

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Colorado

**Regarding a Federal-State Partnership
to Test a Managed Fee-for-Service (MFFS)
Financial Alignment Model for Medicare-Medicaid Enrollees**

**Colorado Demonstration to Integrate Care
for Medicare-Medicaid Enrollees**

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I. STATEMENT OF INITIATIVE

To establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the State of Colorado (State), Department of Health Care Policy and Financing (Department), to implement the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees (Demonstration), a Managed Fee-for-Service (MFFS) Financial Alignment Model, to better serve individuals eligible for both Medicare and Medicaid (“enrollees” or “beneficiaries”). The Demonstration is intended to coordinate services across Medicare and Medicaid and achieve cost savings for the Federal and the State government through improvements in quality of care and reductions in unnecessary expenditures. CMS plans to begin this MFFS Financial Alignment Model Demonstration on July 1, 2014, and continue until December 31, 2017, unless terminated or extended pursuant to the terms and conditions of the Final Demonstration Agreement to be finalized before initiation of this Demonstration (see Appendix 1 for definitions of terms used in this MOU).

Medicare-Medicaid enrollees’ needs and experiences, including the ability to self-direct care, be involved in one’s care, and live independently in the community, are central to this Demonstration. Key objectives of the Demonstration are to improve beneficiary experience in accessing care, promote person-centered planning, promote independence in the community, improve quality of care, assist beneficiaries in getting the right care at the right time and place, reduce health disparities, improve transitions among care settings, and achieve cost savings for the Federal and the State government through improvements in health and functional outcomes.

Individuals eligible for this Demonstration are those meeting the following criteria: are enrolled in Medicare Parts A and B and eligible for Part D; receive full Medicaid benefits under Fee-for-Service (FFS) arrangements; have no other private or public health insurance; and are a resident of the State. Additional details are included in Section III.B below and in Appendix 3.

Under this Demonstration, the State will be accountable for improving the coordination of care across existing providers and Medicare and Medicaid service delivery systems. In return, the State will be eligible to receive a retrospective performance payment based on its performance on quality and savings criteria as outlined later in this document in Section III.G and in Appendix 6.

The primary objectives of this Demonstration are to alleviate fragmentation and to improve coordination of services for Medicare-Medicaid enrollees served in FFS systems of care. The goal of the Demonstration is to eliminate duplication of services for Medicare-Medicaid enrollees, expand access to needed care and services, and improve the lives of beneficiaries, while lowering costs.

To accomplish these goals, Colorado's Demonstration builds upon its existing Accountable Care Collaborative (ACC) Program, a managed FFS program for Medicaid beneficiaries throughout the State. The ACC Program has two central goals. First, it aims to improve health outcomes of enrollees through a coordinated, client/family-centered system by proactively addressing beneficiaries' health needs, whether simple or complex. Second, it seeks to control costs through reducing avoidable, duplicative, variable, and inappropriate use of health care resources. The Demonstration extends the benefits of the ACC Program to the State's dual eligible Medicare and Medicaid enrollees. The ACC Program has three core elements which serve as a foundation for the Demonstration: Regional Care Collaborative Organizations (RCCOs), Primary Care Medical Providers (PCMPs), and the Statewide Data and Analytics Contractor (SDAC). In addition, RCCOs will work with the State's Single Entry Point agencies (SEPs) and Community Centered Boards (CCBs) to optimize existing service delivery coordination and develop additional linkages between the long-term services and supports (LTSS) systems and the physical and behavioral health systems in the Demonstration.

Under the Demonstration, Medicare-Medicaid enrollees will continue to have access to all of the same services they currently receive, including primary and acute medical care as well as LTSS, which are made available through Medicaid Home and Community-Based Services (HCBS) waiver programs and coverage for institutional care. RCCOs have implemented written protocols with Colorado's Behavioral Health Organizations (BHOs) in their corresponding regions. The State aims to strengthen integration through contractual arrangements that put a special focus on Medicare-Medicaid enrollees with behavioral health needs.

One of the core tenets of the existing ACC Program is collaboration. This includes collaboration between the State and the RCCOs, collaboration among the RCCOs, and collaboration among different delivery systems, such as LTSS and behavioral health. The RCCOs are held accountable for collaboration in their contracts with the State. RCCOs are

responsible for establishing working relationships with a variety of specialists and ancillary providers to meet their beneficiaries' needs. All of these relationships comprise the networks of primary, specialty, and ancillary providers that will be leveraged to successfully serve the Demonstration population.

CMS will also assign beneficiaries to this Demonstration for the purposes of analyzing how the Demonstration affects quality and costs and for determining retrospective performance payments. Assignment will have no impact on the services beneficiaries receive or on provider reimbursement (see Section III.B and Appendix 7 for additional details).

The Medicare aspect of this Demonstration will be implemented under Title XVIII of the Social Security Act (the Act) as waived pursuant to section 1115A of the Act. Medicaid authority necessary to carry out this Demonstration includes State Plan and waiver authority. Section III.A and Appendices 4 and 5 of this MOU provide additional explanation of the specific authorities.

Oversight will focus on performance measurement and continuous quality improvement based on the Demonstration's key objectives. Except as otherwise specified in this MOU, the State will be required to comply with applicable Medicaid rules and regulations and to promote access to all Medicare-covered services. The State must also comply with all terms and conditions specific to this Demonstration and evaluation requirements, including the requirements specified in the Final Demonstration Agreement.

Preceding the signing of this MOU, the State has undergone necessary planning activities consistent with CMS standards and conditions for participation as detailed through supporting documentation provided in Appendix 2. These activities include an ongoing and robust beneficiary- and stakeholder-engagement process. In addition, before execution of the Final Demonstration Agreement, the State must satisfy all readiness requirements.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING (MOU)

This document details the principles under which CMS and the State plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State shall conduct in preparation for implementation of the Demonstration before the parties execute a Final Demonstration Agreement, which sets forth the terms and conditions of the Demonstration. CMS and the State intend to enter into this Final Demonstration Agreement following the signing of this MOU and prior to implementation of the Demonstration.

III. DEMONSTRATION DESIGN/OPERATIONAL PLAN

The following is a summary of the terms and conditions the parties intend to incorporate into the Final Demonstration Agreement as well as those activities the parties intend to conduct prior to entering into the Final Demonstration Agreement and initiating the Demonstration. The Final Demonstration Agreement will also include additional operational and technical requirements pertinent to the implementation of the Demonstration that exceed the terms of this MOU. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

A. DEMONSTRATION AUTHORITY

1. Demonstration Authority: Under the authority at section 1115A of the Social Security Act (the Act), the Center for Medicare and Medicaid Innovation is authorized to “...test payment and service delivery models...to determine the effect of applying such models under [Medicare and Medicaid]...” Such models include but are not limited to the models described in section 1115A(b)(2)(B) of the Act. Section 1115A(d)(1) authorizes the Secretary to waive such requirements of titles XI and XVIII of the Act and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) of the Act as may be necessary solely for purposes of testing models described in Section 1115A(b).

2. Medicare Authority: The Medicare portions of the Demonstration shall operate according to existing Medicare law, regulation, and sub-regulatory guidance and are subject to existing requirements for financial and program integrity, except to the extent these requirements are waived or modified as provided for in Appendix 4.

3. Medicaid Authority: The Medicaid elements of the Demonstration shall operate according to existing Medicaid law, regulation, and sub-regulatory guidance and are subject to existing requirements for financial and program integrity, and Colorado’s approved State Plan and applicable waiver programs, except to the extent these requirements are waived or modified as provided for in Appendix 5. Colorado will submit a 1932(a) State Plan amendment to allow Medicare-Medicaid enrollees to participate in the ACC Program. Implementation of this Demonstration is contingent on CMS approval of the necessary State Plan authority.

B. ELIGIBILITY

1. Eligible Populations: Beneficiaries must meet all of the following criteria to be eligible for assignment to this Demonstration:

- Be enrolled in Medicare Parts A and B and eligible for Part D; and
- Receive full Medicaid benefits under FFS arrangements;
- Have no other private or public health insurance; and
- Be a resident of the State.

Beneficiaries not eligible for assignment excluded from enrollment in this Demonstration include:

- Individuals enrolled in a Medicare Advantage plan, the Program of All-inclusive Care for the Elderly (PACE), the Denver Health Medicaid Choice Plan, or the Rocky Mountain Health Plan;
- Individuals who are residents of an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID); and
- Individuals who are participating in the Colorado House Bill 12-1281 ACC Program Payment Reform pilot.

Such beneficiaries may be eligible for assignment and participate in this Demonstration if they disenroll from their existing programs. Beneficiaries that are enrolled and subsequently become ineligible will be disenrolled.

CMS will work with the State to address beneficiary or provider participation in other Medicare shared savings programs or initiatives, such as Accountable Care Organizations (ACOs) or the Comprehensive Primary Care initiative.

If a beneficiary qualifies for assignment to this Demonstration and another model that involves Medicare shared savings and both start on the same date, the beneficiary will be assigned to this Demonstration. Medicare-Medicaid enrollees in Colorado who are already assigned to a Medicare initiative involving shared savings as of the beginning of this Demonstration will remain assigned to that model and will not be assigned to this Demonstration until they no longer qualify for assignment to that model (see Appendix 7 for additional information).

- 2. Enrollment and Disenrollment Processes:** The Department has developed ACC Program enrollment processes that identify and minimize disruption to existing enrollee-provider relationships. The Department will use these processes to enroll Medicare-Medicaid beneficiaries into the Demonstration, taking into account existing beneficiary relationships with Medicare providers. The SDAC will look at a Medicare-Medicaid enrollee's previous 12 months of Medicare and Medicaid claims history to understand which medical provider the beneficiary has seen most frequently.

Enrollment in the Demonstration will be closely related to attributing a beneficiary to a PCMP. The PCMP is a fundamental component of the ACC Program and the Demonstration, and the Department's objective is to maintain existing beneficiary-provider relationships to avoid disruption in care and services. Appendix 7 further describes the enrollment process.

Enrollment into the ACC Program does not reduce entitlement or access to Medicaid or Medicare services. The Demonstration will not require that any beneficiaries change providers.

- 3. Assignment Date:** Assignment is the process by which CMS will work with the State to align beneficiaries with this Demonstration to create the Demonstration group for purposes of evaluation and making performance payment determinations, including ensuring that beneficiaries are appropriately assigned across Medicare shared savings initiatives. Assignment has no impact on the services beneficiaries are eligible to receive or on provider reimbursement. Beneficiaries are assigned to this Demonstration beginning on the date on which the beneficiary meets the Demonstration eligibility requirements. Assigned beneficiaries are those eligible for the Demonstration (as specified in Section III.B.1 and Appendix 7). With the exception of beneficiaries who are newly eligible for this Demonstration due to gaining Medicare-Medicaid enrollee status or moving into the Demonstration area, beneficiaries must be assigned to this Demonstration within nine (9) months of the Demonstration's implementation (see Appendix 7 for additional details).
- 4. Outreach and Education:** The State will develop outreach and education materials designed to ensure beneficiaries are meaningfully informed about the opportunity to participate in the Demonstration. The State will provide these materials to eligible beneficiaries prior to enrollment in the Demonstration. In addition, the State will make a Frequently Asked Questions (FAQ) document and an ACC Program handbook available to beneficiaries at the time of enrollment; these materials describe the program in more detail and include information on eligibility for the Demonstration as applicable.

Materials may include, but are not limited to, outreach and education materials and benefit coverage information. In accordance with Federal guidelines for Medicare and Medicaid, materials must be accessible and understandable to beneficiaries, including individuals with disabilities and those with limited English proficiency. Materials will be translated into languages required under applicable Medicare and Medicaid rules, guidelines, standards, and

policy, using the program standard that is more generous to beneficiaries. In addition, the State will provide all enrollment materials in English and in Spanish; furnish contact information on all enrollment packet envelopes in Chinese, Russian, Spanish, Vietnamese, and Korean; and offer interpretation services in more than 200 languages through the State's customer contact center and enrollment broker. RCCOs will partner with local organizations serving minority and underserved populations to increase the likelihood of reaching beneficiaries whose first language is not English. In addition, materials will be available in alternative formats, such as large font, if requested by a beneficiary.

Notices for the Demonstration must contain the following information:

- Full Medicare and Medicaid benefits remain unchanged;
- Beneficiaries maintain their choice of providers;
- Description of new opportunities and supports provided under the Demonstration;
- Resources for the beneficiary to obtain additional information on the Demonstration;
- Date the Demonstration will begin; and
- Beneficiary complaint, grievance, and appeal rights.

CMS and the State will coordinate to provide additional outreach activities, which may include but not be limited to regional meetings, direct mailings, posters, and the ability for local organizations and providers to refer potentially eligible beneficiaries. The State will also distribute fact sheets and other informational materials to ensure partner organizations that provide information, assistance, and options counseling are informed regarding Demonstration services.

Because Colorado has no single statewide Ombudsman that serves Medicare-Medicaid beneficiaries, the Department and its partners have created a collaborative alliance among beneficiary rights and protections service organizations to better inform and serve Medicare-Medicaid enrollees in the Demonstration. The alliance fosters common aims of education and information about benefits options and enrollee rights; seamless access to services provided by alliance members; and assistance to and advocacy on behalf of Medicare-Medicaid

enrollees who have complaints or grievances.

Current alliance members include the Department, the seven RCCOs, the Long-term Care Ombudsman, the Medicaid Managed Care Ombudsman, the State Health Insurance Assistance Program, the Colorado Center on Law and Policy, and the Colorado Cross-Disability Coalition. Permanently invited alliance participants and guests include CMS Regional Office, Colorado Legal Services, Medicare-Medicaid beneficiaries of the Demonstration's Advisory Subcommittee, and the Medicare Quality Improvement Organization.

The alliance also supports the creation and development of consistent education and outreach materials for Demonstration beneficiaries, using plain language in a simple format, and interactive training and reference materials for staff and volunteers. Education and outreach materials along with training and reference materials foster coordinated communications and referrals to ensure a more positive experience for Demonstration beneficiaries.

Educational notices will be distributed by the State. Outreach to enrolled beneficiaries will be performed by the Department and the RCCOs. All outreach and education materials and activities referencing this Demonstration shall require approval by CMS prior to dissemination unless otherwise agreed upon by CMS and the State.

C. DELIVERY SYSTEMS AND BENEFITS

- 1. Delivery Systems:** The State will implement this Demonstration by expanding upon the existing ACC Program. Under the MFFS Financial Alignment Model and as defined in this MOU, the State is eligible to benefit from savings resulting from this Demonstration if it meets the applicable quality standards. The State will ensure coordination and facilitate access to all necessary services across the Medicare and Medicaid programs.

The vision of the ACC Program is to transform the health care delivery system from a traditional, unmanaged FFS model to a regional, outcome-focused, client/family-centered

coordinated system of care. Under the ACC, payment to providers continues to be on a FFS basis, and beneficiaries remain free to choose among all participating Medicaid (and, in this Demonstration, Medicare) providers. However, through the seven Regional Care Collaborative Organizations, the ACC creates an accountability structure missing from a typical unmanaged FFS delivery system.

Each beneficiary in the Demonstration will be enrolled with the RCCO serving his/her area of the State. RCCOs offer care coordination, either through RCCO staff or arrangements with local providers. RCCOs also manage virtual networks of providers to promote beneficiary access to care and support providers with clinical tools, data, and analytics.

The ACC model drives primary care reform through Primary Care Medical Providers. PCMPs provide whole-person, coordinated, culturally-competent care for beneficiaries. Through the ACC, participating PCMPs are eligible to receive per member per month payments, and required to offer increased access to beneficiaries through, for example, extended office hours or same-day appointments.

The State has contractual relationships with all RCCOs and PCMPs. RCCO and PCMP contracts include their distinct, shared, and/or delegated responsibilities in the ACC Program. Under this Demonstration, RCCOs and PCMPs will be responsible for working together and with the State to ensure the integration and coordination of primary care, acute care, prescription drugs, behavioral health care, and LTSS across Medicare and Medicaid for those eligible Medicare-Medicaid enrollees who participate in the Demonstration. RCCOs and PCMPs will work with existing service delivery systems, authorizing entities, and specialty care/case managers and will not duplicate functions provided within these systems of care. The State will monitor and hold RCCOs accountable for total Medicare and Medicaid costs of care under the demonstration.

Improved communication among providers is critical in improving care coordination; in many cases, multiple entities provide services to Medicare-Medicaid beneficiaries. In the Demonstration, the State will utilize case management and care coordination already

provided by those serving Medicare-Medicaid beneficiaries in conjunction with care coordination furnished by RCCOs and PCMPs in the ACC Program. Integrated Medicare-Medicaid data supplied by the SDAC will also contribute to a more comprehensive picture of beneficiary services and needs. In addition to fulfilling responsibilities in their current contracts, RCCOs have developed written protocols with community partners and service providers that outline how they will work together to coordinate care and better serve Demonstration enrollees.

The State is accountable for ensuring the provision of person-centered care coordination, which must include robust and meaningful mechanisms to involve the beneficiary in improving health outcomes and in getting the right care at the right time and place. A number of functions are critical to this work, including ensuring smooth care transitions to maximize continuity of care. Examples of strategies to improve care transitions include: a notification system between RCCOs, PCMPs, hospitals, nursing facilities, and residential/rehabilitation facilities to provide prompt communication of a beneficiary's admission or discharge. RCCOs and PCMPs are actively involved in all phases of care transition, which may include in-person visits during hospitalizations or nursing home stays, post-hospital/institutional stay home visits, and telephone calls. To facilitate the delivery of person-centered services, RCCOs and PCMPs are required to work with beneficiaries and their caregivers and with other providers to create a Plan of Care (see Appendices 1 and 7 for additional details).

- 2. Medicare and Medicaid Benefits:** The State shall demonstrate its ability to assure coordination of all necessary Medicare and Medicaid-covered services, including primary care, acute care, prescription drugs, behavioral health, and LTSS. Medicare-covered benefits shall be provided in accordance with existing Medicare FFS rules, Medicare Part D rules, and all other applicable laws and regulations. Medicaid-covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, any applicable Medicaid waiver programs, and all other applicable laws and regulations. This Demonstration does not change Medicare or Medicaid benefits in any way, nor does it affect a beneficiary's choice of Medicare and Medicaid providers.

D. BENEFICIARY RIGHTS AND PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

- 1. Choice of Providers:** Consistent with requirements for the Demonstration, Medicare-Medicaid enrollees will maintain their choice of qualified primary care provider and may exercise that choice at any time. In addition, beneficiaries will maintain their choice of plans and providers and may exercise that choice at any time. This includes the right to choose to continue to receive care through Medicare FFS providers and a Prescription Drug Plan, to choose a Medicare Advantage Plan, and to receive Medicaid services consistent with Colorado's approved Medicaid State Plan and applicable waiver programs. To ensure that Medicare-Medicaid enrollees receive appropriate and timely care, RCCOs are required to develop a robust network of PCMPs in their respective regions of Colorado. With the addition of Medicare-Medicaid enrollees in the ACC Program, PCMPs who work with Medicare beneficiaries will be recruited for participation by the RCCOs. Also, in anticipation of the Demonstration's implementation, the RCCOs are making the establishment of informal agreements with ancillary providers a high priority.
- 2. Continuity of Care:** CMS and the State will ensure that beneficiaries continue to have access to all covered items, services, and primary care, acute care, prescription drugs, behavioral health, and LTSS. This Demonstration does not change Medicare or Medicaid benefits in any way, nor does it change a beneficiary's choice of Medicare and Medicaid providers.
- 3. Person-Centered, Appropriate Care:** CMS, the State, RCCOs, and PCMPs shall ensure that services are person-centered and can accommodate and encourage beneficiary direction, that appropriate covered services are provided to beneficiaries, and that services are delivered in the least restrictive community setting and in accordance with the beneficiary's Plan of Care. CMS, the State, RCCOs, and PCMPs shall promote the coordination of all medically necessary covered benefits to beneficiaries in a manner that is sensitive to the beneficiary's functional and cognitive needs, language and culture, and personal preferences and choices;

allows for involvement of caregivers; and is in an appropriate care setting with a preference for the home and the community when indicated by the beneficiary.

4. Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Civil Rights Act of 1964: CMS and the State believe provider compliance with the ADA, Section 504 of the Rehabilitation Act, and the Civil Rights Act of 1964 is crucial to the success of the Demonstration and will support better health outcomes for beneficiaries. In particular, CMS and the State recognize that successful person-centered care requires physical access to buildings, services and equipment, and flexibility in scheduling and processes. CMS and the State will require RCCOs and PCMPs to demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their enrollees. CMS and the State also recognize access includes effective communication. CMS and the State will require RCCOs and PCMPs to communicate with beneficiaries in a manner that accommodates their individual needs, including requiring interpreters for those who are deaf or hard of hearing and interpreters for those who do not speak English as their primary language. Finally, CMS and the State recognize the importance of staff training on accessibility and accommodation, independent living and recovery, and wellness philosophies. CMS and the State will continue to work with stakeholders, including beneficiaries, to further develop learning opportunities, monitoring mechanisms, and quality measures to ensure providers comply with all requirements of the ADA and the Civil Rights Act.

5. Beneficiary Participation on Governing and Advisory Boards: As part of the Demonstration, CMS and the State shall require the establishment of mechanisms to ensure meaningful beneficiary input processes and the involvement of beneficiaries in planning and process improvements. In addition, the State will provide avenues for ongoing beneficiary input into the Demonstration model, including beneficiary participation through the Colorado Medicare-Medicaid Enrollees Advisory Subcommittee, the ACC Program Improvement Advisory Committee and its standing subcommittees, the Community Living Advisory Group and its subcommittees, and the Nursing Facility Culture Change Accountability Board, which provide regular feedback to the State on the Demonstration. The Department

also will continue to gather and incorporate stakeholder feedback as it works collaboratively with other state agencies and local partners serving Medicare-Medicaid enrollees in the Demonstration. Additionally, the State will monitor client and provider experiences through surveys, focus groups, and data analyses. The State will develop input processes and systems to monitor and measure the level of care provided to Medicare-Medicaid enrollees in the Demonstration. Moreover, as referenced previously in Section III.B.4, the State will utilize the beneficiary rights and protections alliance as a vehicle for additional beneficiary input and feedback throughout the Demonstration's planning processes, implementation, and operation.

- 6. Customer Service Representatives:** CMS will equip 1-800-MEDICARE call center representatives with information on the Demonstration. The State will also train its Customer Contact Center employees and Health*Colorado* staff with information on this Demonstration so that they can assist beneficiaries who call with questions about their enrollment choices and Demonstration services, facilitate enrollment and disenrollment from the Demonstration (see Section III.B.2 for additional information), and provide information about the Demonstration. The Customer Contact Center operates Monday through Friday from 7:30 a.m. to 5:15 p.m. Mountain Time. Health*Colorado* operates Monday through Friday from 8:00 a.m. to 5:00 p.m. Mountain Time. They are responsible for activities including beneficiary assistance, education and information, access to necessary services, enrollment, and disenrollment.

The State ensures access to interpreter services for beneficiaries who call the Customer Contact Center and Health*Colorado*. Materials in alternative formats can also be requested. CMS and the State shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the beneficiary population.

- 7. Privacy and Security:** CMS and the State shall require all RCCOs and PCMPs to ensure privacy and security of beneficiary health records and to provide access by beneficiaries to such records as required by HIPAA and all other applicable Federal and State laws.

8. **Appeals and Grievances:** As referenced in Appendix 7, the State, RCCOs, and other beneficiary rights and protections alliance members will assist Medicare-Medicaid enrollees in being informed of and exercising grievance and appeal rights under Medicare and/or Medicaid, as applicable (see Section III.B.4 for additional information). Grievance and appeal processes and timeframes will remain the same under the Demonstration as currently exist under the Medicare and Medicaid programs.

E. ADMINISTRATION AND REPORTING

1. **Readiness Review:** Prior to implementation, a readiness review will be conducted to ensure the State has the necessary infrastructure and capacity to implement, monitor, and oversee the Demonstration. The readiness review may include, but will not be limited to, a review of provider capacity to meet beneficiary needs under the Demonstration, provider and beneficiary materials, State training modules, monitoring and oversight processes, and data systems. The readiness review will take place prior to the signing of the Final Demonstration Agreement. If gaps in readiness are identified, the State must address these for implementation to proceed.
2. **Monitoring:** The State will be responsible for monitoring the Demonstration on an ongoing basis with periodic reporting to CMS in an agreed upon manner and timeline. This responsibility includes not only the State's existing accountability for oversight and monitoring of the ACC Program but also the State's communication to CMS of any changes to the ACC Program that could impact the Demonstration or its beneficiaries. Ongoing monitoring and oversight activities (including Medicare Part D oversight and provider licensure, survey, and certification activities occurring at the Federal and State level) will continue by CMS and the State, respectively, independent of the Demonstration.
3. **Data:** CMS, or its designated agent(s), and the State shall accept and process uniform beneficiary-level data as may be necessary for the purposes of program eligibility, payment, or evaluation. Submission of data to CMS and the State must comply with all relevant Federal and State laws and regulations including, but not limited to, regulations related to

HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in greater detail in Appendix 7.

F. QUALITY MANAGEMENT

- 1. Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure beneficiaries are receiving high quality care (see Appendix 7 for additional details).
- 2. Quality Standards:** CMS and the State shall monitor the Demonstration's performance through an array of quality measures. Any performance payment will be contingent upon meeting the established quality standards to assure the Demonstration not only produces savings but also improves quality of care. Performance payments will be tiered relative to quality thresholds (see Appendix 6 for additional information). The State will also implement, in coordination with CMS, a quality strategy for the Demonstration that includes reporting of a core set and State-specific process and Demonstration measures.

G. FINANCING AND PAYMENT

Medicare and Medicaid Payment and Savings: Providers will receive FFS payments from CMS for Medicare services. In the MFFS model currently in place for the ACC Program, Medicaid-covered acute care wraparound services, as well as LTSS, are provided in accordance with requirements in the approved Medicaid State Plan and applicable HCBS waivers. For the Demonstration, the State will pay for Medicaid services based on its prevailing approved Medicaid authorities and payment methodologies. Under this Demonstration, the State will be eligible to receive a retrospective performance payment based on quality and savings criteria. Appendix 6 specifies the methodology for savings determinations and the calculation of performance payments.

H. EVALUATION

- 1. Evaluation Data to Be Collected:** CMS and the State have developed processes and protocols for collecting and reporting to CMS the data needed for evaluation as specified in Appendix 7.

- 2. Monitoring and Evaluation:** CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration, including the impacts on person-level health outcomes and beneficiary experience of care; changes in patterns of primary care, acute care, and LTSS utilization and expenditures; and any shifting of services between medical and non-medical expenses. Rapid-cycle evaluation and feedback will be used to inform the implementation of the Demonstration and to guide midcourse corrections and improvements as needed. Key aspects and administrative features of the Demonstration will also be examined through qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives and seek to isolate the effect of this Demonstration as appropriate. The State will collaborate with CMS or its designated agent(s) during all monitoring and evaluation activities. The State will submit all data required for the monitoring and evaluation of this Demonstration. The State will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

- 3. Review of Findings:** CMS and the State will meet at least annually to review interim evaluation findings, including quality of care measures and analysis to review eligibility for the retrospective performance payment.

I. EXTENSION OF FINAL DEMONSTRATION AGREEMENT

The State may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Act and based on whether the

Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality of care and reducing spending. Any extension request may be granted at CMS's sole discretion.

J. MODIFICATION OR TERMINATION OF FINAL DEMONSTRATION AGREEMENT

The State agrees to provide advance written notice to CMS of any State Plan, waiver, or policy changes that may have an impact on the Demonstration. This includes any changes to underlying Medicaid provisions that impact rates to providers or policy changes that may impact provisions under the Demonstration.

- 1. Modification:** Either CMS or the State may seek to modify or amend the Final Demonstration Agreement per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality of care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

- 2. Termination:** The parties intend to allow Termination of the Final Demonstration Agreement under the following circumstances:
 - a. Termination without Cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days' advance written notice to the other entity and 60 days' advance written notice to beneficiaries and the general public.

 - b. Termination pursuant to Section 1115A(b)(3)(B) of the Act.

 - c. Termination for Cause - Either party may terminate upon 30 days' advance written notice due to a material breach of a provision of the Final Demonstration Agreement.

- d. Termination due to a Change in Law - In addition, CMS or the State may terminate upon 30 days' advance written notice due to a material change in law or with less or no notice if required or permitted by law.

3. Demonstration Phase-out: Any planned termination during or at the end of the Demonstration must follow the following procedures:

- a. Notification of Suspension or Termination - The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than five (5) months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct Tribal Consultation in accordance with its approved Tribal Consultation State Plan Amendment. The State shall summarize comments received and share such summary with CMS. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must begin no sooner than 14 days after CMS approval of the phase-out plan.
- b. Phase-out Plan Requirements - The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), and any community outreach activities.
- c. Phase-out Procedures - The State must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration beneficiaries as outlined in 42 CFR Sections 431.220 and 431.221. If a Demonstration beneficiary requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Section 431.230.

- d. Federal Financial Participation (FFP) - If the Demonstration is terminated, FFP shall be limited to normal close-out costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participating beneficiaries from the Demonstration.
- e. Close Out of Performance Payment - If the Demonstration is terminated for cause due to a material breach of a provision of this MOU or the Final Demonstration Agreement, the State will not be eligible to receive any outstanding performance payments. If the Demonstration is terminated without cause by the State, the State will only be eligible to receive performance payment(s) for performance in Demonstration year(s) that have concluded prior to termination. If the Demonstration is terminated without cause by CMS, the State will be eligible to receive a prorated performance payment for the time period up until the termination of the Demonstration.

K. General Provisions

- a. Limitations of MOU - This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.
- b. Modification – Either CMS or the State may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality of care and reducing spending. Any material modification shall

require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

c. Termination – The parties may terminate this MOU under the following circumstances:

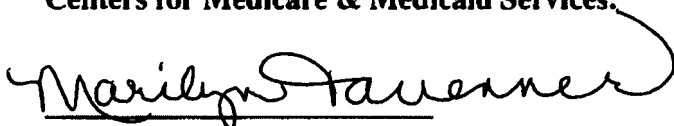
- Termination without Cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days' advance written notice to the other entity and 60 days' advance written notice to beneficiaries and the general public.
- Termination pursuant to Section 1115A(b)(3)(B) of the Act.
- Termination for Cause - Either party may terminate this MOU upon 30 days' advance written notice due to a material breach of a provision of this MOU or the Final Demonstration Agreement.
- Termination due to a Change in Law - In addition, CMS or the State may terminate this MOU upon 30 days' advance written notice due to a material change in law or with less or no notice if required by law.

L. SIGNATURES

This MOU is effective on February 28, 2014.

In Witness Whereof, CMS and the State of Colorado have caused this Agreement to be executed by their respective authorized officers:

**United States Department of Health and Human Services,
Centers for Medicare & Medicaid Services:**



Marilyn Tavenner
Administrator

FEB 28 2014

(Date)

**State of Colorado,
Colorado Department of Health Care Policy and Financing**



Susan E. Birch MBA, BSN, RN
Executive Director

2/27/14

(Date)

APPENDICES

- Appendix 1: Definitions
- Appendix 2: CMS Standards and Conditions Checklist and Supporting State Documentation
- Appendix 3: Details of State Demonstration Area
- Appendix 4: Medicare Authorities and Waivers
- Appendix 5: Medicaid Authorities and Waivers
- Appendix 6: Performance Payments to the State
- Appendix 7: Demonstration Parameters

Appendix 1: Definitions

Accountable Care Collaborative (ACC) Program is a Colorado Medicaid program designed to improve beneficiaries' health and reduce costs. Medicaid beneficiaries enrolled in the program receive the regular Medicaid benefits package on a Fee-for-Service (FFS) payment basis, are assigned to a Regional Care Collaborative Organization (RCCO), and choose a Primary Care Medical Provider (PCMP).

Assignment is the process by which CMS will work with the State to identify beneficiaries for Demonstration participation and align beneficiaries with unique interventions for the purposes of making performance payment determinations. CMS and the State will ensure that beneficiaries are appropriately assigned across Medicare shared savings programs and other initiatives or demonstrations to ensure that shared savings are not duplicated across programs. A beneficiary is considered eligible for assignment to the Demonstration, for the purposes of evaluation and determination of performance payments, regardless of whether or not they are enrolled in the Demonstration. For the purposes of this Demonstration, beneficiary assignment and beneficiary alignment have the same meaning.

Attribution is the process or set of rules the State uses to associate or link a beneficiary to a PCMP and/or a RCCO in the ACC Program.

Behavioral Health Organization (BHO) is an entity contracting with Colorado's Department of Health Care Policy and Financing to provide only behavioral health services.

Care Coordination is a process used by a person or a team to assist beneficiaries in gaining access to Medicare, Medicaid, and waiver services regardless of the funding source of these services. It is the deliberate organization of beneficiary care, service, and support activities between two or more participants (including the beneficiary) who are involved to facilitate the appropriate delivery of health care services. It involves bringing together personnel and other needed resources to carry out all required beneficiary care, service, and support activities, and it is often managed by the exchange of information among participants responsible for different aspects.

Center for Medicare and Medicaid Innovation (CMMI) was established by Section 3021 of the Affordable Care Act. CMMI was established to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.

Centers for Medicare & Medicaid Services (CMS) is a branch of the U.S. Department of Health and Human Services. It is the federal agency responsible for administering the Medicare and Medicaid programs as well as the Children's Health Insurance Program.

Client/Family-Centered is used to refer to bringing the perspectives of clients and their families directly into the planning, deliver, and evaluation processes of health care.

Community Centered Board (CCB) is a private non-profit organization designated in Colorado statute as the single entry point into the LTSS system for persons with developmental disabilities. A CCB is responsible for case management services including intake, eligibility determination, service plan development, arrangement for services, delivery of services (either directly and/or through purchase), and monitoring. A CCB is also responsible for assessing service needs and developing plans to meet those needs in its local service area.

Comparison Group is a group of Medicare-Medicaid enrollees from states or regions of states not pursuing implementation of demonstrations under the Financial Alignment Initiative (or from geographic areas of financial alignment states where there is no demonstration activity). The comparison group is used to identify the change in costs and certain quality metrics from one period of time to another. A change in costs for the comparison group will be compared with the change in costs for the State's Demonstration group. The methodology for defining the Comparison Group is identified in Appendices 6 and 7.

Covered Services is the set of services to be coordinated as part of this Demonstration.

Customer Contact Center is the Department's managed call center established to respond to inquiries about any Department of Health Care Policy and Financing program.

Demonstration Group consists of those individuals eligible to participate in this Demonstration. They are those beneficiaries enrolled in Medicare Parts A and B and eligible for Medicare Part D; and receive full Medicaid benefits under FFS arrangements; and have no other private or public health insurance; and are a resident of the State.

Department is the Colorado Department of Health Care Policy and Financing.

Enrollment is the process used to place eligible beneficiaries into the ACC Program and associate beneficiaries with a Regional Care Collaborative Organization.

Evaluation Contractor is the independent contractor selected by CMS to measure the impact of the Demonstration. CMS and the State will collaborate and coordinate during all evaluation activities.

Final Demonstration Agreement is the agreement developed to implement the terms of the MOU and that further specifies the operational and technical requirements of Demonstration implementation.

Intent to Treat refers to an evaluation approach in which all individuals who meet the criteria to receive the "treatment" are considered part of the "intervention group" for purposes of evaluation, regardless of whether they elect to receive these services or actively participate in the intervention. In this Demonstration, all individuals who are eligible for the Demonstration (as specified in Section III.B.1) are considered part of the intervention group (Demonstration group), regardless of whether they are enrolled in the Demonstration.

Implementation Contractor is the contractor selected by CMS to assist with implementation of the Financial Alignment Initiative. Under the MFFS Financial Alignment Model, the Implementation Contractor will determine whether the State met the quality thresholds, factor State performance on individual quality measures into the performance payment calculation, and finalize the performance payment amount, if any.

Long-term Services and Supports (LTSS) is a wide variety of services and supports that provide persons with disabilities and with chronic conditions choice, control, and access to a full continuum of services that assure optimal outcomes such as independence, health, and quality of life. Services are intended to be person-driven, inclusive, effective and accountable, sustainable and efficient, coordinated and transparent, and culturally competent. Medicaid allows for the coverage of LTSS through several vehicles and across a spectrum of settings, including home and community-based and institutional settings such as hospitals, intermediate care facilities for persons with intellectual disabilities (ICF/ID), and nursing facilities.

Managed Fee-for-Service (MFFS) is an arrangement in which quality and utilization are improved through greater payer-provider collaboration than in traditional Fee-for-Service (FFS) programs. Most or all payments for services remain FFS with little or no insurance risk to providers. Payments may be based on such arrangements as bundling of certain services and/or incentives for high quality and efficient performance.

Medicare-Medicaid Coordination Office is formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medicaid is the program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

Medicaid Significance Factor (MSF) is the minimum threshold for determining whether any increases in Federal Medicaid costs will be deducted from Medicare savings (see Appendix 6 for more details).

Medicare is the Federal health insurance program authorized under Title XVIII of the Social Security Act.

Minimum Savings Rate (MSR) is the minimum threshold of Medicare savings the State must achieve to benefit from Medicare savings (see Appendix 6 for more details).

Passive Enrollment is the process of enrolling clients into the ACC Program; it includes the selection of clients appropriate for enrollment, notification of clients selected for enrollment, and Choice Counseling to assist clients in making an informed decision about enrollment. Clients receive advance notice informing them of the Department's intent to enroll them in the ACC Program, providing them information about their enrollment choices, providing contact information for Choice Counseling services, and allowing 30 days for the client to make an active choice before being enrolled in the ACC Program.

Plan of Care is a document that articulates the beneficiary's short- and long-term goals and objectives, and it becomes the blueprint for meeting beneficiary goals and improving health outcomes. The RCCOs and PCMPs will use a standardized Plan of Care to collaborate with the beneficiary and to coordinate among providers. The Plan of Care includes the beneficiary's basic demographic information; release of information; cultural and linguistic considerations; prioritized domains of care; available interventions and potential methods; contacts and objective timelines; and timeframes for updates and revisions.

Primary Care Medical Provider (PCMP) is one of the Accountable Care Collaborative (ACC) Program's three main components. It is the designation for a primary care provider participating in the ACC Program who serves as the Medicaid beneficiary's main health care provider and medical home where the beneficiary receives the majority of primary care services. The PCMP helps to identify the most appropriate service provider for beneficiaries who need specialty care.

Privacy refers to those requirements established in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, implementing regulations, and relevant State privacy laws.

Readiness Review is a series of pre-implementation activities conducted to ensure the State has the necessary infrastructure and capacity to implement and oversee the proposed Demonstration. The State must address any gaps in readiness identified during the review before implementation can proceed.

Regional Care Collaborative Organization (RCCO) is one of the Accountable Care Collaborative (ACC) Program's three main components. Each RCCO is responsible for connecting Medicaid beneficiaries, and the Demonstration's Medicare-Medicaid beneficiaries, to providers and for assisting beneficiaries in finding community and social services in their area. The RCCO helps providers communicate with beneficiaries and with each other to ensure that beneficiaries receive coordinated care.

Single Entry Points (SEPs) are state agencies that determine functional eligibility for community-based LTSS programs, provide care planning and case management for individuals in these programs, and make referrals to other resources.

State refers to the State of Colorado.

Statewide Data and Analytics Contractor (SDAC) is one of the Accountable Care Collaborative (ACC) Program's three main components. It provides the Department, RCCOs, and PCMPs with client utilization and program performance data. It provides a continuous feedback loop of critical information to foster accountability and ongoing improvement.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

Standard/ Condition	Standard/Condition Description	Location in Proposal (i.e., page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary care, acute care, prescription drugs, behavioral health, and LTSS.	pp. 8-12, 13-15, Appendix H & O
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	p. 6-10, 12-17, Appendix B, D J, Addendum
Stakeholder Engagement	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	p. 5
	State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative.	pp. 23-24

Standard/ Condition	Standard/Condition Description	Location in Proposal (i.e., page #)
Beneficiary Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary’s needs. At a minimum, States will be required to:	
	· Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model.	pp. 21-24
	· Develop, in conjunction with CMS, enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the Demonstration, including those with disabilities, speech, hearing, and vision limitations, and limited English proficiency.	p. 24
	· Ensure privacy of enrollee health records and provide for access by enrollees to such records.	Addendum
	· Ensure that all care meets the beneficiary’s needs, allows for involvement of caregivers, and is in an appropriate setting, including in the home and community.	pp. 14, 19
	· Ensure access to services in a manner that is sensitive to the beneficiary’s language and culture, including customer service representatives who are able to answer enrollee questions and respond to complaints/concerns appropriately.	Addendum
	· Ensure an adequate and appropriate provider network, as detailed below.	pp. 5-8, Appendix H
	· Ensure that beneficiaries are meaningfully informed about their care options.	p. 15, 34-35, Addendum
	· Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	

Standard/ Condition	Standard/Condition Description	Location in Proposal (i.e., page #)
	State will ensure a mechanism is in place for assisting the beneficiary in the MFFS Financial Alignment Model in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.	p. 23
	State demonstrates that it has the necessary infrastructure and capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp. 29-30, Appendix N
State Capacity	The Demonstration will ensure adequate access to medical and supportive service providers who are appropriate for and proficient in addressing the needs of the target population as further described in the MOU.	pp. 12-14, 25
Network Adequacy	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model’s quality and cost outcomes for the target population. These metrics may include, but are not limited to, beneficiary experience, access to and quality of all covered services (including behavioral health and LTSS), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	pp. 29-30, Appendix N
Measurement/ Reporting	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
Data	· Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;	State has integrated Medicare data with SDAC; n/a

Standard/ Condition	Standard/Condition Description	Location in Proposal (i.e., page #)
	<ul style="list-style-type: none"> · Description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three-year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.): and 	p. 17-19, 26-27, Appendix O
	<ul style="list-style-type: none"> · State supplemental payments to providers (e.g., DSH, UPL) during the three-year period. 	Addendum
	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	p. 6-7, 31-32, Addendum
Enrollment	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	<i>Not finalized</i>
Expected Savings	State has provided sufficient public notice, including:	
Public Notice	<ul style="list-style-type: none"> · At least a 30-day public notice process and comment period; 	p. 19-23, appendix O
	<ul style="list-style-type: none"> · At least two (2) public meetings prior to submission of a proposal; and 	p. 19-23, appendix O
	<ul style="list-style-type: none"> · Appropriate Tribal Consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals. 	p. 19-23, appendix O
	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
Implementation	<ul style="list-style-type: none"> · Continued meaningful stakeholder engagement. 	p. 19-23, appendix O
	<ul style="list-style-type: none"> · Submission and approval of any necessary Medicaid waiver applications and/or State Plan Amendments. 	p. 31, Addendum
	<ul style="list-style-type: none"> · Receipt of any necessary State legislative or budget authority. 	Appendix O

Standard/ Condition	Standard/Condition Description	Location in Proposal (i.e., page #)
	· Beneficiary outreach/notification of enrollment processes, etc.	p. 6-7, 31-32

Appendix 3: Details of State Demonstration Area

The Demonstration will be implemented statewide and is organized around the existing seven geographic regions of the ACC Program. The Demonstration regions and RCCOs with counties served appear in the table below.

RCCO REGIONS	COUNTIES		
Region 1 – Rocky Mountain Health Plans http://acc.rmhp.org/Home 970-254-5771 800-667-6434	Archuleta Delta Dolores Eagle Garfield Grand Gunnison Hinsdale	Jackson La Plata Larimer Mesa Moffat Montezuma Montrose	Ouray Pitkin Rio Blanco Routt San Juan San Miguel Summit
Region 2 – Colorado Access www.coaccess-rcco.com 303-368-0035 855-267-2094	Cheyenne Kit Carson Lincoln Logan	Morgan Phillips Sedgwick	Washington Weld Yuma
Region 3 – Colorado Access www.coaccess-rcco.com 303-368-0037 855-267-2095	Adams Arapahoe Douglas		
Region 4 – Integrated Community Health Partners www.ichpcolorado.com/ 855-959-7340	Alamosa Baca Bent Chaffee Conejos Costilla Crowley	Custer Fremont Huerfano Kiowa Lake Las Animas	Mineral Otero Prowers Pueblo Rio Grande Saguache
Region 5 – Colorado Access www.coaccess-rcco.com 303-368-0038 855-384-7926	Denver		
Region 6 – Colorado Community Health Alliance http://cchacares.com/en-us/home.aspx 303-260-2888 877-919-2888	Boulder Broomfield Clear Creek Gilpin	Jefferson	
Region 7 – Community Care of Central Colorado http://www.mycommunitycare.org/ 719-314-2560 866-938-5091	El Paso Elbert Park Teller		

Appendix 4: Medicare Authorities and Waivers

All statutory and regulatory requirements of Medicare Parts A, B, and D, including the provisions of Title XI of the Act, shall apply to the Demonstration project, except that the provisions of Section 1899 of the Act, and applicable implementing regulations, are waived to the extent such provisions are inconsistent with the provisions of this MOU or the Final Demonstration Agreement. Waivers issued pursuant to Section 1899(f) of the Act, as amended or superseded from time to time, do not apply to this Demonstration, nor do waivers issued for any other demonstration or pilot program.

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, including the provisions of Title XI of the Act, shall apply to the Demonstration project. The ACC Program currently operates as a primary care case management (PCCM) program under Section 1932(a) State Plan authority. The implementation of this Demonstration is contingent upon the State receiving CMS approval for its SPA to expand the ACC Program for Medicare-Medicaid enrollees.

Appendix 6: Performance Payments to the State

I. General

Under this Demonstration, the State will have the opportunity to earn a retrospective performance payment. The retrospective performance payment will be calculated and paid assuming the following principles:

- Qualification for the retrospective performance payment is contingent on performance and quality. No retrospective performance payment will be made if quality requirements, outlined in Appendix 7, are not met.
- Qualification for the retrospective performance payment is contingent on achieving overall Federal savings. Therefore, in determining the retrospective performance payment, any Medicare savings may be offset by any increases in Federal Medicaid expenditures.
- The same Medicare savings cannot be shared more than once. Therefore, CMS will apply assignment (alignment) rules to ensure that the experiences of specific beneficiaries are not simultaneously assigned to this Demonstration and to other Medicare shared savings initiatives. Assignment rules are described further in Appendix 7.
- The State of Colorado is primarily responsible for the new investments and operating costs associated with the Demonstration, with costs eligible for Federal matching funds based on applicable Medicaid rules. Therefore, the State assumes some financial risk associated with those new investments. If the Demonstration is failing to meet performance and quality objectives, CMS will pursue corrective action or termination, as described in Section III.J *Modification and Termination of Final Demonstration Agreement* in the body of this MOU.

Demonstration Years: Figure 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort.

Figure 6-1. Demonstration Year Dates

Demonstration Year	Calendar Dates
1	July 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

II. Elements of the Medicare Savings Calculation

1. Comparison Groups

- *Independent Evaluator* – CMS has contracted with an independent evaluator (Evaluation Contractor) to measure, monitor, and evaluate the impact of the Colorado MFFS Demonstration. The Evaluation Contractor will:
 - Employ a pre-post evaluation design with a comparison group using an intent-to-treat framework.
 - Select a comparison group using pre-Demonstration period data and measure changes in both the Demonstration group (individuals eligible for assignment to the Demonstration, see Appendix 1 for additional details) and comparison group.
 - Contrast the changes in outcomes and costs for the Demonstration group with the changes in outcomes and costs observed for a comparison group.

- *Comparison Group Selection* – The savings determination will compare actual spending for the Demonstration group to the spending that would have been expected in the absence of the Demonstration. Based on the anticipated implementation schedule and geographic scope of this Demonstration, CMS and its Evaluation Contractor will establish a comparison group of Medicare-Medicaid enrollees in other states matched to the Demonstration group in Colorado.
 - The Evaluation Contractor will draw a comparison group of Medicare-Medicaid enrollees from states or regions of states not pursuing

implementation of a Financial Alignment Model (or from geographic areas of Financial Alignment Model states where there is no Financial Alignment Model Demonstration activity).

- The Evaluation Contractor will use cluster analysis to identify potential comparison states that are most statistically similar to Colorado by analyzing data on factors such as Medicare and Medicaid expenditures for Medicare-Medicaid enrollees, LTSS users by type of provider, and managed care penetration rates, among other factors. CMS and the Evaluation Contractor will also consider factors, such as timeliness of data reporting, in selection of comparison states.
- Once the comparison states are selected, all Medicare-Medicaid enrollees in the comparison area or areas, who would have met Colorado's eligibility criteria to participate in its MFFS Financial Alignment Model Demonstration had the Demonstration been implemented in that area, will be identified as potential members of the comparison group. The comparison group will be weighted so that the distribution of beneficiary characteristics prior to the start of the Demonstration matches that of Colorado's Demonstration group.

2. Medicare and Medicaid Savings Calculations

- *General* - The savings calculation will be based on the difference in changes over time in both Medicare and Federal Medicaid expenditures found between the Demonstration group and the comparison group.
 - The savings determination will compare actual spending for the Demonstration group to the spending that would have been expected in the absence of the Demonstration.
 - Expected spending will be estimated by trending forward baseline per capita spending for the Demonstration group, using a trend observed in the comparison group.

- *Savings Calculation Details* - The Evaluation Contractor will calculate savings using the methodology as outlined below:
 - Calculate a pre-Demonstration baseline Medicare Parts A and B and Medicaid per capita spending for the Demonstration group and the comparison group. The baseline spending will be based on actual Medicare and Medicaid costs during a two-year period prior to the start of the Demonstration for those beneficiaries eligible for the Demonstration.
 - Calculate a Medicare Parts A and B growth percentage and a Medicaid growth percentage by measuring the actual rate of increase in Medicare Parts A and B and Medicaid per capita spending in the comparison group between the baseline and performance years.
 - Apply the growth percentages to the Demonstration group Medicare Parts A and B and Medicaid baselines to determine per capita expected cost for the Demonstration group.
 - Calculate savings as the difference between the expected costs and actual costs for the Demonstration group.

- *Adjustments in the Calculation* – The Evaluation Contractor will make necessary adjustments to the data including:
 - Cap all beneficiary expenditures at the 99th percentile of costs; and
 - Monitor and make adjustments for changes in Federal and State policies or related factors that could affect the calculations, as appropriate.

3. **Medicaid Increase:** For the purposes of this Demonstration, the Medicare savings as calculated above will be offset by the Federal share of Medicaid cost increases to determine the total amount available for sharing with the State.

- The Federal Medicaid increase will be assessed based on all Federal Medicaid costs (including any new care coordination payments in the Demonstration group). For the purposes of retrospective performance payments, any increases are only applicable to the extent such increases exceed the Medicaid Significance Factor (MSF) described below in Section III.2.
- The Medicaid increase calculation will follow the comparison group and adjustment approaches described for the Medicare savings calculation above.

III. Calculation of the Retrospective Performance Payment

1. General Parameters

- Implementation Contractor - CMS has contracted with an independent contractor to calculate retrospective performance payments. The Implementation Contractor will:
 - Determine whether Medicare savings calculated above meet the minimum savings requirements outlined in this section;
 - Calculate the amount available for retrospective performance payments to the State; and
 - Calculate the amount of the retrospective performance payment to the State based on the State's quality performance.
- Retrospective Performance Payment Guidelines - Once Medicare savings are determined according to the calculation above, Colorado will have the opportunity to earn a retrospective performance payment.
 - The savings calculated must meet a Medicare Minimum Savings Rate (MSR) before any savings can be shared with the State.
 - In order to receive a retrospective performance payment, the State must meet the quality requirements as outlined in Appendix 7.
 - The State will not be at risk for Medicare cost increases during the Demonstration. However, increased Medicare costs may trigger corrective action or termination.

- Retrospective performance payments made to States under this Demonstration are Federal funds and may not be used as the non-Federal share of Medicaid payments for matching purposes.

2. Payment Calculation

- *Medicare Minimum Savings Rate (MSR)* – CMS will develop a Medicare Minimum Savings Rate for the Demonstration. The MSR will be applied to this Demonstration depending on the size of the Demonstration population. The minimum MSR will be 2%. Figure 6-2 shows examples of the MSRs for various levels of potential enrollment in the Demonstration. This figure demonstrates the MSR as applied at various points. An MSR within this range will be applied each year based on actual number of beneficiaries considered as part of the savings calculation. Beneficiary points not shown below will be extrapolated based on the underlying curve.

Figure 6-2. Medicare MSR Range

Number of Beneficiaries	MSR
5,000	4.50%
10,000	3.20%
20,000	2.45%
50,000+	2.00%

- *Application of the MSR* – Medicare Parts A and B savings, as calculated above, will be compared to the MSR established for the State’s Demonstration. If the Medicare Parts A and B savings calculated are less than the MSR, the State will not qualify for a retrospective performance payment.
- *Medicaid Significance Factor (MSF)* – CMS will develop a Medicaid significance factor for the Demonstration. This factor will be set at the same percentage as the Medicare MSR for the State’s Demonstration.
- *Application of the MSF* – Medicaid costs, as calculated above, will be compared to the MSF established for this Demonstration. If increases in

Federal Medicaid costs are less than the MSF, CMS will not deduct from the Medicare savings for the purposes of calculating a retrospective performance payment.

- *Deduction of Medicaid increases* – If increases in Medicaid costs exceed the MSF, then the Federal share of the Medicaid increase (including costs below the MSF) will be deducted from the amount of Medicare savings to establish the net Federal savings for the purposes of calculating a retrospective performance payment.
- *Net Federal savings available for sharing with the State* – If Medicare savings calculated exceed the MSR, the State will qualify to earn up to 50% of the net Federal savings (i.e., 50% of the total Medicare savings after deducting the Federal Medicaid increase, if the Federal Medicaid increase exceeds the MSF).
- *Quality Percentage Distribution* – If the State meets the minimum quality requirements as outlined in Appendix 7, it will be eligible to receive 60% of the amount calculated above. The remaining 40% will be scaled based upon State performance on individual measures.
- *Maximum Payment* – The performance payment shall be no greater than 6% of total Medicare Parts A and B expenditures for the Demonstration population.

IV. Timing: CMS will calculate retrospective performance payments on an annual basis. Each annual calculation will be independent of the prior year's findings. The timing of performance payments is dependent on data availability, including the timeliness of State submission of Medicaid data to CMS. To account for claims run-out and the time necessary for analysis and review, the earliest Colorado would be able to receive a performance payment would be 9 to 11 months after the end of each Demonstration year.

V. Process for Reviewing Findings: CMS will consult with the State on methodological issues and data collection to execute the retrospective performance payment calculations.

As described in Section III.H.3 of the body of this MOU, CMS and the State will meet at least annually to review the analysis and findings from the retrospective performance payment calculations.

The State of Colorado may request, in writing, that CMS reconsider the calculation of the retrospective performance payment or the calculations behind the payment's components (e.g., quality measures). The State must initiate any such requests within 90 days of written notification from CMS on the amount of the performance payment (or lack thereof).

Any subsequent review of the retrospective performance payment may require that additional data be provided and reviewed. Parties agree to provide this data timely to resolve the issue. If, in the judgment of CMS, an error occurred in the original payment calculation resulting in an underpayment, CMS will pay the additional amount necessary to correct the mistake. If an error produced payment to the State exceeding the appropriate amount, the State will refund the difference.

The terms of this MOU are subject to Federal program audit and expenditure requirements. If it is determined as a result of an independent audit or program review that there has been an overpayment made, both parties are responsible for complying with those findings.

Appendix 7: Demonstration Parameters

The purpose of this appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its July 8, 2011, State Medicaid Directors' Letter. CMS and the State have further established these parameters, as specified below.

I. State of Colorado Delegation of Administrative Authority and Operational Roles and Responsibilities

The Colorado Department of Health Care Policy and Financing (Department) is the single state agency for the Medicaid program. The Department is responsible for the provision and oversight of mental health, chemical dependency, developmental disability, and LTSS to individuals eligible for Medicaid.

The Department will support the Demonstration with oversight, data, analytics, and information.

II. Grievances and Appeals

Demonstration enrollees will also have access to the same appeals process available to all Medicare and Medicaid beneficiaries in Colorado. The State will provide Demonstration enrollees with assistance in exercising grievance and appeals rights as applicable under Medicare and/or Medicaid. The State and CMS will leverage existing State and Federal resources to further assist individuals with grievances and appeals. Demonstration enrollees in Colorado will continue to have several avenues for addressing problems and complaints, such as the Medicare Beneficiary Ombudsman, the Long-term Care Ombudsman, and/or the Medicaid Managed Care Ombudsman.

While the Demonstration does not fundamentally change the Medicare or Medicaid appeals processes, the State and its partners will utilize a collaborative alliance, as previously outlined in Section III.B.4, among beneficiary rights and protections service organizations to better inform

and serve Medicare-Medicaid enrollees in the Demonstration. The alliance seeks to provide education and information about benefits options and enrollee rights; seamless access to services provided by alliance members; and assistance to and advocacy on behalf of Medicare-Medicaid enrollees who have complaints or grievances. These activities supplement and support, but do not replace, the State's responsibility to ensure beneficiaries are informed of their rights and State compliance with 42 C.F.R. 431.206 and 42 C.F.R. 431.210.

In addition, the ACC Program has a defined process that enrollees may use for service complaints. Enrollees receive an ACC Program handbook that provides contact information and outlines the complaint process:

- 1) Address service complaint with PCMP or RCCO.
- 2) Contact the Medicaid Managed Care Ombudsman if complaint is unresolved.
- 3) File appeal and request a State Fair Hearing if believed to have been wrongfully denied services.

As ACC Program enrollees, Demonstration beneficiaries will have access to the process outlined above. The ACC Program's complaint, grievance, and appeals process is also documented in existing contracts between the Department, the Medicaid Managed Care Ombudsman, RCCOs, and PCMPs.

Contractual requirements mandate that each RCCO be responsive to and assist beneficiaries with any problems they experience in receiving care and services. RCCOs are specifically required to document and maintain a record of the following:

- 1) All problems and issues presented by beneficiaries with respect to access to and quality of their care; and
- 2) All proposed solutions to the problems raised by beneficiaries.

On a quarterly basis, RCCOs provide the Department a Stakeholder Feedback Report that summarizes complaints and other input from ACC Program enrollees, providers, and the community at large; describes feedback themes and trends; identifies overarching issues and proposed solutions; and includes comments and recommendations from each RCCO's

Performance Improvement Advisory Committee. Furthermore, the Medicaid Managed Care Ombudsman submits a monthly report to the Department that categorizes and summarizes contacts, issues, inquiries and cases, and levels of resolution related to the ACC Program.

The Department reserves the right to review records and direct the provision of alternative solutions should the original solution be determined insufficient or inappropriate.

All Medicaid beneficiaries are informed of their appeal rights when:

- 1) An application for services is denied or is not acted upon with reasonable promptness.
- 2) The recipient requesting the hearing believes the action is erroneous.
- 3) The resident of a nursing facility believes the facility has erroneously determined that s/he must be discharged.
- 4) An individual who believes the determination with regard to the preadmission and annual resident review requirements is erroneous.

III. Administration and Oversight

1. Beneficiary Assignment and Enrollment:

Enrollment into the ACC Program, or disenrollment from the ACC Program, does not reduce entitlement or access to Medicaid or Medicare services. The ACC Program utilizes a passive enrollment process that attributes Medicare-Medicaid beneficiaries to the RCCO in the geographic area and, where applicable as noted below, to a PCMP, based on existing beneficiary-provider relationships. Individuals receive advance notice and have sufficient time and opportunity to make an informed choice about participation in the Demonstration and the ACC Program. Individuals who do not wish to participate in the Demonstration and ACC Program may opt out or request disenrollment at any time. Regardless of enrollment status, entitlement or access to Medicaid or Medicare services does not change. The State will continue to work with CMS to ensure that enrollment and disenrollment processes for Medicare-Medicaid beneficiaries meet all requirements of the Demonstration.

A beneficiary whose primary care provider participates in the ACC Program will receive all the benefits the ACC Program offers. For a beneficiary whose primary care provider is not currently participating in the ACC Program, RCCOs will continue to conduct outreach to the beneficiary and to the provider, make every attempt to involve the provider, and take steps to ensure that the beneficiary receives comprehensive, coordinated care, services, and supports in the Demonstration.

A beneficiary whose primary care provider does not participate in the ACC Program receives support through the ACC Program as described above. Additionally, if extensive outreach and education efforts by the Department and the RCCOs are unsuccessful in persuading the beneficiary's existing primary care provider to participate in the ACC Program and if the beneficiary would like to receive greater benefit from the ACC Program, the Department and the RCCOs will work to assist the beneficiary in finding a participating primary care provider.

The Department recognizes the importance of existing beneficiary-provider relationships, and its objective is to maintain those relationships to avoid disruption in care and services. No ACC Program client is, and no Demonstration beneficiary will be, asked to change primary care providers. The Department and the RCCOs will continue to direct outreach efforts to ensure as many primary care providers for Medicare-Medicaid enrollees as possible are in the ACC Program as PCMPs before the Demonstration's implementation. The Department has a strong commitment to maintaining existing beneficiary-provider relationships and to ensuring that all beneficiaries have access to the enhanced care coordination services and supports provided by the Demonstration.

The Department will use a six (6) month phase-in to enroll Medicare-Medicaid beneficiaries into the Demonstration. This deliberate, phased-in approach will allow the Department to optimize solid infrastructure that already exists and to build upon that foundation as more beneficiaries are enrolled. In preparation for the Demonstration, the Department is

categorizing, on a monthly basis, potentially eligible Demonstration enrollees into a matrix distinguished by RCCO, county, delivery system, and provider type. The four delivery systems are: community relatively well, waiver, high waiver, and skilled nursing facility. In addition, based on Medicare and Medicaid claims history, providers for potentially-eligible Demonstration enrollees may be categorized as: existing PCMPs in the ACC Program; Medicare-Medicaid primary care providers not yet in the ACC Program; and Medicare primary care providers without a Medicaid billing identification number. This analysis provides useful information to the Department and to the RCCOs for provider recruitment and readiness efforts prior to implementation of the Demonstration. The Department anticipates enrolling no more than 7,500 beneficiaries per month based on the following strategy:

- First month – Those in the community relatively well category whose primary care providers are already PCMPs in the ACC Program
- Second month – The remainder of those in the community relatively well category whose primary care providers are already PCMPs in the ACC Program; those in the community relatively well category whose Medicare-Medicaid primary care providers are not yet in the ACC Program
- Third month – Those in the community relatively well category whose Medicare-Medicaid primary care providers are not yet in the ACC Program and those receiving waiver services whose Medicare-Medicaid primary care providers are in the ACC Program
- Fourth month – The remainder of those in the community relatively well category and those receiving waiver services whose Medicare-Medicaid primary care providers are not yet in the ACC Program
- Fifth month – The remainder of those receiving waiver services and those receiving high waiver services whose Medicare-Medicaid primary care providers are not yet in the ACC Program or whose Medicare primary care providers have no Medicaid billing identification number

- Sixth month – Those in skilled nursing facilities, including residents receiving nursing facility services for which Colorado Medicaid is the primary payer
- Seventh month— The remainder of those in skilled nursing facilities, including residents receiving nursing facility services for which Colorado Medicaid is the primary payer

Note: The Department also anticipates some beneficiaries whose primary care providers are newly participating PCMPs in the ACC Program to be enrolled each month.

CMS will allow beneficiaries to be assigned to only one initiative involving Medicare shared savings, based on the following principles:

- In order to promote continuity of care, a Medicare-Medicaid enrollee in Colorado who is already assigned to a Medicare initiative involving shared savings as of the beginning of this Demonstration will remain assigned to that model and will not be assigned to this Demonstration until s/he is no longer assigned to that model.
- If a beneficiary is not already assigned to a Medicare initiative involving shared savings, CMS will assign that beneficiary to this Demonstration (Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees) if s/he qualifies for assignment to this Demonstration (see Section III.B.1 for additional information).
- If a beneficiary qualifies for this Demonstration and could be assigned to another initiative that involves Medicare shared savings and both start on the same date, the beneficiary would be assigned to this Demonstration.
- Once the Demonstration is in effect, additional beneficiaries will be assigned to this Demonstration on a monthly basis as they become Medicare-Medicaid enrollees or otherwise become eligible to enroll in the Demonstration. For a beneficiary who becomes newly eligible for assignment to the Demonstration during a performance year, Medicare and Medicaid payments on behalf of the beneficiary will be included in the performance payment calculations if the

beneficiary meets the eligibility criteria for the Demonstration and is not already participating in another Medicare initiative involving shared savings.

- For this Demonstration, once a beneficiary is assigned, that beneficiary will continue to be so assigned until s/he loses eligibility for this Demonstration.

2. ***Monthly Eligibility File Submissions:*** Beginning May 2014, the State must submit a monthly eligibility file to CMS' beneficiary alignment contractor. Data will be updated into CMS' Master Database Management (MDM) system for beneficiary assignment purposes and used by the Evaluation Contractor to identify the eligible population.

i. The State will need to provide information including but not limited to the following:

1. Beneficiary-level data identifying beneficiaries eligible for the Demonstration
2. Medicare Beneficiary Claim Account Number (HICN)
3. State-specific MSIS number or other Medicaid ID
4. Social Security Number
5. Gender
6. Person first and last name, birthdate, and Zip Code
7. Eligibility identification flag coded 0 if not identified as eligible for the Demonstration, 1 if identified by administrative criteria (e.g., claims), or 2 if by non-administrative criteria
8. Monthly Demonstration eligibility indicator coded 1 if eligible or 0 if not eligible

ii. The State shall also submit on a quarterly basis to the Evaluation Contractor both the monthly information under Appendix 7 Section III.2.1 above (i.e., each quarterly submission will contain data for each month of the quarter) and the information below for each month of the quarter:

1. Facility status (e.g., coded 1 if in a nursing facility or 0 if not).

2. HCBS waiver status (e.g., coded 1 if enrolled in HCBS waiver or 0 if not).
- iii. The State shall also submit summary level data for the State Data Reporting System on a quarterly basis, including, but not limited to, monthly data for the following:
 1. The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries not eligible for the Demonstration.
 2. The number of beneficiaries who are no longer eligible for the Demonstration (e.g., through Medicare Advantage enrollment or moving out of the State).

3. Quality Metrics and Reporting for Determining the Retrospective Performance Payment:

General Principles: Under this Demonstration, Colorado will be eligible to receive a retrospective performance payment based on its performance on savings and quality criteria, as outlined in Appendix 6 and in this section.

The quality metrics and requirements outlined in this Section are for purposes of determining the State's retrospective performance payment. A separate evaluation conducted as part of the Demonstration will complement this analysis and more extensively examine beneficiary experiences, outcomes, and service utilization patterns. Additional discussion of the evaluation is provided in Appendix 7, Section 4.

Approach: The State will receive the full retrospective performance payment in the first Demonstration year based on complete and accurate reporting of all measures included in that Demonstration year. In subsequent Demonstration years, the State is eligible to receive 60% of the retrospective performance payment by meeting the minimum quality threshold and may receive the

remaining 40% of the retrospective performance payment scaled on performance above these thresholds.

Measurement Groups: The Demonstration will consider quality for payment purposes in three grouping:

- Model Core Measures
- State-specific Process Measures
- State-specific Demonstration Measures

Benchmarking and Scoring State Performance: CMS will establish benchmarks for the Demonstration based on a set of principles. Once benchmark levels are set, CMS will provide the State with no less than 30 days to review the benchmark levels, the methodological considerations, and the data supporting any baseline calculations.

All benchmarks will consider the population served under the Demonstration, and for measures in which the baseline is set from pre-Demonstration experience, the extent to which pre-Demonstration experience data are reflective of the Demonstration population. Benchmarks will include minimum achievement levels, improvement relative to those levels, or both (i.e., either/or).

For claims-based measures, where it is feasible to assess experience prior to the start of the Demonstration, improvement-focused benchmarking will be based on improvement from the pre-Demonstration baseline. For measures for which the baseline cannot be based on pre-Demonstration experience, improvement-focused benchmarking will be based on improvement from the reporting period baseline.

The State may earn credit on measures in two ways:

1. If the State meets the established benchmark on an individual measure;
- or

2. If the State meets the established goal for closing the gap between its performance in the 12 months prior to the performance period and the established benchmark by a stipulated percentage.

Scoring Methodology: The State will receive a “pass” or “fail” score for each measure. If the State meets the determined benchmark, it will receive a “pass” for that measure. If the State does not meet the benchmark, it will receive a “fail” for that measure.

For the measures based solely on reporting (as indicated in the table below), a “pass” is based on full and accurate reporting. For each measure, receiving a “pass” is contingent on the State attesting to complete and accurate reporting for that measure and is subject to CMS validating the data being reported.

The Retrospective Performance Payment: The maximum retrospective performance payment available to the State under this model is described in greater detail elsewhere but is generally equal to 50% of savings calculated according to the MOU, with an annual cap of 6% of total Medicare Parts A and B expenditures. The performance payment qualifications will vary by year:

Demonstration Year 1: In year one, payment is based on the percentage of measures for which the State has completely and accurately reported data. The State would qualify for the full retrospective performance payment in the first Demonstration year based on complete and accurate reporting of all measures included in that Demonstration year.

Demonstration Year 2: In year two, the retrospective performance payment will be distributed in three components.

The first component (30% of the retrospective performance payment) will be distributed once it is determined that the State has completely and accurately

reported all measures included in that Demonstration year, except for the two measures newly introduced in year two.

The second component (30% of the retrospective performance payment) will be distributed once it is determined that the State has scored a “pass” on at least 50% of the “benchmark” measures included in that Demonstration year. If the State does not “pass” at least 50% of these measures, no payment will be made for this component.

The third component (40% of the retrospective performance payment) is only available if the State has met the criteria for the first two components. The third component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a “pass,” multiplied by $(4/3)$, including all measures included in that Demonstration year, with each measure weighted equally. (For example, if the State passes 60% of measures, it will qualify for one-third of this component. If the State passes 70% of measures, it will qualify for two-thirds of this component.) Passing 80% or more of all measures would qualify the State for the maximum performance payment.

Demonstration Year 3: In year three, the retrospective performance payment will be distributed in two components.

The first component (60% of the retrospective performance payment) will be distributed once it is determined that the State has scored a “pass” on at least 50% of the “benchmark” measures included in that Demonstration year. If the State does not “pass” at least 50% of these measures, no payment will be made for this component.

The second component (40% of the retrospective performance payment) is only available if the State has met the criteria for the first component. The second

component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a “pass,” multiplied by (4/3), including all measures included in that Demonstration year, with each measure weighted equally. (For example, if the State passes 60% of measures, it will qualify for one-third of this component. If the State passes 70% of measures, it will qualify for two-thirds of this component.) Passing 80% or more of all measures would qualify the State for the maximum performance payment.

Implementation Contractor: The independent Implementation Contractor will determine whether the State met the quality thresholds, factor State performance on individual quality measures into the performance payment calculation, and finalize the performance payment amount, if any.

Any revisions to the minimum quality threshold and scoring calculations will be established in the Final Demonstration Agreement.

Measures: See following table.

MFSS Measure Table (By Demonstration Year)

Model Core Measures	Year 1	Year 2	Year 3
All Cause Hospital Readmission (Plan All Cause Readmission NQF #1768) Claim-based Measure	Reporting	Benchmark	Benchmark
Ambulatory Care-Sensitive Condition Hospital Admission (PQI Composite #90) Claim-based Measure	Reporting	Benchmark	Benchmark
ED Visits for Ambulatory Care-Sensitive Conditions (Rosenthal) Claim-based Measure	Reporting	Benchmark	Benchmark
Follow-Up after Hospitalization for Mental Illness (NQF #0576) Claim-based Measure	Reporting	Benchmark	Benchmark
Depression screening and follow-up care (#0418) Partially Claim-based Measure		Reporting	Benchmark
Care transition record transmitted to health care professional (NQF #648) Partially Claim-based Measure		Reporting	Reporting
Screening for fall risk (NQF #0101) Partially Claim-based Measure			Reporting
Initiation and engagement of alcohol and other drug dependent treatment: (a) initiation, (b) engagement (NQF #0004) Partially Claim-based Measure			Reporting
State-Specific Process Measures	Year 1	Year 2	Year 3
Care Coordination/Plan of Care: Percentage of enrollees with a Plan of Care within 60 days of connecting with a Regional Care Coordination Organization (RCCO)	Reporting	Benchmark	Benchmark

Training on Disability, Cultural Competence, and Health Assessment: Percentage of providers within a RCCO who have participated in training for disability, cultural competence, or health assessment	Reporting	Benchmark	Benchmark
Hospital Discharge and Follow Up: Percentage of enrollees who received first follow-up visit within 30 days of hospital discharge	Reporting	Reporting or Benchmark	Benchmark
State-Specific Demonstration Measures (measure stewards in parens)	Year 1	Year 2	Year 3
Client/Caregiver Experience of Care: Percentage of enrollees reporting that their doctor or health care provider do the following: a) Listen to you carefully? b) Show respect for what you had to say? c) Involve you in decisions about your care? (AHRQ/CAHPS)	Reporting	Benchmark	Benchmark
Care for Older Adults: Percentage of enrollees 66 years and older who had each of the following during the measurement year: advance care planning, medication review, functional status assessment, and pain screening (HEDIS)	Reporting	Benchmark	Benchmark
Control of Blood Pressure: Percentage of enrollees who have a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) (NCQA/HEDIS)	Reporting	Benchmark	Benchmark
Percent of high-risk beneficiaries receiving community-based LTSS.	Reporting	Benchmark	Benchmark
Percent of high-risk beneficiaries receiving LTSS services in SNF/other non-HCBS setting.	Reporting	Benchmark	Benchmark

**CMS will adapt base measures to incorporate a denominator relative to the Demonstration specific populations at a State level.*

Timing:

For the purposes of quality measurement under the Demonstration:

- Complete reporting means that all parts or elements of the measure must be reported in order for it to be considered “complete.” Even if the answers are “No, a certain action was not taken” or even if clinical values are unfavorable, full credit would be given because all parts of the measure were reported completely.
- Accurate reporting means that all parts of the measure are reported truthfully. All quality measures reported should accurately reflect medical record data, non-medical data, and other information contained in the source data systems. Even if reported values are unfavorable, full credit would be given because all parts of the measure were reported accurately.

Other Related Activities: In addition to the quality measures noted above and the activities noted in Appendix 7, Section 4, CMS and the State will undertake the following activities to collect and evaluate the experience of beneficiaries in this Demonstration:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS): CMS will administer a standardized experience of care survey. The State, as part of the requirements of the Demonstration, will assist CMS and its designated contractor in administering the survey by helping to identify appropriate beneficiaries and providing necessary data. While the State is required to participate in the CMS-sponsored CAHPS survey as part of the Demonstration, the CAHPS measures will not be scored for purposes of determining the retrospective performance payment.

- Medicaid Statistical Information System (MSIS) Data: The State will submit both historical MSIS data and continue to submit all ongoing MSIS data in a timely manner.
- SDAC: The State will continue to maintain the SDAC to support coordinated service delivery through use of Medicare and Medicaid data, among other sources of information. The SDAC will play a critical role in the Demonstration. The SDAC minimizes the reporting burden of the RCCOs and provides them with national expertise. It will be necessary to risk adjust claims data, define appropriate quality metrics, and create a collaborative data-sharing environment. Based on agreements with CMS, the Department will receive historical Medicare data as well as Medicare data on an ongoing basis. Upon receipt, the SDAC will be able to match and link the Medicare and Medicaid data to provide a more complete picture of the conditions, service utilization, costs, and opportunities to provide additional support and care coordination for Medicare-Medicaid enrollees in Colorado. The Department will continue to foster a robust quality measurement process that includes client experience, which is another expected outcome in an improved health care system.

4. Requirements for the ACC Program (RCCOs, PCMPs, and the SDAC)

The Department has formal contractual relationships with the RCCOs, PCMPs, and the SDAC. All requirements and responsibilities are specified in each entity's contract. The Department maintains all contracts and amendments, and they are also available on the Department's website.

5. Care Model

The vision of the ACC Program is to transform the health care delivery system from a traditional, unmanaged FFS model to a regional, outcome-focused, client/family-

centered coordinated system of care. Under the ACC, payment to providers continues to be on a FFS basis, and beneficiaries remain free to choose among all participating Medicaid (and, in this Demonstration, Medicare) providers. However, through the seven Regional Care Collaborative Organizations, the ACC creates an accountability structure missing from a typical unmanaged FFS delivery system.

The ACC model drives primary care reform through Primary Care Medical Providers. PCMPs provide whole-person, coordinated, culturally-competent care for beneficiaries. Through the ACC, participating PCMPs are eligible to receive per member per month payments and required to offer increased access to beneficiaries through, for example, extended office hours or same-day appointments. RCCOs also manage virtual networks of providers to promote beneficiary access to care and support providers with clinical tools, data, and analytics.

The Demonstration will modify the existing ACC Program framework to support the potentially complex needs of Medicare-Medicaid enrollees and the particular financing of their services. The State will work with RCCOs, PCMPs, and other providers and systems of care to ensure that appropriate, high-quality care coordination is available for all beneficiaries who are served under the Demonstration. The Demonstration will include the full continuum of Medicare and Medicaid services that individuals eligible for both programs are entitled to receive, including Medicare Parts A and B and Part D, and all Medicaid State Plan and appropriate waiver services.

Each beneficiary in the Demonstration will be enrolled with the RCCO serving his/her area of the State. For beneficiaries attributed to a PCMP, the RCCO or its designee will perform a comprehensive in-person health screening and work with the beneficiary to complete a Plan of Care within 60 days of enrollment in the RCCO. The Plan of Care articulates the beneficiary's short- and long-term goals and objectives, and it becomes the blueprint for meeting beneficiary goals and improving

health outcomes. The RCCOs and PCMPs will use a Plan of Care that contains required, standardized elements to collaborate with the beneficiary and to facilitate coordination among the beneficiary's other service providers. The Plan of Care includes the beneficiary's basic demographic information; release of information; cultural and linguistic considerations; prioritized domains of care; available interventions and potential methods; contacts and objective timelines; and timeframes for updates and revisions. The Plan of Care is reviewed no less frequently than every six months by the RCCOs and PCMPs, the beneficiary, and the beneficiary's other service providers and updated accordingly. The Plan of Care is intended to complement, rather than duplicate, other assessments or care plans currently in place (e.g., through HCBS waiver programs). To prevent duplication, strengthen relationships, and improve coordination in serving Demonstration enrollees, RCCOs have worked collaboratively with SEPs, CCBs, BHOs, hospitals, home health organizations, disability organizations, skilled nursing facilities, and hospice organizations to establish written protocols. The protocols describe the process for identifying and working with beneficiaries, fulfilling existing responsibilities and mutually agreed upon support functions, and establishing regular contact and communication. These written protocols direct the RCCOs and the collaborative partner to ensure Medicaid waiver responsibilities for persons with disabilities are fulfilled by the appropriate contracted entity; identify the organization responsible for primary care coordination; have regular meetings to discuss clients' care coordination needs; and include individual client's choices throughout care coordination decision-making. Colorado will share any proposed changes to the written protocols 30 days in advance of the effective date for CMS review and comment. This process will be detailed in the Final Demonstration Agreement.

The Plan of Care will provide a single, comprehensive view of all elements needed to coordinate a Demonstration enrollee's physical, behavioral, and social health care, services, and supports. It ensures communication and coordination with the beneficiary, across delivery systems, and among providers. To support beneficiaries

in implementing their Plans of Care, RCCOs will offer care coordination, either through RCCO staff or arrangements with local providers. RCCOs and PCMPs coordinate with direct services providers to arrange for timely post-institutional or facility discharge follow-up, including medication reconciliation and substance use treatment and mental health after care. RCCOs will be responsible for ensuring Plan of Care completion and timely review and updates and for providing training and guidance as needed. Where clients may have care plans through SEPs, CCBs, BHOs, or other Medicaid providers, the Plan of Care is meant to complement the existing care plans done for clients.

Many Medicare-Medicaid beneficiaries already have limited-service care management through HCBS waivers of the specialty mental health system. Under the Demonstration, the State does not intend to add another care coordinator or case manager to the existing systems of care for Medicare-Medicaid enrollees. Instead, the RCCOs will work collaboratively with current systems of care to achieve a more effective and streamlined approach to services for beneficiaries. These collaborative activities may include but are not limited to RCCOs notifying home health organizations of inpatient admission or discharge dates, RCCOs assisting clients on waiting lists for HCBS waiver services, providing access to the PCMP directory to identify a list of possible medical homes for clients, referring clients that could benefit from SEP or CCB or RCCO services, and assistance with finding clients and connecting them with medical homes. Care coordination for Medicare-Medicaid enrollees, in particular, will be flexible enough to respond when a beneficiary's needs increase or decrease. The State has worked collaboratively to develop enhanced care coordination requirements for different groups of Medicare-Medicaid enrollees, and RCCOs are continuing to develop relationships with community providers serving persons with physical and developmental disabilities.

While the Plan of Care and new care coordination opportunities drive improvement at the beneficiary level, the Demonstration will create new relationships across primary

and acute care, LTSS, and behavioral health systems. In support of Medicare-Medicaid beneficiaries in the Demonstration, RCCOs have worked collaboratively with SEPs, CCBs, BHOs, hospitals, home health organizations, disability organizations, skilled nursing facilities, and hospice organizations to establish and test written protocols in their corresponding regions and communities. These protocols have been approved by the Demonstration's Advisory Subcommittee and recommended to the Department for use during readiness for and implementation of the Demonstration. Reference to the protocols has been included in RCCO contract amendments.

6. Evaluation

CMS has contracted with an Independent Evaluator to measure, monitor, and evaluate the impact of this Demonstration on beneficiary experience, quality, utilization, and cost. The Independent Evaluator will also explore how the Demonstration operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences of care. The evaluation will assess beneficiary perspective and experience related to key Demonstration goals, including the ability to self-direct care, be involved in one's care, and live independently in the community. The key issues targeted by the evaluation will include (but are not limited to):

- Beneficiary health status and outcomes;
- Beneficiary satisfaction and experience;
- Quality of care provided across care settings;
- Beneficiary access to and utilization of care across care settings;
- Administrative and systems changes and efficiencies; and
- Overall costs or savings for Medicare and Medicaid.

The Independent Evaluator will design a State-specific evaluation plan for this Demonstration using a mixed methods approach to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative

analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative methods will consist of tracking and analyzing changes in selected quality, utilization, and cost measures over the course of the Demonstration; evaluating the impact of the Demonstration on quality, utilization, and cost measures; and calculating savings attributable to the Demonstration. Specific evaluation strategies include:

- Focus groups conducted with beneficiaries, family members and caregivers;
- Key informant interviews conducted with advocacy organizations and other stakeholders;
- Analysis of beneficiary survey results, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys as well as surveys administered by the State.
- Analysis of Medicare and Medicaid data to examine quality, utilization, and cost experience, as well as Minimum Data Set data, and additional data on State-specific measures to be reported by the State. The evaluation will also assess program data, including complaint, appeal and grievance data.

The evaluation will employ a pre-post evaluation design with a comparison group using an intent-to-treat framework. The Independent Evaluator will contrast the change in outcomes and savings for the Demonstration group of Medicare-Medicaid enrollees eligible to participate in the Demonstration in Colorado with the changes in outcomes and savings observed for a comparison group. The Independent Evaluator will use pre-Demonstration period data to select the comparison group and measure changes in both the Demonstration and comparison groups.

The Independent Evaluator will draw a comparison group of Medicare-Medicaid enrollees from statistically similar states or regions not pursuing a Financial

Alignment Model under this CMS Demonstration. The Independent Evaluator will use cluster analysis to identify potential comparison states that are most similar to Colorado on factors such as Medicare and Medicaid expenditures for Medicare-Medicaid enrollees, LTSS users by type of provider, and managed care penetration rates, among other factors.

The comparison group will start with all Medicare-Medicaid enrollees in the comparison area who would have met Colorado's eligibility criteria to participate in its Demonstration had the Demonstration been implemented in that area. Within this group, the Independent Evaluator will develop the comparison group by using propensity scoring to adjust for differences in key observed characteristics between the Demonstration and comparison group members and to eliminate certain individuals from the comparison group based on their dissimilarity to the Demonstration group. This reweighting technique adjusts for differences in individual-level characteristics between the Demonstration and comparison group members using data on beneficiary-level (e.g., demographics, health and disability status) and county-level (e.g., health care market and local economic) characteristics.

The Independent Evaluator will develop Colorado-specific annual reports that incorporate qualitative and quantitative findings to date and will submit a final evaluation report at the end of the Demonstration. CMS will share a draft of the final evaluation report with the State before finalization; the final evaluation report will be a public document.

The State is required to cooperate, collaborate, and coordinate with CMS and the Independent Evaluator in all monitoring and evaluation activities. The State must submit all required data for the monitoring and evaluation of this Demonstration. The State will track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll or disenroll, enabling the Independent Evaluator to

identify differences in outcomes for these groups.

Colorado will continue to submit all Medicaid Statistical Information System (MSIS) data in a timely manner. As of September 2012, Colorado has submitted all 2011 MSIS files to CMS.

7. ***Learning and Diffusion Activities:*** The State will also participate in learning and diffusion activities regarding this Demonstration. These may include but not be limited to activities such as sharing lessons learned with other states or participating in periodic webinars and/or teleconferences.