

Final Demonstration Agreement

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 Financial Alignment Model for Medicare-Medicaid Enrollees

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

Table of Contents

I.	Specific Purpose of this Final Demonstration Agreement.....	3
II.	Legal Parameters.....	3
III.	Readiness Review	4
IV.	Process and Operational Provisions.....	4
	A. Statement of Initiative (Section I of the MOU)	4
	B. Specific Purpose of the Memorandum of Understanding (Section II of the MOU).....	5
	C. Program Design/Operational Plan (Section III of the MOU)	5
	D. Definitions (Appendix 1 of the MOU).....	6
	E. CMS Standards and Conditions and Supporting State Documentation (Appendix 2 of the MOU)	6
	F. Details of the State Demonstration Area (Appendix 3 of the MOU)	6
	G. Medicare Authorities and Waivers (Appendix 4 of the MOU)	6
	H. Medicaid Authorities and Waivers (Appendix 5 of the MOU)	7
	I. Performance Payments to the State (Appendix 6 of the MOU).....	7
	J. Demonstration Parameters (Appendix 7 of the MOU).....	14
V.	Extension of Final Demonstration Agreement	21
VI.	Modification or Termination of Final Demonstration Agreement	21
VII.	Standard CMS Terms and Conditions	24
VIII.	Signatures.....	26

I. SPECIFIC PURPOSE OF THIS FINAL DEMONSTRATION AGREEMENT

The purpose of this Final Demonstration Agreement (Agreement) is to provide the terms and conditions for the implementation of the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees (Demonstration), first established in the Memorandum of Understanding (MOU) signed on February 28, 2014. All provisions of the MOU are incorporated by reference into this Agreement unless otherwise specified or unless this Agreement includes provisions that are inconsistent with the MOU. Any provision in this Agreement that is inconsistent with or in conflict with a provision of the MOU will supersede such MOU provision.

Beneficiary 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 State and the Federal government through improvements in health and functional outcomes.

II. LEGAL PARAMETERS

The parties agree to be bound to the terms and conditions of this Agreement.

III. READINESS REVIEW

The purpose of the readiness review is to confirm that the State is prepared to implement the Demonstration in accordance with the model as outlined in the MOU. The goal is to ensure the successful transition of Medicare-Medicaid enrollees into the Demonstration and to ensure the State has the necessary infrastructure and capacity to implement, monitor, and oversee the proposed model.

CMS has conducted a readiness review and determined that the State has reached a level of readiness to implement the Demonstration. CMS and the State will finalize benchmarks for the Demonstration quality metrics for the retrospective performance payment, as described in Section IV.J.3.c and the MOU.

IV. PROCESS AND OPERATIONAL PROVISIONS

Items are listed in accordance to relevant MOU sections; “Intentionally Left Blank” is noted for those sections for which there are no changes from the MOU. For definitions, please refer to the MOU.

A. STATEMENT OF INITIATIVE (SECTION I of the MOU)

CMS and the State agree to begin this Demonstration on September 1, 2014, and continue until December 31, 2017, unless extended or terminated pursuant to the terms and conditions in Section V or VI, respectively, of this Agreement.

B. SPECIFIC PURPOSE OF THE MEMORANDUM OF UNDERSTANDING (SECTION II of the MOU)

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C. PROGRAM DESIGN/OPERATIONAL PLAN (SECTION III of the MOU)

1. Program Authority:

- a. *Medicare Authority:* Intentionally Left Blank.
- b. *Medicaid Authority:* See Section H of this Agreement on Medicaid Authority and Appendix 5 of the MOU.

2. Eligibility: Intentionally Left Blank

3. Delivery Systems and Benefits: Intentionally Left Blank

4. Beneficiary Protections, Participation, and Customer Service: Intentionally Left Blank

5. Administration and Reporting

- a. *Readiness Review:* See Section III of this Agreement for discussion of Readiness Review.
- b. *Monitoring:* Intentionally Left Blank.

6. Quality Management: Intentionally Left Blank

7. Financing and Payment: Intentionally Left Blank

8. Evaluation: Intentionally Left Blank

D. DEFINITIONS (APPENDIX 1 of the MOU)

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***E. CMS STANDARDS AND CONDITIONS AND SUPPORTING STATE
DOCUMENTATION (APPENDIX 2 of the MOU)***

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F. DETAILS OF THE STATE DEMONSTRATION AREA (APPENDIX 3 of the MOU)

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G. MEDICARE AUTHORITIES AND WAIVERS (APPENDIX 4 of the MOU)

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H. MEDICAID AUTHORITIES AND WAIVERS (APPENDIX 5 of the MOU)

On June 5, 2014, CMS approved SPA #TN 14-004, effective July 1, 2014 to authorize the expansion of the Accountable Care Collaborative program for Medicare-Medicaid enrollees.

I. PERFORMANCE PAYMENTS TO THE STATE (APPENDIX 6 of the MOU)

- 1. Demonstration Years:** Figure 6-1 below outlines the updated Demonstration Years for the purposes of this Agreement.

Figure 6-1. Updated Demonstration Year Dates

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

- 2. Savings Calculation Detail:** After each year of the Demonstration, the Evaluation Contractor will perform a calculation to determine whether the Demonstration achieved savings, and the amount of any savings. The calculation will determine the difference in per beneficiary per month (PBPM) spending found between the demonstration group and a target amount determined by trending demonstration group expenditures in a two-year pre-Demonstration base period by the change in costs of the comparison group.

The savings calculations will use an actuarial methodology to provide CMS with the resulting Medicare and Medicaid savings achieved. The calculation will reflect any increase in Federal Medicaid spending, including fees or enhanced FMAP for health home services (if applicable), associated with beneficiaries in Colorado or the comparison group.

- a. *Identifying Beneficiaries Eligible for Inclusion:* Both the demonstration and comparison group will be identified using an intent-to-treat approach. The data used to identify demonstration and comparison beneficiaries will reflect eligibility on the Demonstration start date. The demonstration group will be identified retrospectively, after the Demonstration year has ended, to allow for additional data to become available.
- i. Every beneficiary included in the first performance payment calculation must meet all of the following criteria to be included in the savings calculation:
1. Meet the Demonstration eligibility criteria for at least 3 months and have at least 3 months of baseline claims; and
 2. Not be eligible for Medicaid by short-term spend down. Beneficiaries in long-term care who have patient pay liability will be included in the savings calculations.
- ii. Individuals in a Medicare Advantage (MA) or a Program of All-inclusive Care for the Elderly (PACE) plan on the Demonstration start date will not be included in the base period. Unless such individuals disenroll from MA or PACE and become eligible for the Demonstration, their experience during the Demonstration will also be excluded from the savings calculation. For beneficiaries who disenroll from MA or PACE and become eligible for the Demonstration, the plan capitation payments will be used as the basis for their baseline Medicare and Medicaid costs if applicable, and their actual experience during the Demonstration will be included in the savings calculation.

- iii. Only the member months during which a beneficiary was eligible for the demonstration or comparison group will be included in the calculation. Terminations in eligibility will result from moving out of area, death, loss of eligibility for Medicare Parts A and B, Medicare becoming a secondary payer, or loss of eligibility for full Medicaid benefits. The same rules for terminating eligibility for inclusion in the savings calculation will be applied to both the demonstration and comparison groups.

b. *Beneficiaries who Become Eligible for this Demonstration After the Start Date*

- i. The baseline for beneficiaries who become eligible for the Demonstration after the Demonstration start date will be their experience from their date of Demonstration eligibility to the end of that Demonstration year. Such beneficiaries will then enter the calculation on the first day of the next Demonstration year. The same approach will be used to determine baseline experience for beneficiaries in the comparison group who newly meet Demonstration eligibility criteria after the Demonstration start date.
- ii. The actual savings achieved for beneficiaries who become eligible for this Demonstration after the start date will not be included in the savings calculation until the following year (i.e., until the beneficiaries' first full Demonstration year of eligibility).
 - 1. For the Demonstration year in which the beneficiary became eligible for this Demonstration after the start date, the savings percentage calculated for beneficiaries that are included in the savings calculation (i.e. beneficiaries in the demonstration and comparison groups who were eligible on the Demonstration start date, or at the beginning of the previous Demonstration year, as

applicable) will be attributed to the beneficiaries who become eligible for this Demonstration after the start date in the year that they become eligible.

2. Each Demonstration year, a new cohort will be created for beneficiaries who became newly eligible the previous year.
- iii. Beneficiaries becoming eligible for the Demonstration during the first year will be incorporated into the savings calculation using the attribution approach described in IV.I.2.b.ii, above. These beneficiaries will be included in a new cohort on the start date of the second Demonstration year.
- iv. All beneficiaries that become eligible for the Demonstration during the second Demonstration year will form a cohort that begins in the third Demonstration year.
- v. Beneficiaries becoming eligible in Demonstration year three will not be included in the calculation of savings percentages, but will have savings applied to their expenditures using the methodology described in IV.I.2.b.ii .
- vi. For each new cohort of demonstration beneficiaries, there will be a corresponding new cohort of comparison beneficiaries.

c. Cell Structure

- i. Beneficiaries in the demonstration group and the comparison group will be grouped into cells according to characteristics that influence expected

costs (e.g., residing in a nursing facility, serious and persistent mental illness, age).

- ii. The cells are the following:
 - 1. Three by category of care delivery: facility, HCBS waiver, and community other.
 - 2. Two by mental condition: the presence or absence of serious and persistent mental illness (SPMI).
 - 3. Two by age: age 65 and older, and under age 65.
- iii. If a particular cell contains zero or a small number of member months, as determined by CMS and its evaluation contractor, the cell category will be eliminated and any beneficiaries in the eliminated cell will be included in another applicable cell. A cell will also be eliminated if data needed to make the cell placements are not available.
- iv. Beneficiaries will be placed into cells according to their characteristics as of the date they enter the savings calculation (i.e. the Demonstration start date or the first date of a new cohort), and will remain in that cell throughout the Demonstration, for the months they remain eligible for the Demonstration.
- v. Savings will be measured separately for each cell. Aggregate savings will be determined by weighting each comparison group cell according to the distribution of the demonstration population.

- d. *Capping Individual Costs:* The annual costs of individuals included in the savings calculation will be capped at the 99th percentile of annual expenditures. Medicare and Medicaid expenditures will be capped separately.
- e. *Savings Calculation:* Savings will be calculated one cell at a time, one year at a time, and one cohort at a time, as follows:

$$S\$_{X,P} = M_{X,D} * (TPBPM_{X,P} - PBPM_{X,D,P}), \text{ where:}$$

- i. $S\$_{X,P}$ = savings in dollars for a particular cell (X) for a particular cohort in a particular Demonstration year for a particular program (Medicare or Medicaid)
- ii. $M_{X,D}$ = months of eligibility for the beneficiaries in cell (X) in the demonstration group. Each cell in the comparison group will have the same weight as the corresponding cell in the demonstration group.
- iii. $TPBPM_{X,P}$ = target per beneficiary per month cost in cell (X) for a particular program
- iv. $PBPM_{X,D,P}$ = actual per beneficiary per month cost of the beneficiaries in cell (X) in the demonstration group for a particular program
 - 1. The $PBPM_{X,D,P}$ is equal to the Medicare A/B costs or the Medicaid costs (excluding the costs above the cap) incurred during the period of eligibility for all beneficiaries in cell (X) in the demonstration group, divided by the months of eligibility for all beneficiaries in cell (X) in the demonstration group.

2. Whenever a beneficiary is eligible for part of a month (e.g. for a death that occurs in the middle of a month), then a fraction of the month will be used in determining the total number of months of eligibility.
- v. Aggregate savings across all cells will be the sum of the savings for all cells and for both programs: $S\$_A = \sum \sum S\$_X$
 - vi. The target PBPM ($TPBPM_{X,P}$) is a projection of the baseline PBPM of a cell (X) and the program (P) of the demonstration group based on the rate of increase of the corresponding cell of the comparison group:

$$TPBPM_{X,P} = PBPM_{X,D,P}(BY) * (PBPM_{X,C,P}(DY) / PBPM_{X,C,P}(BY)),$$

where:

1. $PBPM_{X,D,P}(BY)$ = the demonstration group PBPM in the base years in cell (X) and program (P)
 2. $PBPM_{X,C,P}(BY)$ = the comparison group PBPM in the base years in cell (X) and program (P)
 3. $PBPM_{X,C,P}(DY)$ = the comparison group PBPM in the demonstration year in cell (X) and program (P)
- vii. Percentage savings in aggregate across all cells and both Medicare and Medicaid is calculated as follows:

$$S\%_{Cohort} = S\$_{Cohort} / (M_{Cohort} * TPBPM_{Cohort})$$

viii. Total dollar savings will be the dollar savings from those beneficiaries in the calculation of the percentage savings plus the attributed savings to the cohort of beneficiaries who become eligible for this Demonstration after the start date:

1. $S\$_{Total} = S\$_{Cohort} + S\%_{Cohort} * E_{NewCohort}$, where: $S\%_{Cohort}$, $S\$_{Cohort}$, M_{Cohort} , and $TPBPM_{Cohort}$ have the meanings described above but summed across all cells and the for the Medicaid and Medicare programs.
2. $E_{NewCohort}$ represents the amount spent on beneficiaries in the cohort of beneficiaries who become eligible for this Demonstration after the start date; the percentage savings calculated for the previous cohort(s) is being attributed to the cohort of beneficiaries who become eligible for this Demonstration after the start date in the equation IV.I.2.e.viii, immediately above.

J. DEMONSTRATION PARAMETERS (APPENDIX 7 of the MOU)

- 1. State of Colorado Delegation of Administrative Authority and Operational Roles and Responsibilities:** Intentionally Left Blank
- 2. Grievances and Appeals:** Intentionally Left Blank
- 3. Administration and Oversight:**
 - a. *Beneficiary Assignment and Enrollment:* Intentionally Left Blank

b. *Monthly Eligibility File Submissions: Intentionally Left Blank*

c. *Quality Metrics and Reporting for Determining the Retrospective Performance Payment*

- i. CMS will review and update the Demonstration core measures and measure specifications annually to ensure compliance with current science and measure development.
- ii. The State will review and, with CMS approval, update State-specific measures and measure specifications annually to ensure compliance with current science and measure development. Where applicable, CMS will adhere to nationally-endorsed specifications for relevant measures.
- iii. CMS will establish benchmarks for each measure based on an analysis of the State’s quality performance, as described in the MOU.
- iv. The Demonstration Measurement Set (including core measures revised from the MOU, State-specific process measures, and State-specific Demonstration measures) is as follows:

Model Core Measures	Year 1	Year 2	Year 3
All Cause Hospital Readmission <i>(Plan All Cause Readmission NQF #1768)</i> Claim-based Measure	Reporting	Benchmark	Benchmark
Ambulatory Care-Sensitive Condition Hospital Admission <i>(PQI Composite #90)</i> Claim-based Measure	Reporting	Benchmark	Benchmark
ED Visits for Ambulatory Care-Sensitive Conditions <i>(Rosenthal)</i> 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 (measure stewards in parens)	Year 1	Year 2	Year 3
Care Coordination/Plan of Care: Percentage of enrollees with a Service Coordination Plan within 90 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	Benchmark
State-Specific Demonstration Measures	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
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

d. *Requirements for the ACC Program (RCCOs, PCMPs, and the SDAC:*

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e. *Care Model:* Colorado will share any proposed changes to the written protocols 30 days in advance of the effective date for CMS review and comment.

The vision of the Accountable Care Collaborative (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 (RCCOs), 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). 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. The RCCO will work with the beneficiary to complete a Service Coordination Plan (SCP) for each beneficiary enrolled in the Demonstration. Beneficiaries determined to be high-risk must have a SCP completed within 90 days of enrollment in the demonstration. All other beneficiaries must have a SCP completed within 120 days of enrollment. The SCP articulates the beneficiary's short- and long-term goals and objectives and becomes the blueprint for meeting beneficiary goals and improving health outcomes. The RCCOs and PCMPs will use a SCP that contains required, standardized elements to collaborate with the beneficiary and to facilitate coordination among the beneficiary's other service providers. The SCP will include 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 SCP will be developed based on protocols developed by the RCCOs. To prevent duplication, strengthen relationships, and improve coordination in serving Demonstration enrollees, RCCOs have worked

collaboratively with Single Entry Points (SEPs), Community Centered Boards (CCBs), Behavioral Health Organizations (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. The SCP will be reviewed no less frequently than every six months by the RCCOs and PCMPs, the beneficiary, and the beneficiary's other case managers and updated accordingly. The SCP will be intended to complement, rather than duplicate, other assessments or care plans currently in place (e.g., through HCBS waiver programs).

The SCP 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 will ensure communication and coordination with the beneficiary, across delivery systems, and among providers. To support beneficiaries in implementing their SCP, RCCOs will offer care coordination, either through RCCO staff or arrangements with local providers. RCCOs and PCMPs will 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 SCP completion and timely review and updates and for providing training and guidance as needed.

Many Medicaid-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. 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 SCP 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.

Given that the State already has achieved one of the lowest rates of institutional long term care placement in the country, the two long-term services and supports State specific demonstration measures will allow credit for maintaining or improving performance over time.

- f. *Evaluation:* The State will work with the evaluation contractor to determine what care coordination/case management data are available and will share data with evaluator to support analysis of care coordination utilization patterns. Based on discussions with the evaluation contractor, the State may be asked to provide additional data, such as HICNs, on beneficiaries receiving care coordination during any given month.

V. 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 Social Security 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 and care and reducing spending. Any extension request may be granted at CMS's sole discretion.

VI. 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 Social Security 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 and 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 notice to the other entity and 60 days advance notice is given to beneficiaries and the general public.
- b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).
- c. Termination for cause - Either party may terminate upon 30 days' prior written notice due to a material breach of a provision of the Final Demonstration Agreement, including termination of any relevant Medicaid authorities.
- d. Termination due to a Change in Law - In addition, CMS or the State may terminate upon 30 days' notice due to a material change in law, or with less or no notice if required 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 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 §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230.

- d. Federal Financial Participation (FFP) - If the Demonstration is terminated, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participating enrollees from health home services to the extent health home services are terminated.

- e. State Plan Amendments - If the State amends section 1932(a) of its State Plan as part of the termination of this Demonstration, the State must follow Medicaid requirements for SPAs. If the changes made to the State Plan eliminate the population impacted by this Demonstration, this Demonstration will also terminate on the same date, and the State shall follow the notification requirements under Section VI.2.c.

- f. 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.

VII. STANDARD CMS TERMS AND CONDITIONS

- A. **Payments** - The State will be entitled to payments under this Demonstration only if all conditions of the MOU (signed by the parties on February 28, 2014) and this Agreement have been satisfied, including compliance with any waivers or other authorities upon which the MOU was contingent.

- B. **Order of Precedence** - Any inconsistency in the documents referenced in this Agreement shall be resolved by giving precedence in the following order:
 - (a) Waivers or other authorities referenced in Section IV of this Agreement.

(b) This Agreement.

(c) The MOU.

(d) The State's proposal and application documents.

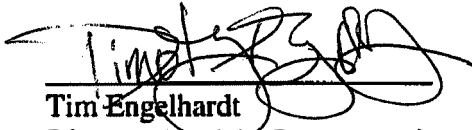
C. **Changes** - Changes in the terms and conditions of this Agreement may be made only by written agreement of the parties.

VIII. SIGNATURES

This Final Demonstration Agreement is effective on September 1, 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:



Tim Engelhardt
Director, Models, Demonstrations, and Analytics Group
Federal Coordinated Health Care Office

7/16/14
(Date)

State of Colorado:



Susan E. Birch MBA, BSN, RN
Executive Director

7/10/14
(Date)