medical Margin	
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i)	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: MCO Name
Report: MLR
COA: Elderly
Time Period: July 1, 2018 - June 30, 2019

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	
b	Taxes, licensing, and regulatory fees (Including HIPF)	
c	Contractor Hold back ((a - b) * Holdback %)	
d	Earned Hold back	
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	
k	Estimated IBNR	
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	
m	Medical Incentive Bonus	
n	Reinsurance Premiums Less Recoveries	
o	Activities that Improve Health Care Quality	
p	Less Related-Party Medical Margin	
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: MCO Name
Report: MLR
COA: Disabled
Time Period: July 1, 2018 - June 30, 2019

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	
b	Taxes, licensing, and regulatory fees (Including HIPF)	
c	Contractor Hold back ((a - b) * Holdback %)	
d	Earned Hold back	
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	
k	Estimated IBNR	
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	
m	Medical Incentive Bonus	
n	Reinsurance Premiums Less Recoveries	
o	Activities that Improve Health Care Quality	
p	Less Related-Party Medical Margin	
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i)	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: MCO Name
Report: MLR
COA: Total
Time Period: July 1, 2018 - June 30, 2019

Line	Earned Revenue for MLR/Risk Corridor	
a	Gross Capitation Payment	$ -
b	Taxes, licensing, and regulatory fees (Including HIPF)	$ -
c	Contractor Hold back ((a - b) * Holdback %)	$ -
d	Earned Hold back	$ -
e	Net Capitation Payment for MLR/Risk Corridor (a - b - c + d)	$ -
f	MMs	-
g	**Earned Revenue for MLR/Risk Corridor (e * f)**	**$ -**

Line	MLR Calculation	
g	Earned Revenue (Total Capitation Payments less HIT and Unearned Hold Backs)	$ -
h	Risk Corridor Profit/(Loss) Share	$ -
i	Adjusted Earned Revenue (g + h)	$ -
j	Claims Incurred	$ -
k	Estimated IBNR	$ -
l	Non-Claim Medical Payments (e.g. CAH settlement, etc.)	$ -
m	Medical Incentive Bonus	$ -
n	Reinsurance Premiums Less Recoveries	$ -
o	Activities that Improve Health Care Quality	$ -
p	Less Related-Party Medical Margin	$ -
q	Total Medical Expenses (Net Qualified Medical Expenses) (j + k + l + m + n + o + p)	$ -
r	Net Qualified Medical Expenses divided by Earned Revenue (q / i)	0.0%
s	Minimum MLR %	89.0%
t	MLR % Reduction (Quality Metrics)	4.0%
u	Final MLR % (s - t)	85.0%
v	Percentage below MLR (r - u)	85.0%
w	**MLR Reconciliation Payment (max(0, i - (q / u)))**	**$ -**

Please describe any "Activities that Improve Healthcare Quality" in the box below, including what the activities are and how they improve healthcare quality

MCO: **MCO Name**
Report: **Submission Certification (by MCO CEO/CFO)**
Time Period: **July 1, 2018 - June 30, 2019**

I certify that, to the best of my understanding, the data summaries included in this template have been completed as instructed, and all data and information provided in this report is accurate and appropriate experience during the incurral time period of July 1, 2018 - June 30, 2019.

By: CEO/CFO

Print name | **Date**

Signature & Title | **Phone number**

Please provide any text, tables, numbers, etc. that you would like to communicate but were not able to include within the preceding reports.

Please provide any details surrounding allocation methodology used in completing template.

State of Colorado

Accountable Care Collaborative Actuarial Certification

July 1, 2018 – June 30, 2019
Draft Behavioral Health Capitation Rates

Optumas
Risk • Strategy • Reform

Table of Contents

1. Executive Summary

This report provides documentation and actuarial certification for behavioral health services covered under the Accountable Care Collaborative (ACC) capitation rate development for rates effective July 1, 2018 – June 30, 2019 (SFY19).

The State of Colorado currently provides Mental Health and Substance Use services under the Medicaid Community Behavioral Health Program. Services are currently provided via managed care entities, known as Behavioral Health Organizations. Historically, behavioral health services have been provided by four contracted BHOs: Colorado Access (ABC), Behavioral Healthcare Inc. (BHI), Colorado Health Partnerships, LLC (CHP), and Foothills Behavioral Health Partners, LLC (FBHP) in five regions. For the SFY19 contract period, the State is soliciting contract bids from Regional Accountable Entities (RAEs) as part of a Request for Proposal (RFP) process.

As the consulting actuaries to HCPF, **Optumas** ensured that the methodology used to develop the rates, effective July 1, 2018 – June 30, 2019, complied with the following:

1. Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rate ranges, CMS Checklist 42 CFR 438.6c
2. Recent CMS Guidance Document
3. All applicable Actuarial Standards of Practice (ASOPs)
    a. ASOP 23 – Data Quality
    b. ASOP 41 – Actuarial Communication
    c. ASOP 5 – Incurred Health and Disability Claims
    d. ASOP 25 – Credibility Procedures
    e. ASOP 49 - Medicaid Managed Care Capitation Rate Development and Certification

Optumas worked with HCPF to identify and gather the rate development components for the contract period, accounting for the covered services and populations as described in the ACC RFP. The final results were developed in accordance with actuarially sound principles and reasonably reflect the experience projected for the SFY19 ACC program. **These capitation rates will be updated in the Spring using more recent information, therefore the SFY19 projected capitation rates may change in the Spring.**

This report presents the capitation rate development process and its results in five sections, as described in Figure 1 below.

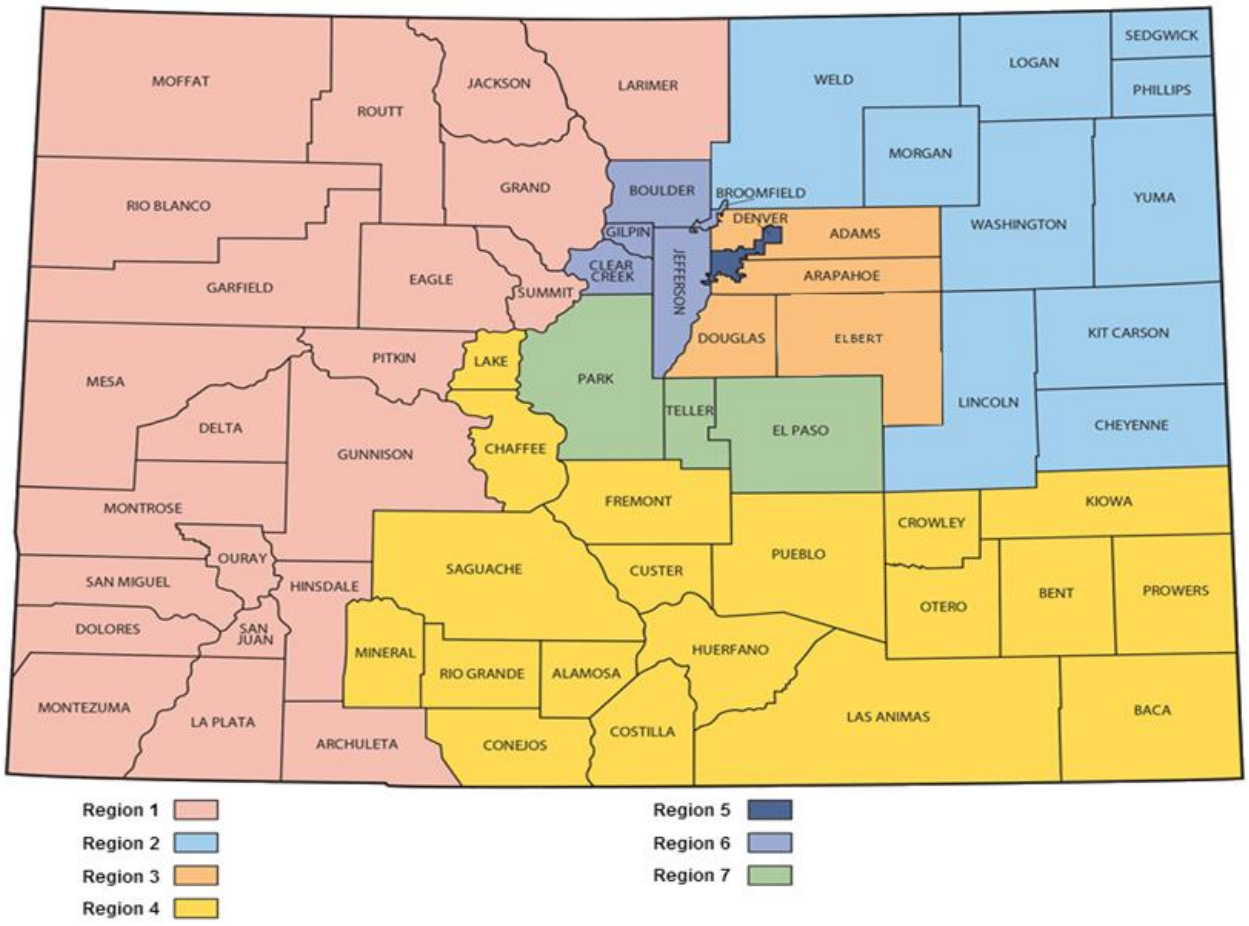
Figure 1. Report Structure

Section	Contents
Background	Provides description of the ACC program and context for rate setting
Rate Development Process	Overview of methodology used when developing the capitation rates, including an explanation of the base, appropriate adjustments, and assumptions
Rates	Resulting rates
Rate Certification	**Optumas'** actuarial certification that the calculated rates comply with guidelines set forth by CMS
Appendices	Detailed tables showing the SFY19 rates and assumptions

2. Background

Colorado Medicaid provides behavioral health services to recipients through a capitated managed care program. The RFP process will solicit bids from managed care entities who will administer these services across seven geographical regions, called Regional Accountable Entities (RAEs). The seven RAEs are shown below in figure 2.

Figure 2. Regional Accountable Entities



Each RAE will be responsible for managing the delivery of behavioral health services to Medicaid-eligible individuals in its assigned geographic service area(s). RAEs must directly provide or arrange for the provision of the following services:

- Inpatient Hospital (includes psych)
  - Under 21 Psychiatric
  - 65 and Over Psychiatric
- Outpatient Hospital (includes psych)
- Physician Services (includes psych)
- Rehabilitative Services
  - Individual psychotherapy
  - Individual brief psychotherapy
  - Family psychotherapy
  - Group psychotherapy
  - Behavioral health assessment
  - Pharmacological management
- Outpatient day treatment
- Emergency/crisis services
- Medication Assisted Treatment (MAT)
- Targeted Case Management
- Psychosocial Rehabilitation
- Emergency
- FQHC
- RHC
- School-based Mental Health Services
- Alcohol/drug Screen Counseling
- Home-Based Services for Children and Adolescents
- Specialized Services for Addressing Adoption issues
- Social/Ambulatory Detoxification
- Substance Use Disorder Assessment
- Intensive Case Management
- Assertive Community Treatment (ACT)
- Respite Care
- Vocational Services
- Clubhouses and drop-in center services- includes peer support services Recovery Services
- Prevention/Early Intervention
- Residential

Rates were developed for each of the seven RAEs independently using methodology that is consistent with the Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rates.

3. Rate Development

3.01 Overview

In developing the SFY19 ACC rate methodology, **Optumas** adhered to guidance provided by CMS in accordance with 42 CFR 438.6(c), the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Optumas specifically applied these criteria in the development of the methodology for calculating ACC capitation rates for the SFY19 contract period.

The base used for the SFY19 rates was SFY15 encounter data provided by each BHO. Once the base data was compiled, HCPF and **Optumas** worked in partnership to determine all adjustments needed to ensure that the SFY15 data was an appropriate proxy for the contract period. The adjustment categories are presented below in Figure 3.

Figure 3. Rate Development Process Adjustments

Adjustment	Overview
Base Data Adjustments	Adjustments to the base data including service exclusions, data smoothing, and IBNR
Trend	Factors to account for the forecasted change in utilization and unit costs from the base to the contract period
Program Changes	Prospective program (population and benefit) changes not reflected in the adjusted base data
Third Party Liability Adjustment	Adjustment to account for the impact of third party liabilities (TPL)
Integrated Care Adjustment	Adjustment to facilitate the integration of physical and behavioral health services
Non-Medical Loading	Administrative loads to account for non-medical expenditures, as well as a profit margin

The remainder of this report provides further detail on each of the adjustment categories above.

3.02 Base Data

Data Reporting

The base data used for the SFY19 ACC rate development was SFY15 priced encounters. The encounter data was reported by each BHO with diagnosis, utilization and payment information. The encounter data was priced by HCPF, then shared with **Optumas** for inclusion in the rate methodology. **Optumas** validates the encounter data for reasonableness through various longitudinal analyses, but does not audit the pricing algorithm and relied on the in-depth knowledge and expertise of HCPF.

HCPF provided encounter data with incurred dates of July 2014 through June 2016, paid through July 2016. As described in prior rate certifications, the vast majority of encounters are priced by HCPF using cost reports submitted by the Community Mental Health Centers (CMHCs). These cost reports are finalized and submitted to HCPF in the November following the end of a fiscal year. For example, the SFY16 cost reports are due to HCPF no later than 11/30/2016. Since SFY16 cost reports were not available to price the SFY16 encounter data, **Optumas** used the priced SFY15 encounter data as the base for rate development.

Optumas also utilized a monthly, member-level eligibility file, as well as direction from the State of Colorado, to identify members eligible for Behavioral Health Managed Care for the SFY15 time period. This eligibility file was developed to reflect the days in a given month that a member had eligibility for the program. By using this type of eligibility file, **Optumas** developed the capitation rates in a way that is appropriate for the ACC program to pay partial capitation.

Covered Services

The RAEs are responsible for providing a range of medically necessary Behavioral Health services to their enrolled members. These services can be categorized as those required under the State Plan and those required under HCPF's 1915 (b)(3) waiver:

State Plan Services	1915(b)(3) (Non-State Plan) Services
Clinic Services, Case Management	Assertive Community Treatment (ACT)
Emergency/Crisis Services	Clubhouses/Drop-In Centers
Family Psychotherapy	Intensive Case Management
Group Psychotherapy	Prevention/Early Intervention
Individual Psychotherapy	Recovery Services
Inpatient Hospital – adult 21-64	Residential Services
Inpatient Hospital – under 21	Respite Services
Inpatient Hospital – 65 and over	Vocational Services
Mental Health Assessment	
Outpatient Day Treatment	
Outpatient Hospital	
Pharmacologic Management	
Psychiatrist	
Rehabilitative Services	

State Plan Services	1915(b)(3) (Non-State Plan) Services
School-Based Mental Health Services	
Substance Use Services	

Separate rates have been developed for the Non-State Plan services to be compliant with CMS regulations. Non-State Plan services are included because the state has a 1915 waiver allowing the provision of b(3) services. Under the 1915 waiver, these services have been demonstrated to be budget neutral compared to the State Plan service that would be provided in lieu of the b(3) services.

Category of Aid

For each of the seven RAEs, the base data was summarized into cohorts that represented different levels of risk, referred to as the following Categories of Aid (COAs):

- Categorically Eligible Low Income Adults (Non-expansion Parent)
- Children
- Foster Care
- 65 and Older (Elderly)
- Disabled Adults 60-64 (Disabled)
- Disabled Individuals to 59 (Disabled)
- Expansion Parent
- MAGI Adults

These eight COAs are grouped into seven rate cells (the two Disabled COAs above are aggregated into one rate cell called Disabled). The purpose of the rate cells is to group similar risk together to create credible and homogenous cohorts that assist in better matching payment to risk with regards to developing capitation rates. Actuarially sound rates are developed for each of these rate cells for each region. The seven rate cells are:

- Elderly
- Disabled
- Non-expansion Parent
- Children
- Foster Care
- Expansion Parent
- MAGI Adults

3.03 Base Data Adjustments

The encounter data used as the base included SFY15 dates of service, with runout through July 2016. The base data can be found in Appendix I.A.

Service Exclusions

The SFY15 encounter data included services that will not be covered under the SFY19 ACC program. As such, HCPF and **Optumas** worked in partnership to remove these encounters from the base data. The service exclusions applied to the encounter data can be summarized in the following categories:

1. Services that have a diagnosis code or procedure code that will not be covered under the SFY19 ACC program
2. The first six FQHC visits for low-acuity procedure codes in a fiscal year

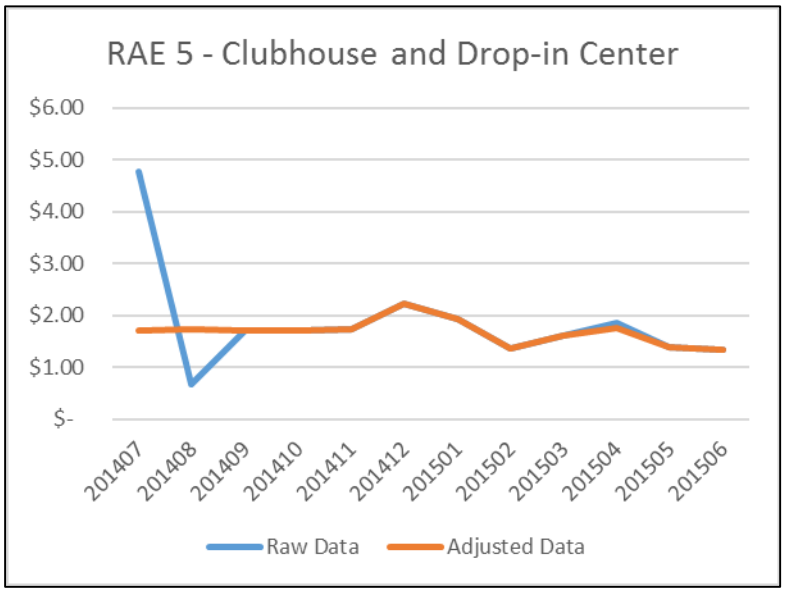
The impact of excluding these services can be found in Appendix I.B.

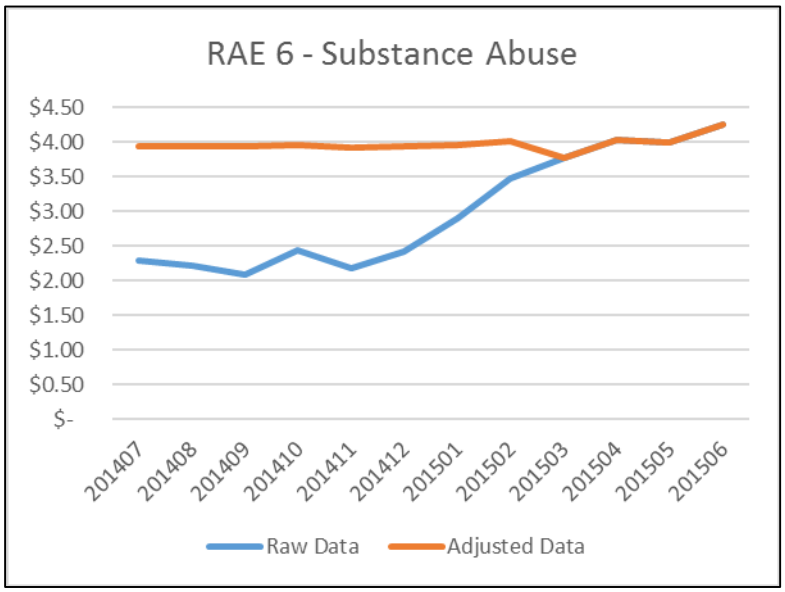
Base Data Smoothing

Optumas arrayed the data across time to check for any data anomalies. **Optumas** checked both volume of claims and total expenditures by looking at the data longitudinally. As described in the SFY17 certification letter, the base data adjustment is comprised of two components:

1. A utilization adjustment to the Substance Use category of service to reflect that the base data is understated for this service in the first 9 months of the SFY15 base data time period. **Optumas** had discussions with each BHO to understand what caused the underutilization in the first 9 months. All BHOs confirmed that there had been an increased outreach due to new interventions and increases in staffing, which resulted in an increase in utilization for SUD services in the latter part of SFY15. Since part of the base data did not reflect this enhanced outreach, a base data adjustment was necessary to reflect the level of outreach expected in the contract period. As such, it is necessary to adjust the first three quarters of SFY15 to reflect the appropriate level of outreach that is in place as of the last quarter of SFY15. **Optumas** used PMPM averages of the last quarter of encounter data to inform the SUD base data adjustment.
2. An adjustment to account for data anomalies, such as missing data in a given month, for all services. This ensured that any gaps or spikes in the data were identified and smoothed out before creating the base data. **Optumas** smoothed the data anomalies by using moving averages of previous months.

Please note, the base data smoothing adjustment was done by RAE and COS. The graphs below illustrate a few examples of the data smoothing performed by **Optumas:**





The impact of smoothing these services can be found in Appendix I.C.

Additional Covered Services

HCPF provided **Optumas** with additional SFY15 FFS data for services that are not currently covered under the BHO program, but will be covered under the SFY19 contract period. Under the SFY19 ACC program, members are able to access up to six low-acuity behavioral health services, regardless of diagnosis and without authorization. These six services are reimbursed under fee-for-service when they are billed by a primary care provider and under the behavioral health capitation when they are billed by a specialty behavioral health provider. Members may also receive certain behavioral health services from a specialty behavioral health provider, regardless of the member's diagnosis; these services will now be covered under the behavioral health capitation.

HCPF provided **Optumas** with SFY15 FFS data for these services, and **Optumas** made a base data adjustment to include these services for the base data period. The impact of adding these services can be seen in Appendix I.D.

Incurred but Not Reported (IBNR)

Optumas analyzed the claim payment lag for each region by category of service, through an incurred but not reported (IBNR) analysis. Since the encounter data was paid through July 2016, the results of the IBNR analysis indicated that the SFY15 data was complete. As such, an IBNR adjustment was not necessary.

3.04 Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. The trend adjustments were derived using a thorough review of encounter and financial data, supplemented by trend benchmarks of behavioral health programs comparable to the Colorado Behavioral Health program. The trend and utilization assumptions are not solely based on historical data, but instead incorporate expected changes due to external influences (economy, prevalence rates, underserved population) and changes in the way the services will be provided.

Trend was reviewed and developed separately by utilization and unit cost. **Optumas** arrayed the utilization inherent in the July 2014 – June 2016 encounter data to develop the prospective trend assumptions. Please note, although the SFY16 encounter data did not include appropriate SFY16 pricing, the utilization information was still used to help inform the utilization trend assumptions. **Optumas** analyzed and developed trends by RAE, major COA, and broad COS due to credibility concerns surrounding the size of the cohorts. The trend analysis normalized the data and developed 6-month, 3-month, annual and rolling trends.

Optumas reviewed trends observed in other States for similar populations and benefits, such as Nebraska and Oregon. These sources, in conjunction with actual encounter utilization, were used to guide the utilization trend assumptions.

Since the encounter data is priced using a cost-based approach, **Optumas** reviewed the yearly base unit cost for each CMHC across time. **Optumas** arrayed SFY12-SFY15 base unit cost information. In order to calculate an average base unit cost for each region, **Optumas** weighted the base unit costs by CMHC into the regions using SFY15 priced encounters as the weight. This process allowed **Optumas** to smooth the volatility inherent in the base unit cost for the smaller CMHCs, and resulted in a reasonable base unit cost trend for each BHO.

Trends were developed on an annualized basis and applied for a total of 48 months from the midpoint of the SFY15 base to the midpoint of the SFY19 contract period. Trend assumptions by RAE, major COA, and broad COS are included within Appendix I.E.

3.05 Program Changes

Substance Use Intensive Outpatient (SUD IOP)

Since March 1, 2015, the BHOs have been responsible for providing Substance Use Intensive Outpatient (SUD IOP). Although the SUD IOP benefit change was implemented on March 1, 2015, the SFY15 base data did not contain any SUD IOP utilization. **Optumas** reviewed the SUD IOP utilization inherent in the emerging SFY16 encounter data. The SFY16 SUD IOP costs were trended forward to SFY19, and added to the base by region and COA. The resulting adjustment can be found in Appendix I.F.

3.06 Third Party Liability Adjustment

Optumas used a supplemental file provided by HCPF to address the impact of third party liabilities (TPL). This file contained the TPL amounts reported by each BHO for the SFY15 time period. The amount of TPL reported by the BHOs is the amount that any third party payers are actually or potentially liable for some or all of the costs of Covered Services to BHO enrollees. These amounts were deducted from the base data in order to reflect the appropriate level of expenditures for each RAE. The impact of this adjustment is shown in Appendix I.G.

3.07 Integrated Care Costs

The integrated care adjustment is meant to reflect the expenses that each RAE will incur due to the efforts surrounding integrating care between behavioral health and physical health. The BHOs provided HCPF with an estimated cost for these services. Each BHO provided their historical integrated care costs, as well as their projected integrated care costs. **Optumas** discussed and reviewed the estimates provided by each BHO with HCPF. HCPF and **Optumas** then had discussions with each BHO to better understand the costs being reported. These discussions allowed HCPF to compare the reported costs with the expected integrated services outlined in the RFP. These cost were then translated into a statewide adjustment shown in Appendix I.H.

3.08 Non-Medical Loading

Non-medical loading was added to the projected medical costs to account for RAE expenditures for the following items: general administration, underwriting gains, and risk/contingency margin.
The magnitude of each of the non-medical loading components was developed by using the SFY15 financial data provided by each of the BHOs and State-directed policies. **Optumas** reviewed the administrative expenditures in the SFY15 financials for each region and in aggregate. By comparing reported administrative expenditures to reported total expenditures **Optumas** was able to determine the aggregate medical expense as a portion of total premiums. **Optumas** developed a statewide non-medical load to be used for the first year of the program since actual administrative expenses for the new RAEs is not yet known. In subsequent years, administrative levels of the participating RAEs will be reviewed and included in the analysis used to determine non-medical loading.

The administrative load included in the rate development is meant to cover only the administrative cost and not include any risk contingency/profit margin. **Optumas** identifies the risk contingency/profit margin separately, which is a 1.0% load. **Optumas** worked with the State to develop the 1.0%, in developing this amount consideration was given to RBC requirements imposed on the managed care entities. The resulting non-medical load components are listed in Appendix I.I.

4. Rate Certification

I, Zachary Aters, Senior Actuary at **Optumas**, Member of the American Academy of Actuaries (MAAA), and an Associate of the Society of Actuaries (ASA), am certifying the calculation of the rates. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time to time by the Actuarial Standards Board.

The capitation rates provided with this certification are considered actuarially sound for purposes of the 42 CFR 438.6(c), according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rates meet the requirements of 42 CFR 438.6(c).

The actuarially sound rates that are associated with this certification are effective July 1, 2018 – June 30, 2019 for the ACC program.

The actuarially sound capitation rates are based on a projection of future events. The capitation rates offered may not be appropriate for any specific RAE. An individual RAE should review the rates in relation to the benefits that it is obligated to provide to the covered population. The RAE should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with the State.

Please feel free to contact me at 480.588.2495 for any additional information.

Sincerely,

Zachary Aters, ASA, MAAA

5. Appendices

Appendix I.A. Base Data

		SFY15 Base Data			
RAE	Cohort	MMs	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	2,247	$107.26	$20.09
1	Children	902,075	1,083	$134.25	$12.12
1	MAGI Adults	484,006	3,779	$104.97	$33.06
1	Expansion Parent	151,603	1,148	$117.77	$11.27
1	Foster Care	34,889	8,162	$115.35	$78.46
1	Elderly	66,446	1,945	$95.31	$15.45
1	Disabled	130,879	13,345	$76.94	$85.56
2	Non-expansion Parent	161,619	2,518	$86.37	$18.13
2	Children	492,114	1,378	$109.99	$12.63
2	MAGI Adults	157,465	5,840	$78.27	$38.09
2	Expansion Parent	72,166	1,468	$79.54	$9.73
2	Foster Care	19,694	9,362	$107.88	$84.17
2	Elderly	37,489	3,117	$30.05	$7.81
2	Disabled	64,213	15,432	$55.71	$71.64
3	Non-expansion Parent	525,843	3,306	$65.90	$18.15
3	Children	1,651,355	1,583	$116.67	$15.39
3	MAGI Adults	601,429	6,338	$65.82	$34.76
3	Expansion Parent	231,625	1,688	$70.86	$9.97
3	Foster Care	60,938	14,230	$90.86	$107.75
3	Elderly	98,548	3,302	$41.89	$11.53
3	Disabled	193,461	21,990	$58.81	$107.77
4	Non-expansion Parent	235,836	4,170	$81.63	$28.37
4	Children	548,232	1,430	$121.58	$14.48
4	MAGI Adults	306,717	4,797	$94.13	$37.63
4	Expansion Parent	93,555	1,648	$99.38	$13.65
4	Foster Care	25,516	6,941	$119.05	$68.86
4	Elderly	71,436	2,314	$84.41	$16.28
4	Disabled	150,732	13,394	$93.29	$104.13
5	Non-expansion Parent	302,473	4,536	$57.07	$21.57
5	Children	939,387	1,464	$118.05	$14.41
5	MAGI Adults	549,629	11,950	$46.55	$46.35
5	Expansion Parent	110,459	1,680	$70.88	$9.93
5	Foster Care	30,164	13,473	$82.07	$92.14
5	Elderly	93,098	7,383	$34.39	$21.16
5	Disabled	169,545	49,542	$40.25	$166.19
6	Non-expansion Parent	264,370	3,023	$91.48	$23.05
6	Children	678,280	1,903	$120.32	$19.08
6	MAGI Adults	424,718	4,536	$97.99	$37.04
6	Expansion Parent	110,074	1,696	$95.64	$13.52
6	Foster Care	34,685	9,161	$119.48	$91.22
6	Elderly	60,678	1,710	$93.61	$13.34
6	Disabled	122,560	14,496	$83.57	$100.95
7	Non-expansion Parent	319,130	2,566	$78.92	$16.87
7	Children	790,746	1,636	$95.49	$13.02
7	MAGI Adults	407,219	4,146	$94.50	$32.65
7	Expansion Parent	132,603	1,359	$87.95	$9.96
7	Foster Care	35,314	13,387	$69.67	$77.72
7	Elderly	42,143	1,135	$81.38	$7.70
7	Disabled	134,029	7,530	$98.25	$61.65

Appendix I.B. Service Exclusions

		Excluded Services					
RAE	Cohort	MMs	Excluded Dollars	Excluded Units	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	$130,690	1,422	2,198	$107.60	$19.71
1	Children	902,075	$5,861	120	1,081	$134.38	$12.11
1	MAGI Adults	484,006	$89,067	3,059	3,704	$106.53	$32.88
1	Expansion Parent	151,603	$5,559	106	1,140	$118.25	$11.23
1	Foster Care	34,889	$1,068	59	8,142	$115.59	$78.43
1	Elderly	66,446	$3,194	20	1,941	$95.19	$15.40
1	Disabled	130,879	$43,112	806	13,271	$77.07	$85.23
2	Non-expansion Parent	161,619	$23,337	469	2,484	$86.88	$17.98
2	Children	492,114	$33,804	268	1,372	$109.91	$12.57
2	MAGI Adults	157,465	$69,528	1,780	5,704	$79.20	$37.65
2	Expansion Parent	72,166	$7,200	232	1,430	$80.85	$9.63
2	Foster Care	19,694	$996	20	9,350	$107.95	$84.12
2	Elderly	37,489	$0	1,963	2,488	$37.64	$7.81
2	Disabled	64,213	$20,086	1,424	15,166	$56.44	$71.33
3	Non-expansion Parent	525,843	$84,322	1,000	3,283	$65.78	$17.99
3	Children	1,651,355	$112,498	815	1,577	$116.59	$15.32
3	MAGI Adults	601,429	$143,231	2,028	6,297	$65.78	$34.52
3	Expansion Parent	231,625	$13,825	148	1,681	$70.75	$9.91
3	Foster Care	60,938	$8,086	77	14,215	$90.85	$107.62
3	Elderly	98,548	$1,756	579	3,231	$42.74	$11.51
3	Disabled	193,461	$137,164	3,339	21,783	$58.98	$107.06
4	Non-expansion Parent	235,836	$2,680	19	4,169	$81.62	$28.36
4	Children	548,232	$2,760	15	1,429	$121.56	$14.48
4	MAGI Adults	306,717	$3,968	53	4,795	$94.14	$37.61
4	Expansion Parent	93,555	$716	4	1,648	$99.35	$13.64
4	Foster Care	25,516	$376	6	6,938	$119.07	$68.84
4	Elderly	71,436	$0	0	2,314	$84.41	$16.28
4	Disabled	150,732	$10,082	49	13,390	$93.26	$104.07
5	Non-expansion Parent	302,473	$614,298	3,627	4,392	$53.39	$19.54
5	Children	939,387	$1,460,340	7,359	1,370	$112.53	$12.85
5	MAGI Adults	549,629	$1,817,483	10,025	11,731	$44.03	$43.05
5	Expansion Parent	110,459	$91,784	450	1,631	$66.90	$9.09
5	Foster Care	30,164	$154,817	719	13,187	$79.18	$87.01
5	Elderly	93,098	$49,506	286	7,346	$33.70	$20.63
5	Disabled	169,545	$1,061,364	6,314	49,095	$39.09	$159.93
6	Non-expansion Parent	264,370	$15,354	98	3,019	$91.39	$22.99
6	Children	678,280	$19,063	101	1,901	$120.25	$19.05
6	MAGI Adults	424,718	$14,191	102	4,533	$97.97	$37.01
6	Expansion Parent	110,074	$2,815	19	1,694	$95.58	$13.49
6	Foster Care	34,685	$339	2	9,161	$119.47	$91.21
6	Elderly	60,678	$66	1	1,710	$93.61	$13.34
6	Disabled	122,560	$44,575	232	14,473	$83.39	$100.58
7	Non-expansion Parent	319,130	$3,025	15	2,565	$78.90	$16.86
7	Children	790,746	$1,099	16	1,636	$95.49	$13.02
7	MAGI Adults	407,219	$7,661	52	4,144	$94.48	$32.63
7	Expansion Parent	132,603	$3,187	8	1,358	$87.79	$9.94
7	Foster Care	35,314	$296	7	13,384	$69.67	$77.71
7	Elderly	42,143	$0	0	1,135	$81.38	$7.70
7	Disabled	134,029	$12,740	56	7,525	$98.16	$61.56

Appendix I.C. Base Data Smoothing

		Base Data Smoothing				
RAE	Cohort	MMs	Factor	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	0.891	2,577	$102.99	$22.12
1	Children	902,075	0.940	1,145	$135.05	$12.88
1	MAGI Adults	484,006	0.893	4,312	$102.42	$36.80
1	Expansion Parent	151,603	0.903	1,331	$112.14	$12.44
1	Foster Care	34,889	0.942	8,553	$116.87	$83.29
1	Elderly	66,446	0.948	2,113	$92.31	$16.25
1	Disabled	130,879	0.934	14,164	$77.28	$91.22
2	Non-expansion Parent	161,619	0.948	2,693	$84.51	$18.97
2	Children	492,114	0.979	1,397	$110.32	$12.84
2	MAGI Adults	157,465	0.953	6,190	$76.60	$39.51
2	Expansion Parent	72,166	0.957	1,534	$78.75	$10.06
2	Foster Care	19,694	0.980	9,564	$107.69	$85.83
2	Elderly	37,489	1.050	2,336	$38.18	$7.43
2	Disabled	64,213	0.973	16,001	$54.99	$73.33
3	Non-expansion Parent	525,843	0.941	3,578	$64.13	$19.12
3	Children	1,651,355	0.961	1,650	$116.02	$15.95
3	MAGI Adults	601,429	0.950	6,761	$64.51	$36.35
3	Expansion Parent	231,625	0.941	1,837	$68.82	$10.54
3	Foster Care	60,938	0.961	14,923	$90.02	$111.95
3	Elderly	98,548	0.908	3,615	$42.07	$12.67
3	Disabled	193,461	0.956	22,809	$58.88	$111.93
4	Non-expansion Parent	235,836	0.976	4,487	$77.73	$29.06
4	Children	548,232	0.996	1,446	$120.70	$14.54
4	MAGI Adults	306,717	0.977	5,127	$90.13	$38.50
4	Expansion Parent	93,555	0.975	1,766	$95.10	$14.00
4	Foster Care	25,516	0.996	7,020	$118.15	$69.11
4	Elderly	71,436	0.990	2,354	$83.78	$16.44
4	Disabled	150,732	0.993	13,595	$92.54	$104.84
5	Non-expansion Parent	302,473	0.965	4,657	$52.18	$20.25
5	Children	939,387	0.978	1,415	$111.42	$13.13
5	MAGI Adults	549,629	0.972	12,191	$43.59	$44.29
5	Expansion Parent	110,459	0.966	1,727	$65.37	$9.41
5	Foster Care	30,164	0.978	13,610	$78.46	$88.99
5	Elderly	93,098	0.986	7,273	$34.50	$20.91
5	Disabled	169,545	0.992	48,399	$39.97	$161.23
6	Non-expansion Parent	264,370	0.935	3,531	$83.60	$24.60
6	Children	678,280	0.975	1,956	$119.84	$19.53
6	MAGI Adults	424,718	0.942	5,230	$90.18	$39.30
6	Expansion Parent	110,074	0.933	1,992	$87.10	$14.46
6	Foster Care	34,685	0.972	9,484	$118.76	$93.86
6	Elderly	60,678	0.943	1,855	$91.50	$14.15
6	Disabled	122,560	0.950	15,796	$80.41	$105.84
7	Non-expansion Parent	319,130	1.003	2,551	$79.09	$16.82
7	Children	790,746	1.000	1,636	$95.49	$13.02
7	MAGI Adults	407,219	1.003	4,120	$94.74	$32.53
7	Expansion Parent	132,603	1.001	1,354	$87.95	$9.92
7	Foster Care	35,314	1.000	13,384	$69.67	$77.71
7	Elderly	42,143	0.997	1,147	$80.79	$7.72
7	Disabled	134,029	1.002	7,509	$98.16	$61.42

Appendix I.D. Additional Covered Services

		Additional Covered Services					
RAE	Cohort	MMs	Util/K Adj.	PMPM Adj.	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	18	$0.14	2,595	$102.90	$22.26
1	Children	902,075	3	$0.05	1,148	$135.20	$12.93
1	MAGI Adults	484,006	16	$0.16	4,328	$102.47	$36.96
1	Expansion Parent	151,603	15	$0.14	1,346	$112.13	$12.57
1	Foster Care	34,889	24	$0.45	8,577	$117.17	$83.75
1	Elderly	66,446	0	$0.00	2,113	$92.31	$16.25
1	Disabled	130,879	29	$0.30	14,193	$77.37	$91.51
2	Non-expansion Parent	161,619	11	$0.11	2,704	$84.67	$19.08
2	Children	492,114	3	$0.05	1,400	$110.50	$12.89
2	MAGI Adults	157,465	13	$0.13	6,202	$76.70	$39.64
2	Expansion Parent	72,166	4	$0.05	1,538	$78.93	$10.12
2	Foster Care	19,694	39	$0.74	9,603	$108.17	$86.56
2	Elderly	37,489	0	$0.00	2,336	$38.18	$7.43
2	Disabled	64,213	13	$0.22	16,014	$55.11	$73.55
3	Non-expansion Parent	525,843	39	$0.24	3,617	$64.25	$19.37
3	Children	1,651,355	2	$0.02	1,652	$116.06	$15.98
3	MAGI Adults	601,429	43	$0.25	6,804	$64.55	$36.60
3	Expansion Parent	231,625	30	$0.18	1,867	$68.88	$10.72
3	Foster Care	60,938	44	$0.72	14,967	$90.34	$112.67
3	Elderly	98,548	8	$0.04	3,623	$42.10	$12.71
3	Disabled	193,461	64	$0.41	22,873	$58.94	$112.34
4	Non-expansion Parent	235,836	20	$0.08	4,507	$77.58	$29.14
4	Children	548,232	4	$0.02	1,449	$120.61	$14.57
4	MAGI Adults	306,717	4	$0.04	5,130	$90.16	$38.55
4	Expansion Parent	93,555	3	$0.05	1,770	$95.26	$14.05
4	Foster Care	25,516	3	$0.02	7,023	$118.13	$69.14
4	Elderly	71,436	0	$0.00	2,354	$83.78	$16.44
4	Disabled	150,732	3	$0.05	13,599	$92.56	$104.89
5	Non-expansion Parent	302,473	43	$0.25	4,700	$52.34	$20.50
5	Children	939,387	2	$0.01	1,416	$111.39	$13.15
5	MAGI Adults	549,629	38	$0.22	12,230	$43.68	$44.51
5	Expansion Parent	110,459	37	$0.24	1,765	$65.59	$9.65
5	Foster Care	30,164	29	$0.37	13,639	$78.62	$89.36
5	Elderly	93,098	6	$0.03	7,279	$34.53	$20.94
5	Disabled	169,545	19	$0.13	48,418	$39.99	$161.36
6	Non-expansion Parent	264,370	38	$0.26	3,569	$83.57	$24.86
6	Children	678,280	4	$0.05	1,960	$119.93	$19.58
6	MAGI Adults	424,718	30	$0.21	5,260	$90.15	$39.51
6	Expansion Parent	110,074	20	$0.18	2,012	$87.32	$14.64
6	Foster Care	34,685	17	$0.39	9,500	$119.04	$94.24
6	Elderly	60,678	19	$0.08	1,875	$91.06	$14.22
6	Disabled	122,560	55	$0.36	15,851	$80.40	$106.20
7	Non-expansion Parent	319,130	53	$0.44	2,604	$79.51	$17.26
7	Children	790,746	26	$0.27	1,662	$95.92	$13.28
7	MAGI Adults	407,219	71	$0.57	4,192	$94.77	$33.10
7	Expansion Parent	132,603	36	$0.31	1,389	$88.33	$10.23
7	Foster Care	35,314	122	$1.42	13,506	$70.30	$79.13
7	Elderly	42,143	0	$0.00	1,147	$80.79	$7.72
7	Disabled	134,029	124	$1.17	7,633	$98.39	$62.58

Appendix I.E. Trend

		Trend Assumptions						
RAE	Cohort	MMs	Util/K Trend	Unit Cost Trend	PMPM Trend	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	3.2%	-0.4%	2.8%	2,947	$101.28	$24.88
1	Children	902,075	2.4%	0.0%	2.4%	1,262	$135.14	$14.21
1	MAGI Adults	484,006	1.4%	-0.4%	1.0%	4,573	$100.83	$38.42
1	Expansion Parent	151,603	1.3%	-0.3%	0.9%	1,417	$110.57	$13.05
1	Foster Care	34,889	0.8%	-0.1%	0.7%	8,855	$116.67	$86.10
1	Elderly	66,446	1.4%	0.1%	1.5%	2,233	$92.76	$17.26
1	Disabled	130,879	1.2%	0.4%	1.6%	14,903	$78.47	$97.46
2	Non-expansion Parent	161,619	2.2%	0.6%	2.8%	2,955	$86.62	$21.33
2	Children	492,114	1.4%	0.8%	2.2%	1,478	$114.20	$14.07
2	MAGI Adults	157,465	1.7%	0.6%	2.3%	6,632	$78.57	$43.42
2	Expansion Parent	72,166	1.6%	0.6%	2.2%	1,638	$80.89	$11.04
2	Foster Care	19,694	2.1%	0.9%	3.1%	10,449	$112.28	$97.77
2	Elderly	37,489	0.6%	0.9%	1.5%	2,388	$39.61	$7.88
2	Disabled	64,213	0.6%	1.0%	1.6%	16,401	$57.34	$78.37
3	Non-expansion Parent	525,843	4.0%	-0.5%	3.5%	4,238	$62.95	$22.23
3	Children	1,651,355	1.7%	0.7%	2.5%	1,771	$119.38	$17.61
3	MAGI Adults	601,429	0.7%	0.6%	1.3%	6,996	$66.10	$38.54
3	Expansion Parent	231,625	0.8%	0.5%	1.2%	1,925	$70.17	$11.25
3	Foster Care	60,938	1.0%	0.9%	1.9%	15,581	$93.66	$121.60
3	Elderly	98,548	0.1%	0.9%	1.1%	3,641	$43.70	$13.26
3	Disabled	193,461	0.1%	0.9%	1.0%	22,964	$61.14	$117.00
4	Non-expansion Parent	235,836	2.3%	-1.0%	1.2%	4,930	$74.49	$30.60
4	Children	548,232	1.5%	-0.6%	0.9%	1,540	$117.79	$15.12
4	MAGI Adults	306,717	0.6%	-0.9%	-0.2%	5,259	$87.12	$38.18
4	Expansion Parent	93,555	0.6%	-0.8%	-0.2%	1,813	$92.08	$13.91
4	Foster Care	25,516	1.1%	-0.6%	0.5%	7,342	$115.25	$70.51
4	Elderly	71,436	0.3%	-0.2%	0.0%	2,381	$82.97	$16.46
4	Disabled	150,732	0.4%	-0.3%	0.2%	13,828	$91.62	$105.58
5	Non-expansion Parent	302,473	1.9%	0.5%	2.5%	5,077	$53.43	$22.60
5	Children	939,387	1.4%	0.8%	2.2%	1,496	$115.19	$14.36
5	MAGI Adults	549,629	0.7%	0.6%	1.4%	12,576	$44.82	$46.97
5	Expansion Parent	110,459	0.6%	0.6%	1.2%	1,811	$67.15	$10.13
5	Foster Care	30,164	0.5%	1.0%	1.5%	13,926	$81.69	$94.79
5	Elderly	93,098	0.3%	1.2%	1.5%	7,370	$36.14	$22.20
5	Disabled	169,545	0.4%	1.0%	1.4%	49,143	$41.69	$170.72
6	Non-expansion Parent	264,370	2.9%	-0.5%	2.4%	3,995	$82.04	$27.32
6	Children	678,280	1.5%	0.3%	1.9%	2,084	$121.44	$21.09
6	MAGI Adults	424,718	1.7%	0.2%	1.9%	5,622	$90.81	$42.54
6	Expansion Parent	110,074	1.9%	0.1%	2.0%	2,169	$87.60	$15.83
6	Foster Care	34,685	1.3%	0.4%	1.7%	10,002	$120.82	$100.71
6	Elderly	60,678	1.3%	-0.1%	1.2%	1,977	$90.75	$14.95
6	Disabled	122,560	1.4%	-0.1%	1.3%	16,770	$80.15	$112.01
7	Non-expansion Parent	319,130	2.5%	-0.5%	2.0%	2,871	$77.94	$18.65
7	Children	790,746	2.5%	-0.5%	2.0%	1,831	$94.13	$14.36
7	MAGI Adults	407,219	1.0%	-0.7%	0.3%	4,364	$92.05	$33.48
7	Expansion Parent	132,603	0.9%	-0.7%	0.2%	1,440	$85.97	$10.31
7	Foster Care	35,314	0.4%	-0.5%	-0.1%	13,741	$68.91	$78.91
7	Elderly	42,143	0.4%	-0.7%	-0.4%	1,163	$78.52	$7.61
7	Disabled	134,029	0.3%	-0.6%	-0.2%	7,730	$96.21	$61.97

	PMPM Trend by RAE and COS						
COS	1	2	3	4	5	6	7
ACT Services	0.5%	1.6%	1.0%	-0.6%	1.0%	1.8%	0.8%
Clubhouse and Drop-in Center	0.9%	1.6%	1.0%	-0.5%	1.0%	2.2%	0.9%
Intensive Case Management	0.7%	1.6%	1.3%	-0.5%	1.0%	2.1%	0.9%
Other State Plan	2.3%	2.0%	1.5%	0.0%	1.2%	2.5%	1.7%
Prevention and Early Intervention	1.2%	1.8%	1.3%	-0.4%	1.3%	2.0%	1.0%
Recovery Services	0.7%	1.6%	1.0%	-0.5%	0.9%	2.1%	0.7%
Residential Services	1.2%	2.0%	2.7%	1.1%	2.5%	1.2%	0.7%
Respite Care	1.7%	2.0%	1.3%	-0.3%	2.0%	1.9%	0.0%
School-based Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
State Plan	1.5%	2.1%	1.7%	0.3%	1.5%	1.6%	0.8%
Substance Abuse	2.8%	3.7%	4.1%	1.4%	3.2%	2.9%	1.1%
Vocational Services	0.5%	2.0%	1.3%	-0.1%	1.2%	1.5%	1.0%

Appendix I.F. SUD IOP Program Change

		SUD IOP Program Change					
RAE	Cohort	MMs	Util/K Adjustment	PMPM Adjustment	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	4.49	$0.07	2,952	$101.40	$24.94
1	Children	902,075	0.14	$0.00	1,262	$135.13	$14.21
1	MAGI Adults	484,006	8.33	$0.11	4,581	$100.95	$38.54
1	Expansion Parent	151,603	3.80	$0.06	1,420	$110.75	$13.11
1	Foster Care	34,889	0.00	$0.00	8,855	$116.67	$86.10
1	Elderly	66,446	0.00	$0.00	2,233	$92.76	$17.26
1	Disabled	130,879	5.27	$0.08	14,909	$78.51	$97.54
2	Non-expansion Parent	161,619	12.12	$0.18	2,967	$86.99	$21.51
2	Children	492,114	0.00	$0.00	1,478	$114.20	$14.07
2	MAGI Adults	157,465	16.26	$0.23	6,648	$78.79	$43.65
2	Expansion Parent	72,166	11.76	$0.17	1,650	$81.58	$11.21
2	Foster Care	19,694	0.00	$0.00	10,449	$112.28	$97.77
2	Elderly	37,489	0.00	$0.00	2,388	$39.61	$7.88
2	Disabled	64,213	8.36	$0.12	16,410	$57.40	$78.49
3	Non-expansion Parent	525,843	2.78	$0.04	4,241	$63.01	$22.27
3	Children	1,651,355	0.18	$0.00	1,771	$119.38	$17.62
3	MAGI Adults	601,429	5.80	$0.07	7,002	$66.17	$38.61
3	Expansion Parent	231,625	4.74	$0.06	1,929	$70.38	$11.32
3	Foster Care	60,938	2.05	$0.03	15,583	$93.66	$121.63
3	Elderly	98,548	0.00	$0.00	3,641	$43.70	$13.26
3	Disabled	193,461	1.04	$0.01	22,965	$61.14	$117.01
4	Non-expansion Parent	235,836	0.48	$0.01	4,930	$74.50	$30.61
4	Children	548,232	0.20	$0.00	1,540	$117.78	$15.12
4	MAGI Adults	306,717	4.16	$0.05	5,263	$87.18	$38.24
4	Expansion Parent	93,555	0.12	$0.00	1,814	$92.09	$13.92
4	Foster Care	25,516	0.00	$0.00	7,342	$115.25	$70.51
4	Elderly	71,436	0.00	$0.00	2,381	$82.97	$16.46
4	Disabled	150,732	3.73	$0.06	13,832	$91.65	$105.64
5	Non-expansion Parent	302,473	9.57	$0.09	5,086	$53.53	$22.69
5	Children	939,387	0.40	$0.00	1,496	$115.18	$14.36
5	MAGI Adults	549,629	12.48	$0.13	12,589	$44.89	$47.09
5	Expansion Parent	110,459	4.06	$0.05	1,815	$67.30	$10.18
5	Foster Care	30,164	0.83	$0.01	13,926	$81.69	$94.80
5	Elderly	93,098	0.00	$0.00	7,370	$36.14	$22.20
5	Disabled	169,545	2.60	$0.02	49,146	$41.69	$170.73
6	Non-expansion Parent	264,370	22.31	$0.20	4,018	$82.17	$27.51
6	Children	678,280	0.50	$0.00	2,084	$121.43	$21.09
6	MAGI Adults	424,718	17.25	$0.17	5,639	$90.90	$42.71
6	Expansion Parent	110,074	0.97	$0.01	2,170	$87.60	$15.84
6	Foster Care	34,685	0.00	$0.00	10,002	$120.82	$100.71
6	Elderly	60,678	0.00	$0.00	1,977	$90.75	$14.95
6	Disabled	122,560	9.14	$0.13	16,779	$80.20	$112.14
7	Non-expansion Parent	319,130	0.48	$0.01	2,871	$77.95	$18.65
7	Children	790,746	0.20	$0.00	1,831	$94.13	$14.36
7	MAGI Adults	407,219	4.12	$0.05	4,368	$92.11	$33.53
7	Expansion Parent	132,603	0.11	$0.00	1,440	$85.98	$10.32
7	Foster Care	35,314	0.00	$0.00	13,741	$68.91	$78.91
7	Elderly	42,143	0.00	$0.00	1,163	$78.52	$7.61
7	Disabled	134,029	3.68	$0.06	7,733	$96.26	$62.03

Appendix I.G. TPL Adjustment

		TPL Adjustment				
RAE	Cohort	MMs	TPL Adjustment	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	99.4%	2,952	$100.83	$24.80
1	Children	902,075	99.5%	1,262	$134.49	$14.15
1	MAGI Adults	484,006	99.8%	4,581	$100.71	$38.45
1	Expansion Parent	151,603	99.7%	1,420	$110.40	$13.07
1	Foster Care	34,889	99.6%	8,855	$116.16	$85.72
1	Elderly	66,446	95.3%	2,233	$88.43	$16.45
1	Disabled	130,879	98.2%	14,909	$77.06	$95.74
2	Non-expansion Parent	161,619	99.6%	2,967	$86.62	$21.42
2	Children	492,114	99.6%	1,478	$113.72	$14.01
2	MAGI Adults	157,465	99.6%	6,648	$78.46	$43.47
2	Expansion Parent	72,166	99.6%	1,650	$81.23	$11.17
2	Foster Care	19,694	99.6%	10,449	$111.81	$97.36
2	Elderly	37,489	99.6%	2,388	$39.45	$7.85
2	Disabled	64,213	99.6%	16,410	$57.16	$78.17
3	Non-expansion Parent	525,843	99.2%	4,241	$62.53	$22.10
3	Children	1,651,355	99.2%	1,771	$118.47	$17.48
3	MAGI Adults	601,429	99.2%	7,002	$65.67	$38.32
3	Expansion Parent	231,625	99.2%	1,929	$69.84	$11.23
3	Foster Care	60,938	99.2%	15,583	$92.95	$120.71
3	Elderly	98,548	99.2%	3,641	$43.36	$13.16
3	Disabled	193,461	99.2%	22,965	$60.67	$116.12
4	Non-expansion Parent	235,836	99.4%	4,930	$74.02	$30.41
4	Children	548,232	99.5%	1,540	$117.18	$15.04
4	MAGI Adults	306,717	99.9%	5,263	$87.05	$38.18
4	Expansion Parent	93,555	99.7%	1,814	$91.84	$13.88
4	Foster Care	25,516	99.6%	7,342	$114.73	$70.20
4	Elderly	71,436	94.0%	2,381	$77.99	$15.47
4	Disabled	150,732	97.5%	13,832	$89.38	$103.03
5	Non-expansion Parent	302,473	99.7%	5,086	$53.38	$22.63
5	Children	939,387	99.7%	1,496	$114.86	$14.32
5	MAGI Adults	549,629	99.7%	12,589	$44.76	$46.96
5	Expansion Parent	110,459	99.7%	1,815	$67.11	$10.15
5	Foster Care	30,164	99.7%	13,926	$81.46	$94.53
5	Elderly	93,098	99.7%	7,370	$36.04	$22.13
5	Disabled	169,545	99.7%	49,146	$41.57	$170.25
6	Non-expansion Parent	264,370	99.4%	4,018	$81.71	$27.36
6	Children	678,280	99.8%	2,084	$121.18	$21.05
6	MAGI Adults	424,718	99.7%	5,639	$90.65	$42.60
6	Expansion Parent	110,074	99.7%	2,170	$87.36	$15.80
6	Foster Care	34,685	99.7%	10,002	$120.49	$100.43
6	Elderly	60,678	91.7%	1,977	$83.25	$13.71
6	Disabled	122,560	97.8%	16,779	$78.42	$109.65
7	Non-expansion Parent	319,130	99.4%	2,871	$77.46	$18.53
7	Children	790,746	99.5%	1,831	$93.65	$14.29
7	MAGI Adults	407,219	99.9%	4,368	$91.98	$33.48
7	Expansion Parent	132,603	99.7%	1,440	$85.75	$10.29
7	Foster Care	35,314	99.6%	13,741	$68.61	$78.56
7	Elderly	42,143	94.0%	1,163	$73.80	$7.15
7	Disabled	134,029	97.5%	7,733	$93.88	$60.50

Appendix I.H. Integrated Care Costs

		Integrated Care				
RAE	Cohort	MMs	Unit Cost Adjustment	Util/K	Unit Cost	PMPM
1	Non-expansion Parent	345,891	2.0%	2,952	$102.84	$25.30
1	Children	902,075	2.0%	1,262	$137.18	$14.43
1	MAGI Adults	484,006	2.0%	4,581	$102.73	$39.22
1	Expansion Parent	151,603	2.0%	1,420	$112.60	$13.33
1	Foster Care	34,889	2.0%	8,855	$118.48	$87.43
1	Elderly	66,446	2.0%	2,233	$90.20	$16.78
1	Disabled	130,879	2.0%	14,909	$78.60	$97.66
2	Non-expansion Parent	161,619	2.0%	2,967	$88.35	$21.85
2	Children	492,114	2.0%	1,478	$116.00	$14.29
2	MAGI Adults	157,465	2.0%	6,648	$80.03	$44.34
2	Expansion Parent	72,166	2.0%	1,650	$82.86	$11.39
2	Foster Care	19,694	2.0%	10,449	$114.05	$99.30
2	Elderly	37,489	2.0%	2,388	$40.24	$8.01
2	Disabled	64,213	2.0%	16,410	$58.30	$79.73
3	Non-expansion Parent	525,843	2.0%	4,241	$63.78	$22.54
3	Children	1,651,355	2.0%	1,771	$120.84	$17.83
3	MAGI Adults	601,429	2.0%	7,002	$66.98	$39.08
3	Expansion Parent	231,625	2.0%	1,929	$71.24	$11.45
3	Foster Care	60,938	2.0%	15,583	$94.81	$123.12
3	Elderly	98,548	2.0%	3,641	$44.23	$13.42
3	Disabled	193,461	2.0%	22,965	$61.89	$118.44
4	Non-expansion Parent	235,836	2.0%	4,930	$75.51	$31.02
4	Children	548,232	2.0%	1,540	$119.52	$15.34
4	MAGI Adults	306,717	2.0%	5,263	$88.80	$38.95
4	Expansion Parent	93,555	2.0%	1,814	$93.68	$14.16
4	Foster Care	25,516	2.0%	7,342	$117.03	$71.60
4	Elderly	71,436	2.0%	2,381	$79.55	$15.78
4	Disabled	150,732	2.0%	13,832	$91.17	$105.09
5	Non-expansion Parent	302,473	2.0%	5,086	$54.45	$23.08
5	Children	939,387	2.0%	1,496	$117.15	$14.61
5	MAGI Adults	549,629	2.0%	12,589	$45.66	$47.90
5	Expansion Parent	110,459	2.0%	1,815	$68.46	$10.35
5	Foster Care	30,164	2.0%	13,926	$83.09	$96.42
5	Elderly	93,098	2.0%	7,370	$36.76	$22.58
5	Disabled	169,545	2.0%	49,146	$42.40	$173.66
6	Non-expansion Parent	264,370	2.0%	4,018	$83.34	$27.90
6	Children	678,280	2.0%	2,084	$123.60	$21.47
6	MAGI Adults	424,718	2.0%	5,639	$92.47	$43.45
6	Expansion Parent	110,074	2.0%	2,170	$89.11	$16.11
6	Foster Care	34,685	2.0%	10,002	$122.90	$102.44
6	Elderly	60,678	2.0%	1,977	$84.91	$13.99
6	Disabled	122,560	2.0%	16,779	$79.99	$111.84
7	Non-expansion Parent	319,130	2.0%	2,871	$79.01	$18.90
7	Children	790,746	2.0%	1,831	$95.52	$14.57
7	MAGI Adults	407,219	2.0%	4,368	$93.82	$34.15
7	Expansion Parent	132,603	2.0%	1,440	$87.47	$10.49
7	Foster Care	35,314	2.0%	13,741	$69.98	$80.13
7	Elderly	42,143	2.0%	1,163	$75.28	$7.30
7	Disabled	134,029	2.0%	7,733	$95.76	$61.71

Appendix I.I. Non-Medical Loading

		Non-Medical Load		
RAE	Cohort	MMs	Load %	PMPM
1	Non-expansion Parent	345,891	13.0%	$29.08
1	Children	902,075	13.0%	$16.58
1	MAGI Adults	484,006	13.0%	$45.08
1	Expansion Parent	151,603	13.0%	$15.32
1	Foster Care	34,889	13.0%	$100.50
1	Elderly	66,446	13.0%	$19.29
1	Disabled	130,879	13.0%	$112.25
2	Non-expansion Parent	161,619	13.0%	$25.11
2	Children	492,114	13.0%	$16.42
2	MAGI Adults	157,465	13.0%	$50.96
2	Expansion Parent	72,166	13.0%	$13.09
2	Foster Care	19,694	13.0%	$114.14
2	Elderly	37,489	13.0%	$9.20
2	Disabled	64,213	13.0%	$91.64
3	Non-expansion Parent	525,843	13.0%	$25.91
3	Children	1,651,355	13.0%	$20.50
3	MAGI Adults	601,429	13.0%	$44.92
3	Expansion Parent	231,625	13.0%	$13.17
3	Foster Care	60,938	13.0%	$141.52
3	Elderly	98,548	13.0%	$15.42
3	Disabled	193,461	13.0%	$136.14
4	Non-expansion Parent	235,836	13.0%	$35.66
4	Children	548,232	13.0%	$17.63
4	MAGI Adults	306,717	13.0%	$44.77
4	Expansion Parent	93,555	13.0%	$16.27
4	Foster Care	25,516	13.0%	$82.30
4	Elderly	71,436	13.0%	$18.14
4	Disabled	150,732	13.0%	$120.79
5	Non-expansion Parent	302,473	13.0%	$26.53
5	Children	939,387	13.0%	$16.79
5	MAGI Adults	549,629	13.0%	$55.06
5	Expansion Parent	110,459	13.0%	$11.90
5	Foster Care	30,164	13.0%	$110.83
5	Elderly	93,098	13.0%	$25.95
5	Disabled	169,545	13.0%	$199.61
6	Non-expansion Parent	264,370	13.0%	$32.07
6	Children	678,280	13.0%	$24.68
6	MAGI Adults	424,718	13.0%	$49.95
6	Expansion Parent	110,074	13.0%	$18.52
6	Foster Care	34,685	13.0%	$117.74
6	Elderly	60,678	13.0%	$16.08
6	Disabled	122,560	13.0%	$128.55
7	Non-expansion Parent	319,130	13.0%	$21.73
7	Children	790,746	13.0%	$16.75
7	MAGI Adults	407,219	13.0%	$39.25
7	Expansion Parent	132,603	13.0%	$12.06
7	Foster Care	35,314	13.0%	$92.10
7	Elderly	42,143	13.0%	$8.39
7	Disabled	134,029	13.0%	$70.93

Appendix I.J. Rates

RAE	Cohort	MMs	Final PMPM
1	Non-expansion Parent	345,891	$29.08
1	Children	902,075	$16.58
1	MAGI Adults	484,006	$45.08
1	Expansion Parent	151,603	$15.32
1	Foster Care	34,889	$100.50
1	Elderly	66,446	$19.29
1	Disabled	130,879	$112.25
2	Non-expansion Parent	161,619	$25.11
2	Children	492,114	$16.42
2	MAGI Adults	157,465	$50.96
2	Expansion Parent	72,166	$13.09
2	Foster Care	19,694	$114.14
2	Elderly	37,489	$9.20
2	Disabled	64,213	$91.64
3	Non-expansion Parent	525,843	$25.91
3	Children	1,651,355	$20.50
3	MAGI Adults	601,429	$44.92
3	Expansion Parent	231,625	$13.17
3	Foster Care	60,938	$141.52
3	Elderly	98,548	$15.42
3	Disabled	193,461	$136.14
4	Non-expansion Parent	235,836	$35.66
4	Children	548,232	$17.63
4	MAGI Adults	306,717	$44.77
4	Expansion Parent	93,555	$16.27
4	Foster Care	25,516	$82.30
4	Elderly	71,436	$18.14
4	Disabled	150,732	$120.79
5	Non-expansion Parent	302,473	$26.53
5	Children	939,387	$16.79
5	MAGI Adults	549,629	$55.06
5	Expansion Parent	110,459	$11.90
5	Foster Care	30,164	$110.83
5	Elderly	93,098	$25.95
5	Disabled	169,545	$199.61
6	Non-expansion Parent	264,370	$32.07
6	Children	678,280	$24.68
6	MAGI Adults	424,718	$49.95
6	Expansion Parent	110,074	$18.52
6	Foster Care	34,685	$117.74
6	Elderly	60,678	$16.08
6	Disabled	122,560	$128.55
7	Non-expansion Parent	319,130	$21.73
7	Children	790,746	$16.75
7	MAGI Adults	407,219	$39.25
7	Expansion Parent	132,603	$12.06
7	Foster Care	35,314	$92.10
7	Elderly	42,143	$8.39
7	Disabled	134,029	$70.93

Appendix I.K. State Plan vs 1915(b)(3)

RAE	Cohort	1915(b)(3) Rate	State Plan Rate
1	Non-expansion Parent	$1.24	$27.83
1	Children	$0.08	$16.50
1	MAGI Adults	$3.45	$41.63
1	Expansion Parent	$0.57	$14.75
1	Foster Care	$0.98	$99.52
1	Elderly	$4.91	$14.38
1	Disabled	$17.39	$94.86
2	Non-expansion Parent	$1.80	$23.31
2	Children	$0.19	$16.23
2	MAGI Adults	$5.75	$45.21
2	Expansion Parent	$0.41	$12.68
2	Foster Care	$1.87	$112.27
2	Elderly	$2.72	$6.48
2	Disabled	$23.91	$67.73
3	Non-expansion Parent	$0.81	$25.09
3	Children	$0.24	$20.25
3	MAGI Adults	$5.15	$39.77
3	Expansion Parent	$0.20	$12.96
3	Foster Care	$5.25	$136.27
3	Elderly	$3.87	$11.55
3	Disabled	$25.28	$110.85
4	Non-expansion Parent	$4.99	$30.67
4	Children	$0.03	$17.61
4	MAGI Adults	$5.76	$39.00
4	Expansion Parent	$1.30	$14.98
4	Foster Care	$1.62	$80.68
4	Elderly	$5.55	$12.60
4	Disabled	$39.35	$81.44
5	Non-expansion Parent	$2.62	$23.91
5	Children	$0.01	$16.78
5	MAGI Adults	$10.72	$44.34
5	Expansion Parent	$0.50	$11.40
5	Foster Care	$0.99	$109.84
5	Elderly	$8.52	$17.43
5	Disabled	$71.05	$128.55
6	Non-expansion Parent	$2.44	$29.64
6	Children	$0.00	$24.67
6	MAGI Adults	$6.26	$43.69
6	Expansion Parent	$1.02	$17.50
6	Foster Care	$0.20	$117.54
6	Elderly	$4.62	$11.45
6	Disabled	$42.24	$86.31
7	Non-expansion Parent	$5.34	$16.39
7	Children	$0.64	$16.11
7	MAGI Adults	$13.03	$26.23
7	Expansion Parent	$3.04	$9.02
7	Foster Care	$3.84	$88.26
7	Elderly	$1.50	$6.89
7	Disabled	$16.81	$54.12

Deliverables by Interval – updated 10/25/16

Startup

RFP Section Number	Deliverable	Due Date	Interval
5.1.8.2.4.1	Communication Plan	DUE: Within ten (10) Business Days after the Effective Date	Start Up
5.1.9.2.1	Business Continuity Plan	DUE: Within ten (10) Business Days after the Effective Date.	Start Up
5.2.11.1	Final list of names of the individuals assigned to the Contract	Within five (5) Business Days following the Effective Date	Start Up
5.2.11.3	Organizational Chart	DUE: Thirty (30) days from the Contract's Effective Date.	Start Up
5.2.11.8	Name of each Subcontractor and items on which each Subcontractor will work	No later than thirty (30) days prior to the Subcontractor beginning work or the effective date	Start Up
5.5.8.3	ACC Program Member Handbook section specific to the Contractor's Region	DUE: Thirty (30) days from the Contract's Effective Date.	Start Up
5.7.8.3	Provider Credentialing Policies and Procedures	DUE: Within sixty (60) days following the Operational Start Date.	Start Up
5.9.7.1	Population Stratification Methodology and Population Health Management Plan	Sixty (60) days after the Contract's Effective Date	Start Up
5.13.11.5	Quality of Care Concerns Process	DUE: Within thirty (30) days following the Operational Start Date.	Start Up
6.6.3.4	Start-Up Plan	DUE: Five (5) days after the Effective date.	Start Up
6.6.3.7	Closeout Plan	DUE: Thirty (30) days following the Effective Date	Start Up
5.5.8.5	Network Directory	DUE: Five (5) business days prior to the Operational Start Date and monthly by the first day of the month, unless an extension is allowed by the Department.	Start Up/ Monthly
5.10.10.2	Practice Support Plan	DUE: Thirty (30) days after the Contract Effective Date and then annually, on July 31st.	Start Up/ Annually
5.18.25	Compliance Program Plan	DUE: Thirty (30) days after the Effective Date and annually on July 31st.	Start Up/ Annually
5.10.10.4	Provider Payment Report	DUE: Thirty (3) days after the Contract Effective Date and then annually, on July 31st.	Start Up/Annually

5.15.11.7	Disclosure of Information on Persons Convicted of Crimes	DUE: Upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date of a written request by the Department.	Start Up/ Upon Request
5.15.24.12	Ownership or Control Disclosures	DUE: At the time of executing the Contract with the Department, at Contract renewal or extension, and within thirty-five (35) calendar days of either a change of ownership or a written request by the Department.	Start Up/ Upon Request
5.12.15.1	Utilization Management Program and Procedures	DUE: Thirty (30) days after the Contract Effective Date and thirty (30) days after any significant change is made.	Start Up/ Initiating Event

Monthly

RFP Section Number	Deliverable	Due Date	Interval
5.5.8.5	Network Directory	DUE: Five (5) business days prior to the Operational Start Date and monthly by the first day of the month, unless an extension is allowed by the Department.	Start Up/ Monthly
5.11.15	Third Party Identification Report	DUE: Ten (10) Business Days following the reporting month.	Monthly
5.13.5.1	Certified Encounter Data Submission	DUE: Monthly	Monthly
5.15.24.3	Suspended Payments Report	DUE: On the last business day of each month in which the Contractor suspends payments.	Monthly

Quarterly

RFP Section Number	Deliverable	Due Date	Interval
5.6.12.2	Member Grievance and Appeals Report	DUE: Forty-five (45) days after the end of the reporting quarter.	Quarterly
5.7.8.2	Network Report	DUE: Quarterly, on the last business day of July, October, January, and April.	Quarterly
5.11.15	1915(b)(3) Waiver (Alternative) Services Report	DUE: Forty-five (45) days after the end of the reporting quarter.	Quarterly
5.11.15	Third Party Recovery Report	DUE: Within thirty (30) days following the end of the reporting quarter.	Quarterly

5.14.11.5	QOC Report	DUE: Quarterly	Quarterly
5.14.11.6	COUP Report	Quarterly, by the 10th business day of the month following the end of the calendar quarter that the report covers	Quarterly
5.15.25.2	Graduate Medical Education Report	DUE: Quarterly on July 31st, October 31st, January 31st, and April 30th.	Quarterly
5.15.10	Fraud, Waste, and Abuse Compliance Report	DUE: Within forty-five (45) days of the end of the reporting quarter and an annual summary on July 31st	Quarterly/ Annually

Semi-Annually

RFP Section Number	Deliverable	Due Date	Interval
5.5.8.1	Member Engagement Report	Every 6 months	Semi-annually
5.8.7.1	Health Neighborhood and Community Report	DUE: Semi-annually, by January 31st and July 31st of each year	Semi-annually
5.9.7.3	Care Coordination Report	Semi-annually on November 1, reporting for the period of April 1 through September 30; and May 1, reporting for the period of October 1 through March 30; except that the deliverable due November 1, 2018 will be for the reporting period of July 1, 2018 through September 30, 2018.	Semi-annually

Annually

RFP Section Number	Deliverable	Due Date	Interval
5.10.10.2	Practice Support Plan	DUE: Thirty (30) days after the Contract Effective Date and then annually, on July 31st.	Start Up/ Annually
5.18.25	Compliance Program Plan	DUE: Thirty (30) days after the Effective Date and annually on July 31st.	Start Up/ Annually
5.10.10.4	Provider Payment Report	DUE: Thirty (30) days after the Effective Date and annually on July 31st.	Start Up/ Annually
5.15.10	Fraud, Waste, and Abuse Compliance Report	DUE: Within forty-five (45) days of the end of the reporting quarter and an annual summary on July 31st	Quarterly/ Annually
5.1.8.2.4.4	Annual Communication Plan Update	DUE: Annually, by July 31st of each year	Annually

5.1.9.3.1	Updated Business Continuity Plan	DUE: Annually, by July 31st of each year.	Annually
5.5.8.2	Evaluation of Member Programs to Promote Health and Wellness	Thirty (30) days following the end date of each Contract year	Annually
5.7.8.1	Network Adequacy Plan	Annually, on July 31st	Annually
5.9.7.2	Population Stratification Methodology and Population Health Management Plan Update	Annually on July 1 beginning on July 1, 2019	Annually
5.10.10.4	Health Information Exchange Connectivity Assessment	Annually, on July 31st	Annually
5.11.15	Child Mental Health Treatment Act (CMHTA) Report	DUE: Annually on September 1st.	Annually
5.14.11.1	Quality Improvement Plan	DUE: Annually, no later than the last Business Day of September of each contract year.	Annually
5.14.11.2	Annual Quality Report	DUE: Annually by the last Business Day of September for the preceding fiscal year's quality activities.	Annually
5.14.11.3	Performance Improvement Projects	TBD by Department	Annually
5.14.11.4	CG-CAHPS Survey Raw Data	TBD by Department	Annually
5.14.5	Data Governance Policy and Activities Update	DUE: Annually on July 31st	Annually
5.15.25.3	Provider-Preventable Conditions Report	DUE: Annually, on July 31st of each year.	Annually
5.16.25	Health Insurance Providers Fee Report	DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963.	Annually
6.6.3.8	Closeout Plan Update	DUE: Annually, by July 31st of each year.	Annually

Upon Request

RFP Section Number	Deliverable	Due Date	Interval
5.15.11.7	Disclosure of Information on Persons Convicted of Crimes	DUE: Upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date of a written request by the Department.	Start Up/ Upon Request

5.15.24.12	Ownership or Control Disclosures	DUE: At the time of executing the Contract with the Department, at Contract renewal or extension, and within thirty-five (35) calendar days of either a change of ownership or a written request by the Department.	Start Up/ Upon Request
5.1.8.2.4.7	Interim Communication Plan Update	DUE: Within ten (10) Business Days following the receipt of the request from the Department, unless the Department allows for a longer time in writing.	Upon Request
5.2.11.2	Updated list of names of the individuals assigned to the Contract	Within five (5) business days following the Department's request for an update	Upon Request
5.5.8.6	Updated client materials including changes required by the Department	DUE: Thirty (30) days from the request by the Department to make a change.	Upon Request
5.10.10.1	All Contractor-developed provider materials related to the Accountable Care Collaborative Program or Colorado Medicaid documents and provider contact plans	Ten (10) Business Days from the date the materials or plans are requested by the Department; and ten (10) Business Days from the request by the Department to update documents	Upon Request
5.14.7.2	QOC Description Letter	DUE: Within ten (10) Business Days of the Department's Request	Upon Request
5.15.11.2	Business transaction disclosures	DUE: Within thirty-five (35) calendar days of the date of a request by the Department or by the Secretary of the Department of Health and Human Services.	Upon Request
5.15.11.9	Notices and Disclosures Policies and Procedures	DUE: Within ten (10) Business Days of the Department's request	Upon Request
5.15.24.7	Administrative Report	DUE: Within ten (10) days following the Department's request.	Upon Request
5.2.11.4	Updated Organizational Chart	DUE: Five (5) days from any change in Key Personnel or from the Department's request for an updated Organizational Chart.	Initiating Event/Upon Request
5.2.11.7	All current professional licensure and certification documentation as specified for key personnel or other personnel	Within five (5) Business Days of receipt of updated licensure or upon request by the Department	Initiating Event/Upon Request

Initiating Event

RFP Section Number	Deliverable	Due Date	Interval
5.12.15.1	Utilization Management Program and Procedures	DUE: Thirty (30) days after the Contract Effective Date and thirty (30) days after any significant change is made.	Start Up/ Initiating Event
5.2.11.5	Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during an interim change	DUE: At least five (5) Business Days prior to the change in Key Personnel	Initiating Event
5.2.11.6	Name(s), resume(s), and Key Personnel Clearance Form for the person(s) replacing anyone in a key personnel position who leaves employment with the Contractor	Within ten (10) Business Days following the Contractor's identification of a potential replacement.	Initiating Event
5.5.8.4	Updated Member Handbook section specific to the Contractor's Region whenever significant changes occur	DUE: Thirty (30) days from when changes take effect.	Initiating Event
5.5.8.7	Notice to Members of PCMP termination	DUE: Fifteen (15) days from the notice of termination.	Initiating Event
5.7.8.4	Network Change and Deficiency Notification	DUE: Within five (5) Business Days of Contractor becoming aware of the change or deficiency.	Initiating Event
5.15.11.1	Notification of Actions Involving Licenses, Certifications, Approvals and Permits	DUE: Within two (2) Business Days of Contractor's notification.	Initiating Event
5.15.11.10	Security and HIPAA Violation Breach Notification	DUE: Within five (5) business days of becoming aware of the breach.	Initiating Event
5.15.11.15	Notification of discovery of excluded employee or contractor	DUE: Within five (5) business days of the date of discovery.	Initiating Event
5.15.11.8	Notification of Discovery of Excluded Network Provider	DUE: Within five (5) business days of discovering the exclusion of the Provider.	Initiating Event
5.15.24.15	Conflict of Interest Disclosure Statement	DUE: Within ten (10) Business Days of learning of an existing appearance of a conflict of interest situation.	Initiating Event

5.15.24.16	Solvency Notification	DUE: Within two (2) Business Days, of becoming aware of a possible solvency issue.	Initiating Event
5.15.24.17	Subcontracts and Provider Contracts	DUE: Within five (5) Business Days of the Department's Request.	Initiating Event
5.15.24.2	Suspected Fraud Report	DUE: Within three (3) business days of the Contractor's verbal report to the Department	Initiating Event
5.15.24.20	Warranty and Certification Notification	DUE: Within five (5) Business Days of becoming aware of its inability to offer the warranty and certifications.	Initiating Event
5.15.24.5	Notice of Subcontractor Termination	DUE: At least sixty (60) calendar days prior to termination for all general terminations and within two (2) Business Days of the decision to terminate for quality or performance issue terminations.	Initiating Event
5.15.24.7	Provider and Member Fraud Report	DUE: Three (3) Business Days from the initial discovery of the fraud or abuse.	Initiating Event
6.6.3.5	Member Notifications	DUE: Thirty (30) days prior to termination of the Contract	Initiating Event
6.6.3.6	Provider Notifications	DUE: Thirty (30) days prior to termination of the Contract	Initiating Event
5.2.11.4	Updated Organizational Chart	DUE: Five (5) days from any change in Key Personnel or from the Department's request for an updated Organizational Chart.	Initiating Event/Upon Request
5.2.11.7	All current professional licensure and certification documentation as specified for key personnel or other personnel	Within five (5) Business Days of receipt of updated licensure or upon request by the Department	Initiating Event/Upon Request