

*Colorado Department of  
Health Care Policy and Financing*



Section 1915(b) Waiver Renewal  
Proposal for  
The Colorado Medicaid  
Community Mental Health Services Program  
and  
The Special Connections Substance Abuse Treatment  
Program Postpartum Months  
Three through Twelve

Submitted on March 31, 2011  
for  
Waiver Period July 1, 2011 to June 30, 2013

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Instructions – see separate document

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**Proposal for a Section 1915(b) Waiver  
MCO, PIHP, PAHP, and/or PCCM Program**

**Facesheet**

*Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.*

The **State** of Colorado requests a waiver/~~amendment~~ under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver programs** are the Colorado Medicaid Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program Postpartum Months Three through Twelve. (Please list each program name if the waiver authorizes more than one program.).

**Type of request.** This is an:

- initial request for new waiver
- amendment request for existing waiver, which modifies Section/Part \_\_\_\_
  - Replacement pages are attached for specific Section/Part being amended
  - Document is replaced in full, with changes highlighted
- renewal request
  - This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) are filled out.
  - The State has used this waiver format for its previous waiver period.
    - Section A is  replaced in full
    - carried over from previous waiver period. The State:
      - assures there are no changes in the Program Description from the previous waiver period.
      - assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
  - Section B is  replaced in full
  - carried over from previous waiver period. The State:
    - assures there are no changes in the Monitoring Plan from the previous waiver period.
    - assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.

**Effective Dates:** This ~~waiver/renewal/amendment~~ is requested for a period of two (2) years, effective July 1, 2011 and ending June 30, 2013. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the

first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

**State Contact:** The State contact person for the Community Mental Health Services Program under this waiver is Marceil Case and she can be reached by telephone at (303) 866-3054, or fax at (303) 866-2803, or e-mail at Marceil.Case@state.co.us.

The State contact person for the Special Connections Substance Abuse Treatment Program under this waiver is Lisa Keenan and she can be reached by telephone at (303) 866-3929, or fax at (303) 866-2803, or e-mail at Lisa.Keenan@state.co.us.

The State contact person for the cost effectiveness portion of this waiver is Sharon Liu and she can be reached by telephone at (303) 866-3601, or fax at (303) 866-2370, or e-mail at sharon.liu@state.co.us.

## **Section A: Program Description**

### **Part I: Program Overview**

#### **Tribal consultation**

For initial and renewal waiver requests, please describe the efforts the State has made to ensure federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

*The Department of Health Care Policy and Financing (the Department) sent the Community Mental Health Services Program and Substance Abuse Treatment Program Postpartum Months Three to Twelve renewal waiver to identified stakeholders and the federally recognized tribes in Colorado for their review and comment in early Spring 2011. The recognized tribes are the Northern Navajo, Southern Ute and the Ute Mountain Ute. Additional native stakeholders include Denver Indian Health and Family Services, Utah Navajo Health Systems, Four Corners Regional Health, and New Sunrise Regional Treatment Center. Please see Appendix A.I. for a list of identified stakeholders.*

#### **Program History**

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe, new populations added, major new features of existing program, new programs added).

##### *Community Mental Health Services Program History*

*The Colorado Medicaid Program is administered by the Department, the single state agency authorized to administer the Colorado Medicaid Program.*

*Prior to 1995, most Medicaid beneficiaries in Colorado received mental health benefits through a fee-for-service system. Medicaid beneficiaries who were not enrolled in Health Maintenance Organizations (HMOs) received mental health services from a variety of Medicaid-enrolled providers, such as Community Mental Health Centers (CMHCs), clinics, hospitals, psychiatrists, psychologists and social workers. These health care providers billed the Medicaid Program for each covered service provided to Medicaid beneficiaries. There was no central gatekeeper determining the need for services and no single clinician or case manager coordinating all aspects of an individual's mental health care. Medicaid beneficiaries were free to seek services from any Medicaid-enrolled provider.*

*Medicaid beneficiaries who were enrolled in HMOs received a limited amount of inpatient and outpatient mental health services through these HMOs. Once a beneficiary received the maximum mental health benefits available through the HMO, she/he received any additional necessary mental health services through the Medicaid fee-for-service system described above.*

*In 1992, the Colorado General Assembly passed House Bill 92-1306, authorizing the Department of Human Services and the Department to implement a two-year pilot program to provide comprehensive mental health services to Medicaid beneficiaries through a capitated managed care system. In 1995, shortly before the start of the pilot program, the General Assembly passed Senate Bill 95-78, revising the reporting and termination dates of the pilot program and directing the Departments to implement a statewide mental health managed care program.*

*The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 1995 in 51 counties, and in 1998 in the remaining 12 counties of the state. From 1998 through 2004, eight contractors operated the Program. In 2005, the Department reconfigured the counties into five (5) geographic service areas (please see Section A. Part I. D. 2.). Each contractor operates the Program in a specific geographic area, and only one contractor operates in any given area.*

*In 1993, the federal Health Care Financing Administration (HCFA) granted the State waivers under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act. These waivers allowed the State to implement a managed mental health program for a two-year period, beginning July 1, 1995 and ending June 30, 1997. These initial waivers were subsequently extended by HCFA through March 8, 1998.*

*In 1998, HCFA renewed Colorado's waivers for an additional two years, beginning March 9, 1998 and ending March 8, 2000. These waivers were subsequently extended by HCFA through April 9, 2001. In 2001, HCFA renewed the waivers for an additional two years beginning April 10, 2001 through April 9, 2003. This waiver was extended until July 8, 2003 to allow time for approval of the subsequent renewal waiver, which was approved for the waiver period of May 5, 2003 through May 4, 2005 and later extended to June 30, 2005. In 2005, the Centers for Medicare and Medicaid Services (CMS) renewed Colorado's waivers for the waiver period of July 1, 2005 through June 30, 2007. In 2007, CMS again renewed Colorado's waivers for the waiver period of July 1, 2007 through September 30, 2009. In 2009, CMS renewed Colorado's waivers for the current waiver period of October 1, 2009 through June 30, 2011.*

*Legislation that passed April 6, 2004 transferred the program operations from the Department of Human Services to the Department, allowing for more cohesive management of the program, since the Department possesses the authority for the Program's management and the Department manages the entire continuum of Medicaid services and administrative contracts. This shift also allows the Department to be more aware of gaps between physical and mental health care and to better serve Medicaid beneficiaries by having one administrative agency responsible for the provision of their Medicaid services.*

*Special Connections Substance Abuse Treatment Program History*

*On September 29, 2006, the Department submitted an amendment to the Community Mental Health Services Program waiver to include the Colorado Special Connections Substance Abuse Treatment Program Postpartum Months Three to Twelve (hereafter referred to as the Special Connections Substance Abuse Treatment Program). This waiver amendment was approved for the periods of January 1, 2007 through June 30, 2007, for July 1, 2007 through September 30, 2009, and for the current period of October 1, 2009 through June 30, 2011. The Special Connections Substance Abuse Treatment Program portion of the waiver extended the postpartum substance abuse benefits for Special Connections participants from two months postpartum to twelve months postpartum. In order to receive Special Connections services for postpartum months three through twelve, a client must have been enrolled in and receiving Special Connections services prior to giving birth. Additionally, in order for a client to receive State Plan Special Connections services and Special Connections services in postpartum months three through twelve, the client must meet American Society of Addiction Medicine criteria for treatment as assessed and determined by the Special Connections providers.*

*Special Connections is a substance abuse treatment program jointly administered by the Colorado Department of Human Services (DHS), Division of Behavioral Health (DBH), formerly the Alcohol and Drug Abuse Division (ADAD)<sup>1</sup>, and the Department's Medicaid Program Division, formerly the Health Benefits Division<sup>2</sup> (Appendix E1). Since 1992, the Special Connections Substance Abuse Treatment Program has provided substance use disorder treatment and case management services to pregnant and postpartum women with substance use disorder issues. DBH contracts with licensed women's treatment programs to provide Medicaid-paid services through an Interagency Agreement (IA) (Appendix E2) with the Department.*

*Legislation authorizing the Special Connections Substance Abuse Treatment Program was passed in 1991, as Senate Bill 91-56. Rationale for this legislation was that Colorado would benefit from early identification and intervention with pregnant women who had substance use disorders and therefore were at risk of delivering low birth weight babies with other health complications, such as fetal alcohol spectrum disorders, withdrawal complications and neurological, cognitive and physiological deficits. Funding for both residential (room and board excluded) and outpatient treatment was approved at that time.*

*The initial enrollment in the Special Connections Substance Abuse Treatment Program was small, serving 42 clients in 1992. The phase-in of the program focused first on DBH contracting with licensed providers with specialized skill in treating pregnant women with substance use disorders and then working with*

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<sup>1</sup> ADAD became part of the Division of Behavioral Health in late 2008.

<sup>2</sup> The Health Benefits Division name was changed to the Medicaid Program Division in late 2008.

*referral sources throughout the State to make them aware of the services offered. Special Connections providers have worked to educate communities about the program and increase the number of collaborators and partners who can refer clients to the program. DBH currently works with the Department, the Colorado Department of Public Health and Environment, the local county departments of human/social services, DHS Child Welfare Division, the State Court Administrator's Office and the Division of Probation Services.*

*In 2004, the Colorado legislature enacted HB04-1075 to extend the Medicaid postpartum substance use disorder benefits from two months to twelve months postpartum. The legislature reasoned that Medicaid expenditures for care of these infants would decrease as there was a greater likelihood that the mother would remain free from substance abuse if treatment were extended. The intent of the legislation was to expand the eligibility period to provide substance use disorder treatment services to Special Connections clients who deliver in the program. The original legislation was interpreted and applied in that fashion since implementation in 1992. The Special Connections Substance Abuse Treatment Program portion of the waiver provides an additional period of substance use disorder treatment to ensure that the mother remains drug free and able to care for her new infant.*

*All clients identified as being eligible for the Special Connections Substance Abuse Treatment Program must meet the following criteria: 1) Medicaid eligibility, 2) pregnant, 3) assessed at a high risk for a poor birth outcome due to substance abuse or dependence, and 4) willing to receive prenatal care during pregnancy. In order to receive Special Connections services for postpartum months three through twelve, a client must have been enrolled in and receiving Special Connections services prior to giving birth.*

## A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a.  **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b.  **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c.  **1915(b)(3)** - (*Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program*) The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d.  **1915(b)(4)** - (*Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program*) The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- MCO
- PIHP (*Applies to the Community Mental Health Services Program*)
- PAHP
- PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- FFS Selective Contracting Program (please describe) (*Applies to the Special Connections Substance Abuse Treatment Program*)

*All Special Connections Substance Abuse Treatment Programs are currently licensed by DBH. There is an IA between DBH and the Department (refer to attached Appendix E2 for details) for provision of Medicaid services delivered by the Special Connections network. The Special Connections network consists of providers approved by and contracted with DBH for the delivery of Special Connections services, and functions as a subcontract network of DBH. DBH has oversight for prior authorization for residential benefits. Program rates are set up to be comparable with FFS rates when possible for similar types of services.*

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

- a. \_\_\_ **Section 1902(a)(1)** - Statewide--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b.  **Section 1902(a)(10)(B)** – (*Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program*) Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope.
- c.  **Section 1902(a)(23)** – (*Applies to the Community Mental Health Services Program*) Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
- d.  **Section 1902(a)(4)** – (*Applies to the Community Mental Health Services Program*) To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e. \_\_\_ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

## B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a.  **MCO:** Risk-comprehensive contracts are fully capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b.  **PIHP:** (*Applies to the Community Mental Health Services Program*)  
Prepaid Inpatient Health Plan means an entity that:  
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

The PIHP is paid on a risk basis.

The PIHP is paid on a non-risk basis.

c.  **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

d.  **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e.  **Fee-for-service (FFS) selective contracting:** (*Applies to the Special Connections Substance Abuse Treatment Program*) A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

the same as stipulated in the state plan

is different than stipulated in the state plan (please describe)

f. \_\_\_ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement.** The State selected the contractor in the following manner (required by 42 CFR Part 74 if contract over \$100,000). Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

- Competitive** procurement process (*Applies to the Community Mental Health Services Program*) (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement. CMS Regional Office prior approval required.
- Other** (please describe) (*Applies to the Special Connections Substance Abuse Treatment Program*)

*Only specialized providers can provide services to this population. The Special Connections Substance Abuse Treatment Program requires providers with specialty knowledge of pregnancy, postpartum and substance use disorder issues.*

## C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

### 1. Assurances.

\_\_\_ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

(*Applies to the Community Mental Health Services Program*) The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

*The Department contract requires PIHPs to maintain an adequate provider network throughout their service regions to meet access standards. The Department monitors this through reporting on network adequacy, complaints and grievances, member satisfaction surveys and site reviews. Members are also permitted to access covered services from any contracted provider network when they are outside of their home service region.*

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

- \_\_\_ Two or more MCOs
- \_\_\_ Two or more primary care providers within one PCCM system.
- \_\_\_ A PCCM or one or more MCOs
- \_\_\_ Two or more PIHPs.
- \_\_\_ Two or more PAHPs.
- Other: (*Applies to the Community Mental Health Services Program*) (please describe)

*Within the PIHP network, enrollees have a choice of providers.*

### 3. Rural Exception.

\_\_\_ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

- Beneficiaries will be limited to a single provider in their service area (please define service area).
- (*Applies to the Special Connections Substance Abuse Treatment Program*) Beneficiaries will be given a choice of providers in their service area.

*Under the Special Connections Substance Abuse Treatment Program, the outpatient, residential, care management and health education services are provided by a specialty network of providers that have expertise in substance use disorders and pregnancy/postpartum care. They are located throughout the State with no specific defined service area. In the Denver metro area, there are several different providers that are defined by specific services they offer rather than service area.*

## D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

**Statewide** -- (*Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program*) all counties, zip codes, or regions of the State

**Less than Statewide**

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

### Community Mental Health Services Program Geographic Areas of Service and PIHPs

<b>Current PIHP Contractors</b>	<b>Counties Served</b>
Northeast Behavioral Health Partnership, LLC	Cheyenne, Elbert, Kit Carson, Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma
Colorado Access (dba Access Behavioral Care)	Denver
Behavioral Healthcare, Inc.	Adams, Arapahoe, Douglas
Foothills Behavioral Health Partners, LLC	Boulder, Broomfield, Clear Creek, Gilpin, Jefferson
Colorado Health Partnerships, LLC	Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, La Plata, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Otero, Ouray, Park, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, Teller

*The Department completed procurement of the new contract for the Community Mental Health Services Program and awarded contracts to the same contractors, although two contractors have acquired new partners. The contractor names in the table above reflect the new entity names. The contractors are now in the 2<sup>nd</sup> year of the new contract, which was implemented on September 1, 2009.*

Special Connections Substance Abuse Treatment Program Geographic Areas of Service

<b>Region/Area Served</b>	<b>Type of Program (PCCM, MCO, PIHP, PAHP)</b>	<b>Name of Entity (for MCO, PIHP, PAHP)</b>
1. Greeley, Ft. Collins, surrounding areas	Fee for Service	<ul style="list-style-type: none"> <li>• Centennial Mental Health Center, Sterling</li> <li>• North Range Behavioral Health, Greeley</li> <li>• Larimer Center for Mental Health, Ft. Collins</li> </ul>
2. Denver metro area	Fee for Service	<ul style="list-style-type: none"> <li>• ARTS: Women's Outpatient Treatment Services, Denver</li> <li>• ARTS: The Haven, Denver</li> <li>• Arapahoe House: Aspen Center, Denver</li> <li>• Arapahoe House Case Management Services, Thornton</li> </ul>
3. None at this time		
4. Pueblo, Alamosa, and surrounding areas	Fee for Service	<ul style="list-style-type: none"> <li>• Crossroads Turning Points, Alamosa</li> <li>• Crossroads Turning Points, Pueblo</li> </ul>
5. Southwestern Colorado	Fee for Service	<ul style="list-style-type: none"> <li>• Cortez Addictions Recovery Services</li> </ul>
6. Southwestern Colorado	Fee for Service	<ul style="list-style-type: none"> <li>• Southwest Colorado Mental Health Center</li> </ul>
7. Boulder county and surrounding areas	Fee for Service	<ul style="list-style-type: none"> <li>• Boulder County Health Department</li> </ul>

## E. Populations Included in Waiver

1. **Included Populations**. The following populations are included in the Waiver Program:

✓ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

✓ Mandatory enrollment (*Applies to the Community Mental Health Services Program*)

✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

✓ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

✓ Mandatory enrollment (*Applies to the Community Mental Health Services Program*)

✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

✓ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

✓ Mandatory enrollment (*Applies to the Community Mental Health Services Program*)

✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

✓ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

✓ Mandatory enrollment (*Applies to the Community Mental Health Services Program*)

✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

✓ **Aged and Related Populations** (*Applies to the Community Mental Health Services Program only*) are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- Mandatory enrollment (*Applies to the Community Mental Health Services Program*)
- Voluntary enrollment

**Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- Mandatory enrollment (*Applies to the Community Mental Health Services Program*)
- Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

**TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

- Mandatory enrollment
- Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

**Medicare Dual Eligible**--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

**Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

**Other Insurance**--Medicaid beneficiaries who have other health insurance.

**Reside in Nursing Facility or ICF/MR** (*Applies to the Special Connections Substance Abuse Treatment Program*)--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

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

\_\_\_ **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

\_\_\_ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

\_\_\_ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

\_\_\_ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

**SCHIP Title XXI Children** (*Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program*)-- Medicaid beneficiaries who receive services through the SCHIP program.

\_\_\_ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

**Other** (Please define): (*Applies to the Community Mental Health Services Program*)

*The following individuals are not eligible for enrollment in the Community Mental Health Services Program:*

- A. *Qualified Medicare Beneficiary only (QMB-only)*
- B. *Qualified Working Disabled individuals (QWDI)*
- C. *Qualified Individuals 1 (QI 1)*
- D. *Special Low Income Medicare Beneficiaries (SLMB)*
- E. *Undocumented Aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar who are eligible for Federal Medicaid for care and services related to the treatment of an approved emergency medical condition.*
- F. *Program of All-inclusive Care for the Elderly (PACE)*
- G. *Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo (CMHI-P) who are:*
  - *Found by a criminal court to be Not Guilty By Reason Of Insanity (NGRI)*
  - *Found by a criminal court to be Incompetent To Proceed (ITP)*
  - *Ordered by a criminal court to the Institute for evaluation (e.g.*

*Competency to proceed, sanity, conditional release revocation, pre-sentencing)*

- H. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.*
- I. Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Institute and who are eligible for Medicaid are exempted from the Community Mental Health Services program while they are on TPR. TPR individuals remain under the control and care of the Institute, and*
- J. Classes of individuals determined by the Department to require exclusion from the Community Mental Health Services program, currently defined as individuals residing in State Regional Centers for people with developmental disabilities and associated satellite residences for more than ninety (90) days.*
- K. Individual exemptions as defined in 10 CCR 2505-10, §8.212.2 (please see page 52 of this waiver for full definition). A client may request to be exempt from enrollment in the Community Mental Health Services program if: (1) the client has a clinical relationship with a provider of mental health services that the client wishes to maintain and that provider is not part of the provider network of the behavioral health organization in the client's geographic area; or (2) the client and the behavioral health organization have been unable to develop a healthy working relationship and continued enrollment would not be in the best clinical interest of the client.*
- L. Individuals while determined presumptively eligible for Medicaid.*
- M. Children/youth in the custody of the Department of Human Services Child Welfare Office who are placed by that agency in a Psychiatric Residential Treatment Facility (PRTF) as defined in C.R.S. 25.5-4-103.*

## F. Services

List all services to be offered under the Waiver in Appendices D2.S and D2.A of Section D, Cost Effectiveness.

### 1. Assurances.

✓ (Applies to the Community Mental Health Services Program) The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2). State plan services, as listed in Appendix D2.S of Section D, Cost Effectiveness, are:
  - Inpatient Hospital (includes psych)
  - Under 21 Psychiatric
  - 65 and Over Psychiatric
  - Outpatient Hospital (includes psych)
  - Physician Services (includes psych)
  - Rehabilitative Services
    - Individual psychotherapy
    - Individual brief psychotherapy
    - Family psychotherapy
    - Group psychotherapy
    - Mental health assessment
    - Pharmacological management
    - Outpatient day treatment
    - Emergency/crisis services
  - Clinic Services, Case Management
  - Pharmacy
  - FQHC
  - RHC
  - School-based Mental Health Services

*The State has agreed that the State Plan, the State rules, and the BHO contract will be updated to reflect changes included in this waiver renewal. The State submitted a revised State Plan Amendment (SPA) to CMS in December 2010, and will amend the BHO contract and State managed care rules to reflect these changes. At the time of this submittal, the Rehabilitation SPA was still under review at CMS.*

- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b).

- ✓ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement. (See note below for limitations on requirements that may be waived).

*(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* Family planning services are not included under the waiver.

- ✓ *(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable, for the period September 1, 2009 to June 30, 2010. The contracts were renewed for one year via Amendment #3, which CMS reviewed and approved. The current contracts are effective for the period of July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

- ✓ *(Applies to the Special Connections Substance Abuse Treatment Program)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

- (Applies to the Special Connections Substance Abuse Treatment Program)  
The ~~PAHP or PAHP~~ FFS Selective Contracting program does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
- The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
- The State will pay for all family planning services, whether provided by network or out-of-network providers.
- Other (please explain):

- (Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program) Family planning services are not included under the waiver.

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

- (Applies to the Special Connections Substance Abuse Treatment Program)  
The program is **voluntary**, ~~and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.~~

*This is a FFS waiver request and therefore “enrollment” and “disenrollment” are not applicable terms. Clients have the right to obtain FQHC services through the regular Medicaid Program.*

- (Applies to the Community Mental Health Services Program) The program is **mandatory**, ~~and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will~~

~~guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC.~~

*The PIHP shall offer subcontracts to essential community providers in their region in accordance with 25.5-8-110 (4)(b) C.R.S.*

—The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

✓ *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

*Please see the State's note below regarding changes to (b)(3) services provided to children/youth under EPSDT.*

6. **1915(b)(3) Services.**

✓ *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

*Please refer to the Cost Effectiveness Section of this waiver for expenditures specific to the (b)(3) services.*

*For the Community Mental Health Service Program*

*During the previous waiver period, the State worked with CMS to move most (b)(3) services provided to children/youth under EPSDT to an appropriate location in the State Plan and to develop an appropriate methodology for these services. Services for children/youth that remain (b)(3) services are respite and vocational rehabilitation.*

1915(b)(3) services that are provided by each PIHP are:

*Intensive Case Management* *describes community-based services averaging more than one hour per week, provided to adults with serious mental illnesses*

*(SMI) who are at risk of hospitalization, incarceration and/or homelessness due to multiple needs and impaired level of functioning. Services are designed to provide adequate supports to ensure community living. Services are assessment, care plan development, multi-system referrals, assistance with obtaining wraparound services and supportive living services, monitoring and follow-up. Intensive case management services are provided by Bachelors level or Masters level mental health professionals.*

*Assertive Community Treatment (ACT) is a service-delivery model that provides comprehensive, locally-based treatment to adults with serious mental illnesses. Services are highly individualized and are available 24 hours a day, seven days a week, 365 days a year to clients who need significant assistance and support to overcome the barriers and obstacles that confront them as a result of their mental illnesses. ACT teams provide case management, initial and ongoing mental health assessments, psychiatric services, employment and housing assistance, family support and education, and substance abuse services to individuals with co-occurring diagnoses of SA and MI. ACT multidisciplinary treatment teams may consist of the following providers: psychiatrist, Masters level licensed mental health professionals, Bachelor's level mental health professionals, and peer specialists.*

*Respite Care is temporary or short-term care of a child, youth or adult client that is provided by adults other than the birth parents, foster parents, adoptive parents, family members or caregivers that the client normally resides with, that is designed to give the parents, family members or caregivers some time away from the client, to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges. Respite care provider backgrounds range from some college to advanced degrees in mental health. All respite providers receive extensive training to serve clients with mental health issues.*

*Vocational Services are services designed to assist adults and adolescents who are ineligible for state vocational rehabilitation services and require long-term services and supports in developing skills consistent with employment and/or in obtaining employment. Services are skill and support development interventions, educational services (GED, college prep skills), vocational assessment and job coaching. Credentials of vocational providers vary from Bachelor's level staff to Masters level licensed behavioral health staff. Some vocational services are provided by peer specialists.*

*Clubhouses and drop-in center services are peer support services for people who have mental illnesses, provided in Clubhouses and drop-in centers. In Clubhouses, individuals (members) utilize their skills for clerical work, data input, meal preparation, providing resource information or reaching out to fellow members. Staff and members work side by side, in a unique partnership. In drop-in centers, individuals with mental illnesses plan and*

*conduct programs and activities in a club-like setting. There are planned activities and opportunities for individuals to interact with social groups. Clubhouse and drop-in centers are staffed by mental health consumers in recovery. Many of them are trained as peer specialists and some have degrees in mental health or other professions. Clubhouses may also be staffed by mental health clinicians, Bachelor's level or above.*

*Recovery Services are designed to provide choices and opportunities for adults with serious mental illnesses. Recovery-oriented services promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, and rights protection. They also provide social supports and a lifeline for individuals who have difficulties developing and maintaining relationships. These services can be provided at schools, churches or other community locations. Recovery services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring for children and adolescents, Bipolar Education and Skills Training (BEST) courses, NAMI courses, Wellness Recovery Action Planning (WRAP) groups, consumer and family support groups, warm lines and advocacy services. Most recovery services are provided by mental health peers or family members, whose qualifications are having a diagnosis of mental illness or being a family member of a person with mental illness. Although Colorado does not currently require that peer support specialists be licensed, the Department has developed a set of guidelines or "core competencies" for peer support specialists to promote consistent standards across the State. Occasionally, programs such as the BEST courses may be co-facilitated by Masters level licensed mental health providers, as well.*

*Prevention/Early Intervention services are proactive efforts to educate and empower individuals to choose and maintain healthy life behaviors and lifestyles that promote mental health. Prevention and early intervention efforts include services such as mental health screenings, the Nurturing Parent Program, educational programs promoting safe and stable families, senior workshops related to common aging disorders, and Love and Logic classes for healthy parenting skills. These services and programs are provided by Master's level licensed mental health providers.*

*Residential Services. Residential services are defined as twenty-four (24) hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, and are appropriate for adults and older adults whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization.*

*Residential services are a variety of clinical interventions that, individually, may appear to be similar to traditional state plan services. By virtue of being provided in a setting where the client is living, in real-time (i.e. with*

*immediate intervention possible), residential service become a unique and valuable service in its own right that cannot be duplicated in a non-structured community setting. These clinical interventions, coupled together, in real-time, in the setting where a client is living, become a tool for treating individuals in the most cost-effective manner and in the least restrictive setting.*

*Clinical interventions provided in this setting are: assessment and monitoring of mental and physical health status; assessment and monitoring of safety, including suicidal ideation and other behavioral health issues; assessment of level and quality of social interactions; assessment of/support for motivation for treatment; assessment of ability to provide for daily living needs; observation and assessment of group interactions; behavioral interventions to build effective social behaviors and coping strategies; behavioral interventions to reduce social withdrawal and inappropriate behavior or thought processes; individual therapy; group therapy; family therapy; and medication management. Residential services are provided by Bachelors and Masters level clinicians, psychologists, and psychiatrists; medical services may be provided by MDs, NPs, RNs, depending on the service location.*

*For the Special Connections Substance Abuse Treatment Program:*

*The Special Connections Substance Abuse Treatment Program provides substance use disorder treatment to women during pregnancy and 60 days postpartum. The waiver extends the benefit to include three through twelve months postpartum. The program provides risk assessments; individual, group and family counseling; case management services; and group health education. These services may be provided on an outpatient or residential basis depending upon the severity of the substance use disorder and level of need. In order to receive Special Connections services for postpartum months three through twelve, a client must have been enrolled in and receiving Special Connections services prior to giving birth.*

*Additionally, in order for a client to receive State Plan Special Connections services and Special Connections services in postpartum months three through twelve, the client must meet ASAM criteria for treatment as assessed and determined by the Special Connections providers. Services are provided on an outpatient or residential basis depending on an assessment which is done according to ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders (2<sup>nd</sup> Ed, Revised)<sup>3</sup>. These placement criteria determine the level of care into which a client is placed during the course of treatment. Service definitions for Special Connections include:*

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<sup>3</sup> Copyright 1995-2004 American Society of Addiction Medicine

1. Case Management – Medically necessary case management services provided in a licensed substance abuse treatment center by a qualified practitioner.
2. Individual Counseling – Substance use disorder counseling and treatment services with one consumer.
3. Group Counseling – Substance use disorder counseling and treatment services with more than one consumer, of up to and including two hours.
4. Family Counseling – Substance use disorder counseling and treatment services with one consumer and their family of more than 30 minutes, but no more than two hours.
5. Group Health Education – Contact with more than one consumer, of up to and including two hours, on health education of pregnancy, post partum issues, infant care and development, and parenting.
6. Outpatient – A program of care in which the consumer receives substance use disorder treatment services in an DBH licensed treatment program, but does not remain in the facility 24 hours a day.
7. Residential – A DBH licensed program that offers organized substance abuse treatment services with a planned regimen of care in a 24-hour residential setting geared toward substance use disorder and recovery services. Provides for a stable and safe living environment to develop recovery skills to attain and maintain drug and alcohol free lifestyle. Room and board are not covered.

7. **Self-referrals.**

\_\_\_The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

## Section A: Program Description

### Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

#### A. Timely Access Standards

##### 1. Assurances for MCO, PIHP, or PAHP programs.

✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

\_\_\_ The State seeks a waiver a waiver of section 1902(a)(4) of the Act, to waive compliance with of one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

*If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B Capacity Standards.*

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses to assure timely access to services.

#### **NOT APPLICABLE**

a. \_\_\_ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. \_\_\_ PCPs (please describe):
2. \_\_\_ Specialists (please describe):
3. \_\_\_ Ancillary providers (please describe):
4. \_\_\_ Dental (please describe):
5. \_\_\_ Hospitals (please describe):
6. \_\_\_ Mental Health (please describe):
7. \_\_\_ Pharmacies (please describe):
8. \_\_\_ Substance Abuse Treatment Providers (please describe):
9. \_\_\_ Other providers (please describe):

b. \_\_\_ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. \_\_\_ PCPs (please describe):
2. \_\_\_ Specialists (please describe):
3. \_\_\_ Ancillary providers (please describe):
4. \_\_\_ Dental (please describe):
5. \_\_\_ Mental Health (please describe):
6. \_\_\_ Substance Abuse Treatment Providers (please describe):
7. \_\_\_ Urgent care (please describe):
8. \_\_\_ Other providers (please describe):

c. \_\_\_ **In-Office Waiting Times:** The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. \_\_\_ PCPs (please describe):
2. \_\_\_ Specialists (please describe):

- 3. \_\_\_ Ancillary providers (please describe):
- 4. \_\_\_ Dental (please describe):
- 5. \_\_\_ Mental Health (please describe):
- 6. \_\_\_ Substance Abuse Treatment Providers (please describe):
- 7. \_\_\_ Other providers (please describe):

d. \_\_\_ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program. (*Applies to the Special Connections Substance Abuse Treatment Program*)

*DBH requires service standards for access and availability, and will apply these standards to the Special Connections clients. All pregnant women determined to have a substance use disorder must be able to access treatment within 48 hours of initial contact with the treatment program, or they must be provided interim services if such immediate admission is not possible. Any pregnant woman seeking treatment who is not able to be admitted to the program to which she seeks to be admitted must be referred to the Women's Treatment Coordinator at DBH for more immediate placement in another program.*

*DBH currently serves as the monitoring agency for the Special Connections Substance Abuse Treatment Program. The Department requires of DBH, through the IA, quarterly and annual program reporting. The standards used to assure access to services will include yearly auditing and reporting.*

## B. Capacity Standards

### 1. Assurances for MCO, PIHP, or PAHP programs.

✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011, The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

**If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.**

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

#### **NOT APPLICABLE**

- a. \_\_\_ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b. \_\_\_ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.
- c. \_\_\_ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d. \_\_\_ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State’s PCCM program and complete the following.

<b>Providers</b>	<b># Before Waiver</b>	<b># In Current Waiver</b>	<b># Expected in Renewal</b>
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1.			
2.			
3.			
4.			

\*Please note any limitations to the data in the chart above here:

e. \_\_\_ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State’s standard.

f. \_\_\_ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

<i>Area(City/County/Region)</i>	<i>PCCM-to-Enrollee Ratio</i>
<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

g. \_\_\_\_ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

*(Applies to the Special Connections Substance Abuse Treatment Program)*

*Providers having the ability to provide specialized quality services for this specific population have been developed across the State. The current network of Special Connections providers has the capacity to serve the current caseload of Special Connections clients (330 outpatient slots; 52 residential slots). Rates have been evaluated to ensure comparability with other services being offered and to encourage this specialized group of providers to serve this unique population. The Special Connections extension is not expected to increase enrollment significantly at this time.*

## C. Coordination and Continuity of Care Standards

### 1. Assurances For MCO, PIHP, or PAHP programs.

✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

### 2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ✓ *(Applies to the Community Mental Health Services Program)* The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

*The scope of this contract is limited to mental health services; primary care is not included. The Department requires the PIHPs to coordinate with primary care providers and to develop and maintain a treatment plan for all enrollees receiving services, as all enrollees have a special health care need.*

*Based on the Department's definition of Persons with Special Health Care Needs, the scope of the PIHPs' services and the organization of the managed care delivery system, the Department decided not to require PIHPs to meet the primary care requirements nor implement an additional*

*mechanism for identifying, assessing and developing a treatment plan for Persons with Special Health Care Needs.*

- b. \_\_\_ **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.
  - c. \_\_\_ **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.
  - d. \_\_\_ **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
    - 1. \_\_\_ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
    - 2. \_\_\_ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
    - 3. \_\_\_ In accord with any applicable State quality assurance and utilization review standards.
  - e. \_\_\_ **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.
3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

***NOT APPLICABLE***

- a. \_\_\_ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. \_\_\_ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

- c. \_\_\_ Each enrollee is receives **health education/promotion** information. Please explain.
  - d. \_\_\_ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
  - e. \_\_\_ There is appropriate and confidential **exchange of information** among providers.
  - f. \_\_\_ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
  - g. \_\_\_ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
  - h. \_\_\_ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
  - i. \_\_\_ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.
4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

*(Applies to the Special Connections Substance Abuse Treatment Program)*

*Continuity and coordination of care are required components of the Special Connections Substance Abuse Treatment Program. Providers under Special Connections offering services to pregnant and postpartum women must make arrangements for prenatal care and monitor that pregnant women are receiving regular care. Developmental assessments for children already in the client's care must be made available, as well as parenting classes.*

*In order to eliminate the most common barriers experienced by women to participating in substance use disorder treatment, programs provide linkages to child care during the time the woman is in treatment, as well as transportation to and from treatment, access to mental health services for those experiencing co-occurring disorders, domestic violence treatment and family and couples treatment.*

*The Department requires of DBH, through the IA, quarterly and annual program reporting. The Department will provide oversight to and in conjunction with DBH to assure continuity and coordination of care are occurring. The standards used to assure continuity and coordination of care will include yearly auditing and reporting.*

## Section A: Program Description

### Part III: Quality

#### 1. Assurances for MCO or PIHP programs.

- ✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- \_\_\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for its PIHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.
- ✓ *(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.
- ✓ *(Applies to the Community Mental Health Services Program)* Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that the 2007 Quality Strategy was submitted to the CMS Regional Office on September 3, 2009.
- Please refer to Appendix A.III for the 2007 Quality Strategy.*
- ✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	<i>Health Services Advisory Group</i>	✓	✓	

2. **Assurances For PAHP program.**

***NOT APPLICABLE***

\_\_\_ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for its PAHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

\_\_\_ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, and these contracts are effective for the period \_\_\_ to \_\_\_.

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

***NOT APPLICABLE***

a. \_\_\_ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. \_\_\_ **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. \_\_\_ Provide education and informal mailings to beneficiaries and PCCMs;

2. \_\_\_ Initiate telephone and/or mail inquiries and follow-up;

3. \_\_\_ Request PCCM's response to identified problems;

4. \_\_\_ Refer to program staff for further investigation;
5. \_\_\_ Send warning letters to PCCMs;
6. \_\_\_ Refer to State's medical staff for investigation;
7. \_\_\_ Institute corrective action plans and follow-up;
8. \_\_\_ Change an enrollee's PCCM;
9. \_\_\_ Institute a restriction on the types of enrollees;
10. \_\_\_ Further limit the number of assignments;
11. \_\_\_ Ban new assignments;
12. \_\_\_ Transfer some or all assignments to different PCCMs;
13. \_\_\_ Suspend or terminate PCCM agreement;
14. \_\_\_ Suspend or terminate as Medicaid providers; and
15. \_\_\_ Other (explain):

- c. \_\_\_ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. \_\_\_ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. \_\_\_ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. \_\_\_ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

- A.  Initial credentialing
- B.  Performance measures, including those obtained through the following (check all that apply):

- The utilization management system.
- The complaint and appeals system.
- Enrollee surveys.
- Other (Please describe).

- 4.  Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
- 5.  Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
- 6.  Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
- 7.  Other (please describe).

d.  **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

*(Applies to the Special Connections Substance Abuse Treatment Program)*

*Providers for the Special Connections Substance Abuse Treatment Program are selected on their ability to provide quality and innovative outpatient and residential programs to meet the needs of pregnant and postpartum women with substance use disorders.*

*Providers for the Special Connections Substance Abuse Treatment Program meet quality of care standards that are set and monitored by DBH. DBH sets provider licensure criteria and audits each program service provider on a yearly basis. They evaluate the outcomes of the services and appropriate level of care being provided. They audit randomized cases for reduction of symptoms, recovery and improved quality of life. Cases are also reviewed for accurate assessment and identification of the problem(s).*

*The Department requires of DBH, through the IA, quarterly and annual program reporting. The Department will provide oversight to and in conjunction with DBH to assure service quality is occurring in the Special Connections Substance Abuse Treatment Program. The standards used to assure continuity and coordination of care will include yearly auditing and reporting.*

## Section A: Program Description

### Part IV: Program Operations

#### A. Marketing

**Marketing** includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

##### 1. Assurances

✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

\_\_\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

✓ *(Applies to the Special Connections Substance Abuse Treatment Program)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

##### 2. Details

###### a. **Scope of Marketing**

1. \_\_\_\_\_ The State does not permit direct or indirect MCO/PIHP/PAHP or PCCM marketing.
2. ✓ *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* The State permits indirect MCO/PIHP/PAHP or PCCM marketing (e.g., radio and

TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

*For the Community Mental Health Services Program:*

*The PIHP must obtain prior approval from the Department for all proposed marketing materials. Since all beneficiaries within the PIHP region are automatically enrolled, there has not been a need to develop any marketing materials.*

*For the Special Connections Substance Abuse Treatment Program:*

*Brochures, presentations, trainings presented by DBH.*

3. \_\_\_ The State permits direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

**b. Description.** Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. \_\_\_ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.
2. \_\_\_ The State permits MCOs/PIHPs/PAHPs and PCCMs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3.  *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* The State requires MCO/PIHP/PAHP and PCCM to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

*Spanish*

The State has chosen these languages because (check any that apply):

- i.  *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* The languages comprise all prevalent languages in the MCO/PIHP/PAHP/PCCM service area. Please describe the methodology for determining prevalent languages.

*The Department uses the most recent data from the American Community Data Survey to determine the prevalent non-English languages spoken throughout the state. A percentage is then calculated for the identified non-English languages. The most recent data available is from 2007.*

- ii. \_\_\_ The languages comprise all languages in the MCO/PIHP/PAHP/PCCM service area spoken by approximately \_\_\_ percent or more of the population.
- iii. \_\_\_ Other (please explain):

## B. Information to Potential Enrollees and Enrollees

### 1. Assurances.

- (Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- \_\_\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for PIHPs and PAHPs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.
- (Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.
- (Applies to the Special Connections Substance Abuse Treatment Program)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

### 2. Details.

#### a. **Non-English Languages**

- (Applies to the Community Mental Health Services Program)* Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

*Spanish*

The State defines prevalent non-English languages as:  
(check any that apply):

1.  *(Applies to the Community Mental Health Services Program)* The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

*The Department uses the most recent data from the American Community Data Survey to determine the prevalent non-English languages spoken throughout the state. A percentage is then calculated for the identified non-English languages. The most recent data available is from 2007.*

- 2. \_\_\_ The languages spoken by approximately \_\_\_ percent or more of the potential enrollee/ enrollee population.
- 3. \_\_\_ Other (please explain):

✓ (Applies to the Community Mental Health Services Program) Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

*Each PIHP is responsible for providing oral translation services to all enrollees as needed. The PIHP must inform enrollees of the availability of and instructions on how to access oral translation.*

✓ (Applies to the Community Mental Health Services Program) The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

*The PIHPs are contractually responsible for having a mechanism in place to help enrollees understand the requirements and benefits of the plan. This information may be provided in the enrollee handbook. The enrollee may also receive this information by contacting the PIHP Office of Member and Family Affairs (formerly the Office of Consumer and Family Affairs).*

**b. Potential Enrollee Information**

Information is distributed to potential enrollees by:

- \_\_\_ State
- \_\_\_ contractor (please specify) \_\_\_\_\_

✓ (Applies to the Community Mental Health Services Program) There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

**c. Enrollee Information**

The State has designated the following as responsible for providing required information to enrollees:

- (i) \_\_\_ the State
- (ii) \_\_\_ State contractor (please specify): \_\_\_\_\_

(ii) ✓ (*Applies to the Community Mental Health Services Program*) the  
~~MCO/PIHP/PAHP/PCCM~~

## C. Enrollment and Disenrollment

### 1. Assurances.

*(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

*(Applies to the Community Mental Health Services Program)* The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

*42 CFR 438.56 (b) – The PIHP cannot request disenrollment of an enrollee for any reason.*

*42 CFR 438.56 (B) – The enrollee cannot disenroll from the PIHP unless an individual exemption is made. Individual exemptions are made on a case-by-case basis.*

*(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56. Disenrollment requirements and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011, The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

*(Applies to the Special Connections Substance Abuse Treatment Program)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.** Please describe the State's enrollment process for MCOs/PIHPs/PAHP and PCCMs by checking the applicable items below.

a.  **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

**b. Administration of Enrollment Process.**

- State staff conducts the enrollment process.
- The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.
  - The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: \_\_\_\_\_

Please list the functions that the contractor will perform:

- choice counseling
- enrollment
- other (please describe):

- State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

**c. Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

- This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):
- This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):
- If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.
  - i.  Potential enrollees will have \_\_\_\_\_ days/month(s) to choose a plan.
  - ii.  Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.
- (*Applies to the Community Mental Health Services Program*) The State **automatically enrolls** beneficiaries

\_\_\_ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

✓ (Applies to the Community Mental Health Services Program) on a mandatory basis into a single PIHP ~~or PAHP~~ for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

*Once determined eligible for Medicaid, a beneficiary is automatically enrolled with the PIHP based on the beneficiary's county of residence. Foster care beneficiaries are enrolled in the PIHP based on the county that manages the care.*

\_\_\_ on a voluntary basis into a single MCO, PIHP, or PAHP, and beneficiaries can opt out at any time. Please specify geographic areas where this occurs: \_\_\_\_\_

\_\_\_ The State provides **guaranteed eligibility** of \_\_\_ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

✓ (Applies to the Community Mental Health Services Program) The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an ~~MCO/PIHP/PAHP/PCCM~~. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

*Individual exemptions are addressed in Department regulations found in 10 CCR 2505-10 8.212.2, presented below:*

### **8.212.2 INDIVIDUAL EXEMPTIONS**

1. *A client may request to be exempt from enrollment in the Community Mental Health Services program if:*
  - a. *The client has a clinical relationship with a provider of mental health services that the client wishes to maintain and that provider is not part of the provider network of the behavioral health organization in the client's geographic area; or*
  - b. *The client and the behavioral health organization have been unable to develop a healthy working relationship and continued enrollment would not be in the best clinical interest of the client.*
2. *If the client requests an exemption based on Section 8.212.2.1.a:*
  - a. *The client shall notify the behavioral health organization of his/her request to receive necessary mental health services from the provider with whom the client has established a clinical relationship.*
  - b. *Within fourteen (14) calendar days of receiving notice from the client, the behavioral health organization shall determine*

- whether it can contract with the client's chosen provider to provide necessary mental health services to the client and provide written notice to the client and the client's provider of that determination.*
- c. If the behavioral health organization is unable to approve the client's request, the notice shall:
    - i. Identify one or more providers within the behavioral health organization's network who can appropriately meet the client's mental health needs;*
    - ii. Include information on the client's right to request an exemption, the process for requesting an exemption and assistance available to the client.**
  - d. The client may request an exemption with the Department within fourteen (14) calendar days of the date of the notice from the behavioral health organization disapproving the client's request.*
  - e. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.*
- 3. If the client requests an exemption based on Section 8.212.2.1.b:
    - a. The client shall request an exemption from the Department.*
    - b. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.**
  - 4. A client whose request for exemption has been denied by the Department has the right to appeal the determination pursuant to Section 8.057.*
  - 5. A newly Medicaid eligible client who requests an exemption shall be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.*
  - 6. A client who is enrolled in the Community Mental Health Services program and is requesting an exemption shall continue to be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.*
  - 7. A client who wants to reenroll in the Community Mental Health Services program shall notify the Department. The client will be reenrolled within thirty (30) calendar days of receipt of the client's request. The Department shall notify the client and the behavioral*

*health organization of the reenrollment prior to the effective date of reenrollment.*

- ✓ (Applies to the Community Mental Health Services Program) The State **automatically re-enrolls** a beneficiary with the same ~~PCCM or MCO/PIHP/PAHP~~ if there is a loss of Medicaid eligibility of 2 months or less.

**d. Disenrollment:**

- \_\_\_ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
  - i. \_\_\_ Enrollee submits request to State.
  - ii. \_\_\_ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
  - iii. \_\_\_ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

- ✓ (Applies to the Community Mental Health Services Program) The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

*Enrollees may request an exemption from the program as described in Section(c), Enrollment, above.*

*When enrollees move from one region to another, they are automatically enrolled with the PIHP in that region following official notification of address change.*

- \_\_\_ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of \_\_\_ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

- \_\_\_ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without

cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

\_\_\_ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

- i. \_\_\_ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
- ii. \_\_\_ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. \_\_\_ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- iv. \_\_\_ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

## **D. Enrollee rights.**

### **1. Assurances.**

✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

\_\_\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections, and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

✓ *(Applies to the Special Connections Substance Abuse Treatment Program)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

✓ *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

## E. Grievance System

1. **Assurances for All Programs.** States, MCOs, PIHPs, PAHPs, and States in PCCM programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

✓ *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

✓ Please describe any special processes that the State has for persons with special needs.

*(Applies to the Community Mental Health Services Program)*

*The Department currently contracts with Maximus, Inc. to operate an Ombudsman program that is available to all managed care enrollees with medical or mental health issues pursuant to 25.5-5-406 III.(b) C.R.S.:*

“The state department shall establish the position of ombudsman for Medicaid managed care. It is the intent of the general assembly that the ombudsman for Medicaid managed care be independent from the state department and selected through a competitive bidding process. In the event the state department is unable to contract with an independent ombudsman, an employee of the state department may serve as the ombudsman for Medicaid managed care. The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the MCO. The process for expedited reviews shall provide a means by which an enrollee may complain and seek resolution concerning any action or failure to act in an emergency situation that immediately impacts the enrollee's access to quality health care services, treatments, or providers. An enrollee shall be entitled to designate a representative, including but not limited to an attorney, the ombudsman for Medicaid managed care, a lay advocate, or the enrollee's physician, to file and pursue a grievance or expedited review on behalf of the enrollee.”

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to

challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

*(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHPs. Please identify each regulatory requirement waived and the State's alternative requirement.

*(Applies to the Community Mental Health Services Program)* The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, and these contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011. The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

### 3. **Details for MCO or PIHP programs.**

#### a. **Direct access to fair hearing.**

The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

*(Applies to the Community Mental Health Services Program)* The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

#### b. **Timeframes**

*(Applies to the Community Mental Health Services Program)* The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 30 days. (This timeframe was changed to 30 days in 2010 to align with the appeal timeframe for Fee for Service Medicaid.)

*(Applies to the Community Mental Health Services Program)* The State's timeframe within which an enrollee must file a **grievance** is 20 days (may not exceed 90).

4. **Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in

instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

***NOT APPLICABLE***

\_\_\_ The State has a grievance procedure for its \_\_\_ PCCM and/or \_\_\_ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

- \_\_\_ The grievance procedure is operated by:
  - \_\_\_ the State
  - \_\_\_ the State's contractor. Please identify: \_\_\_\_\_
  - \_\_\_ the PCCM
  - \_\_\_ the PAHP.

\_\_\_ Please provide definitions the State employs for the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

\_\_\_ Has a grievance committee or staff who review and resolve grievances. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

\_\_\_ Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

\_\_\_ Specifies a time frame from the date of action for the enrollee to file a grievance, which is: \_\_\_\_\_

\_\_\_ Has time frames for staff to resolve grievances for PCCM/PAHP grievances. Specify the time period set: \_\_\_\_\_

\_\_\_ Establishes and maintains an expedited grievance review process for the following reasons:\_\_\_\_\_. Specify the time frame set by the State for this process\_\_\_\_\_

\_\_\_ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the grievance.

\_\_\_ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

\_\_\_ Other (please explain):

## F. Program Integrity

### 1. Assurances.

✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
- (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

✓ *(Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program)* The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
- 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
- 3) Employs or contracts directly or indirectly with an individual or entity that is
  - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
  - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

### 2. Assurances For MCO or PIHP programs

✓ *(Applies to the Community Mental Health Services Program)* The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

✓ (Applies to the Community Mental Health Services Program) State payments to a PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

\_\_\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for MCOs or PIHPs. Please identify each regulatory requirement waive and the State's alternative requirement.

✓ (Applies to the Community Mental Health Services Program) The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content, Timing of Certification; and 438.608 Program Integrity Requirements. These contracts are effective for the period September 1, 2009 to June 30, 2010. The current contracts were renewed for one year via Amendment #3 and are effective from July 1, 2010 through June 30, 2011, The Department expects to renew the contract for an additional year via an amendment that becomes effective July 1, 2011.

## Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP Capacity, Specialty Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality Assessment and Performance Improvement, PCCM Quality)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring strategy may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the strategies used to monitor the major areas of the waiver. The second is a detailed description of each strategy.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring strategies are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring strategies they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring strategies in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring strategies to use.

1915(b)(4) FFS Selective Contracting Programs: (*Applies to the Special Connections Substance Abuse Treatment Program*) The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

*Answers to these questions have been addressed under Part II: Access. Section A. 3.*

## **PART I. Summary chart**

States should use the chart on the next page to summarize the strategies used to monitor major areas of the waiver program. If this waiver authorizes multiple programs, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

For the Community Mental Health Services Program:

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Accreditation for Deeming												
Accreditation for Participation												
Consumer Self-Report data						✓	✓					✓
Data Analysis (non-claims)				✓		✓	✓	✓				
Enrollee Hotlines												
Focused Studies												
Geographic mapping												
Independent Assessment							✓					✓
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by Plan							✓	✓			✓	
Ombudsman						✓						

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
On-Site Review		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance Improvement Projects							✓	✓	✓			✓
Performance Measures							✓			✓		✓
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review					✓							
Other:												

*For the Special Connections Substance Abuse Treatment Program – DBH is responsible for these monitoring activities:*

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data												
Data Analysis (non-claims)												
Enrollee Hotlines												
Focused Studies												
Geographic mapping												
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by Plan	✓											
Ombudsman												

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
On-Site Review				✓				✓			✓	
Performance Improvement Projects												
Performance Measures												
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data		✓			✓			✓				
Test 24/7 PCP Availability												
Utilization Review			✓					✓				
Other: (describe)												

## PART II. Monitoring Strategies

Please check each of the monitoring strategies or functions below used by the state. A number of common strategies are listed below, but the state should identify any others it uses. If federal regulations require a given strategy, this is indicated just after the name of the strategy. If the state does not use a required strategy, it must explain why.

For each strategy, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of strategy
- Frequency of use
- How it yields information about the area(s) being monitored

a.  Accreditation for Deeming (i.e. the State deems compliance with certain access, structure/operation, or quality requirements for entities that are accredited)

- NCQA
- JCAHO
- AAAHC
- Other (please describe)

b.  Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

- NCQA
- JCAHO
- AAAHC
- Other (please describe)

c.  (*Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program*) Consumer Self-Report data

- CAHPS (please identify which one(s))
- (*Applies to the Special Connections Substance Abuse Treatment Program and the Community Mental Health Services Program*) State-developed survey – Client Satisfaction Survey

*For the Special Connections Substance Abuse Treatment Program:*

*DBH typically conducts a client satisfaction survey annually. The client satisfaction survey assures that all participants are given an opportunity to give feedback on their treatment experience. These surveys are reviewed for tracking and trending of potential areas of concern and are incorporated into quality assurance reporting, monitoring and measurement. Consumers' characteristics are evaluated for tracking and trending to assure access,*

availability and outreach are being done to appropriate populations to receive needed services. Due to staff and funding shortages, DBH has not conducted this survey for the past two years. DBH is committed to resuming the annual survey immediately upon receiving legislative spending authority.

For the Community Mental Health Services Program:

*NOTE: The Department uses client satisfaction surveys; however, these surveys are not State-developed. These surveys are adaptations of nationally used surveys.*

*Each PIHP must participate in a Department approved annual enrollee satisfaction survey administered according to survey guidelines. The PIHP is to incorporate the results of the survey into its overall quality plan. The current consumer satisfaction surveys being used are the Mental Health Statistics Improvement Program (MHSIP) and the Youth Services Survey for Families (YSSF).*

- Disenrollment survey
- (Applies to the Community Mental Health Services Program)
- Consumer/beneficiary focus groups

For the Community Mental Health Services Program:

*For FY 2008 and 2009, the Department obtained stakeholder input via surveys distributed to the Medicaid Mental Health Advisory Committee (MHAC) and the Medicaid Mental Health Planning and Advisory Council (MHPAC) to narrow focus on which standards to review for the compliance site audit required by CMS.*

- d.  (Applies to the Community Mental Health Services Program) Data Analysis (non-claims)

- Denials of referral requests
- Disenrollment requests by enrollee
  - From plan
  - From PCP within plan
- Grievances and appeals data
- PCP termination rates and reasons
- Other (please describe)

*The Department receives quarterly reports on access to care, which provide information on the total number of Medicaid mental health members served by the PIHP and reflect timely access to emergent, urgent and routine care throughout the fiscal year. The Department receives a separate quarterly report on telephone access that includes statistics on call response, call wait time, and rate of call abandonment. If the Department identifies any areas of*

*concern in its review, the PIHP is required to correct these issues. These reports are utilized with other strategies including on-site reviews, enrollee satisfaction surveys, performance measures and performance improvement projects to give a full picture of the PIHP's performance.*

- e. \_\_\_\_\_ Enrollee Hotlines operated by State
- f.  \_\_\_\_\_ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

*Effective July 1, 2009, BHOs have the option of performing a focused study as part of their quality efforts.*

- g. \_\_\_\_\_ Geographic mapping of provider network
- h.  \_\_\_\_\_ (Applies to the Community Mental Health Services Program) Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

*The Department contracts with an external quality review organization (EQRO) to conduct PIHP compliance site reviews, to evaluate performance improvement projects and to validate performance measures. The EQRO assesses of all these activities as related to access, quality and timeliness and summarizes results in an annual technical report.*

- i.  \_\_\_\_\_ Measurement of any disparities by racial or ethnic groups.

*Effective 2008, BHOs measure penetration rate by race and have initiated an internal health disparities group to attempt to measure outcomes for groups at risk.*

- j.  \_\_\_\_\_ (Applies to the Community Mental Health Services Program) Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

*The contract states that the PIHP "shall submit the required documentation as specified by the Department, but no less frequently than the following:*

- *At the time it enters into a Contract with the Department.*
- *At any time there has been a significant change (as defined by the Department) in the Contractor's operations that would affect adequate capacity and services, including:*
  - *Changes in Contractor services, benefits, geographic service area or payments; or*
  - *Enrollment of a new population in the program operated by the Contractor.*

*The Department requires the PIHPs to submit Access to Service reports on a quarterly basis. These reports address the following contract standards for service timeliness:*

- *Emergency services shall be available by phone within fifteen (15) minutes of the initial contact, in-person within one (1) hour of contact in urban and suburban areas, in-person within two (2) hours of contact in rural and frontier areas,*
- *Urgent care shall be available within twenty-four (24) hours; and*
- *Routine services shall be available within seven (7) calendar days.*

*PIHPs also submit quarterly network adequacy reports. The Department uses this information, along with other quality measures, to fully assess the contractor's network adequacy. Questions or concerns are addressed with the PIHP to the Department's satisfaction. PIHPs also integrate network adequacy information into their overall quality improvement plans, which are reported to the Department annually.*

k. ✓ \_\_\_\_\_ (Applies to the Community Mental Health Services Program) Ombudsman

*The Department operates an Ombudsman for Medicaid Managed Care program pursuant to Colorado Statutes 25.5-5-406(1)(b), C.R.S. (2006). The program is utilized to inform and educate Medicaid enrollees about their existing rights and benefits. The Department monitors trends in PIHP issues and outcomes through quarterly and annual reports. This data is reviewed at least semi-annually in conjunction with other information obtained through annual site reviews, PIHP quarterly reports and consumer surveys.*

l. ✓ \_\_\_\_\_ (Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program) On-site review

*For the Community Mental Health Services Program:*

*The Department has contracted with an EQRO to conduct annual on-site reviews. The site review monitoring process is consistent with the CMS compliance monitoring protocol. The scope of the review includes state and federal regulations and contractual standards. The PIHPs must develop Department-approved corrective action plans for all areas of non-compliance. Corrective actions are monitored until the PIHP is in compliance. The annual technical report for each BHO will be submitted to CMS under separate cover.*

*For the Special Connections Substance Abuse Treatment Program:*

*On-site reviews are done annually by DBH to assure facilities and agencies are meeting physical plant and administrative and clinical quality assurance standards.*

m. ✓ \_\_\_\_\_ (Applies to the Community Mental Health Services Program) Performance Improvement projects [**Required** for MCO/PIHP]

- ✓ Clinical
- ✓ Non-clinical

*PIHPs are responsible for having two performance improvement projects (PIPs), or one PIP and one Focused Study in progress at any given time. The PIPs are validated annually by the Department's EQRO pursuant to 42 C.F.R. Section 438 Subpart E. PIPs that cannot be validated must be revised so that validation can occur.*

n. ✓ (Applies to the Community Mental Health Services Program and the Special Connections Substance Abuse Treatment Program) Performance measures

**[Required for MCO/PIHP]**

- Process
- Health status/outcomes
- Access/availability of care
- Use of services/utilization
- Health plan stability/financial/cost of care
- Health plan/provider characteristics
- Beneficiary characteristics

*For the Community Mental Health Services Program:*

*The Department's EQRO validates performance measures annually pursuant to 42 C.F.R. Section 438, Subpart E. The performance measures are part of the PIHPs' overall quality plans and annual reports.*

*The following BHO performance measures were validated in FY 08/09:*

1. *Follow-up After Hospitalization for Mental Illness, 7- and 30-day follow-up)*
2. *Emergency Department Utilization*
3. *Hospital Recidivism*
4. *Overall Penetration Rates*
5. *Inpatient Utilization*
6. *Hospital Average Length of Stay*
7. *Penetration Rates by Service Category*
8. *Penetration Rates by Age Category*

*The following BHO performance measures were validated in FY 09/10:*

1. *Follow-up After Hospitalization for Mental Illness, 7- and 30-day follow-up)*
2. *Emergency Department Utilization*
3. *Hospital Recidivism*
4. *Overall Penetration Rates*
5. *Inpatient Utilization*
6. *Hospital Average Length of Stay*
7. *Penetration Rates by Service Category*
8. *Penetration Rates by Age Category*

9. *Penetration Rates by Medicaid Eligibility Category*
10. *Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer **perceptions of access***
11. *Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of **quality/appropriateness***
12. *Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of **outcome/positive change***
13. *Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of **general satisfaction***
14. *Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of **treatment planning***
15. *Percentage of Medicaid adults surveyed who reported seeing a doctor or nurse face-to-face for health check up or illness*
16. *Percentage of parents surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer **perceptions of access***
17. *Percentage of parents surveyed on behalf of Medicaid children who agreed with the domain score measuring **participation in treatment planning***
18. *Percentage of parents surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer **perceptions of cultural sensitivity***
19. *Percentage of parents surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer perceptions of **quality/appropriateness***
20. *Percentage of parents surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer perceptions of **outcome/positive change***
21. *Percentage of parents surveyed on behalf of Medicaid children who reported the child seeing a doctor or nurse for health check up or illness*

*The performance measures listed under item (n) above are monitored. Performance measures are calculated annually by the Department and the PIHPs to yield information about how care is being delivered and the outcome of interventions being performed.*

*For the Special Connections Substance Abuse Treatment Program:*

*The performance measures listed under item (n) above are monitored. Performance measures are done annually by DBH to yield information about how care is being delivered and the outcome of intervention being performed. Access to services will be monitored to assure those consumers desiring help will receive it in a timely manner.*

*Clinical and fiscal oversight is performed to assure the appropriate level of care is being given meeting ASAM clinical criteria for the designated level of care being given. Audits focus on matching paid claim data with appropriate clinical charting and administrative billing.*

*Providers of care are evaluated to assure appropriate credentialing/ licensure is in place, such as the CAC (Certified Addictions Counselor) credential. The CAC is designated at three levels of clinical practice: Levels I, II and III and is under the oversight of the Department of Regulatory Agencies (DORA) for the State of Colorado.*

- o. \_\_\_\_\_ Periodic comparison of number and types of Medicaid providers before and after waiver
- p. \_\_\_\_\_ Profile utilization by provider caseload (looking for outliers)
- q.  \_\_\_\_\_ (*Applies to the Special Connections Substance Abuse Treatment Program*) Provider Self-report data
  - \_\_\_\_\_ Survey of providers
  - \_\_\_\_\_ Focus groups
- r. \_\_\_\_\_ Test 24 hours/7 days a week PCP availability
- s. \_\_\_\_\_ Utilization review (e.g. ER, non-authorized specialist requests)
- t. \_\_\_\_\_ Other: (please describe)

## Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

- This is an initial waiver request. The State assures that it will conduct the monitoring strategies described in Section B, and will provide the results in Section C of its waiver renewal request.
- This is a renewal request. The State provides below the results of monitoring strategies conducted during the previous waiver.

For each of the strategies checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each strategy. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each strategy identified in Section B:

Strategy:

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

The following results apply to the Special Connections Substance Abuse Treatment Program:

**Strategy: Network Adequacy Assurance by Plan**

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:**

*DBH monitors network adequacy in terms of client choice. Thirteen site locations had their contracts renewed in the last waiver period. Three of the providers from previous years did not submit applications to be Special Connections providers. Two programs did not apply because they had lost their rendering physician providers, and one site did not apply because it no longer wanted to be a Special Connections site. The program cited problems with billing and low reimbursement rates which they felt made it too difficult to participate in the program. The Special Connections provider network offers clients adequate provider choice. Special Connections services are provided at 12 locations by 9 different provider agencies. Choice in providers is limited only by geography, and clients transition to different providers when their treatment needs change, or when they must relocate for other reasons.*

**Problems identified:**

*Provider agencies continue to report difficulties in finding supervising providers due to the providers' lack of time to work closely enough with the programs they would supervise.*

**Corrective action (plan/provider level):**

*No corrective actions were imposed at the provider level.*

**Program change (system-wide level):**

*No programmatic changes have been made at the systems level.*

**Strategy: On-Site Review**

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:**

*Provider agencies were reviewed as to program integrity (review of case files and billings), coordination/continuity of care (audits of types and appropriateness of services provided) and quality of care (assuring continuity between assessments, treatment plans, services provided and identified gaps in services).*

**Problems identified:**

*No patterns of problems on a system-wide basis were noted.*

**Corrective action (plan/provider level):**

*No corrective action plan was imposed at the provider level.*

**Program change (system-wide level):**

*No programmatic changes have been made at the systems level.*

**Strategy: Provider Self-Report Data**

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:**

*Providers reported their marketing strategies (outreach presentations at clinics, probation departments, departments of human/social services, flyers made available at each of these locations). They provided information to their beneficiaries about the effects of drugs and alcohol on a developing fetus, as well as ways to prevent communicable diseases such as HIV and hepatitis. Information on coordination and continuity of care is entered into the Drug and Alcohol Coordinated Data System (DACODS) by the providers and can be accessed by DBH to determine the level to which care is coordinated and continuous.*

**Problems identified:**

*No problems were identified.*

**Corrective action (plan/provider level):**

*No corrective actions were imposed at the provider level.*

**Program change (system-wide level):**

*No programmatic or system-wide changes have been made at the systems level.*

**Strategy: Utilization Review**

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:**

*Providers are adhering to program guidelines with respect to services provided, length of treatment, and appropriate levels of care. Chart reviews were conducted periodically to monitor utilization. Enrollment and disenrollment of clients was monitored as well as continuity of care. Services are being provided appropriately. Generally, clients are being appropriately*

*disenrolled at the end of their waiver period (one year postpartum). Provider education regarding timely disenrollment is offered on a quarterly basis.*

***Problems identified:***

*No problems were identified.*

***Corrective action (plan/provider level):***

*No corrective action was imposed at the provider level.*

***Program change (system-wide level):***

*No programmatic changes were made at the systems level.*

***Strategy: Other – Tracking of Client Grievances/Complaints Regarding Services or Programs***

***Confirmation it was conducted as described:***

Yes

No. Please explain:

***Summary of results:***

*No grievances or complaints were received during the period since the approval of the last waiver.*

***Problems identified:***

*No problems were identified.*

***Corrective action (plan/provider level):***

*No corrective action was imposed at the provider level.*

***Program change (system-wide level):***

*No programmatic changes were made at the systems level.*

*The following monitoring results apply to the Community Mental Health Services Program:*

***Strategy: Consumer Self-Report Data***

***Confirmation it was conducted as described:***

Yes

No. Please explain:

***Summary of results:***

*For FY08-09, 90% of clients who submitted grievances agreed with the BHO's decision. For FY09-10, 86% of clients who submitted grievances agreed with the BHO's decision. The majority of grievances involve concerns about clinical care and customer service, followed by*

*access and availability. Grievances involving financial/billing, rights/legal and benefits packages account for approximately 12-13% of the totals. Less than 1.5% of grievance resolutions were escalated to the Department for review.*

***Problems identified:***

*No problems were identified. (Note that the Department reviews grievance and appeals reports at the end of each quarter, and follows up with each PIHP about areas of concern.)*

***Corrective action (plan/provider level):***

*No corrective actions were implemented.*

***Program change (system-wide level):***

*No programmatic changes were made at the systems level.*

*The Department also collects and reviews data on the timeliness of emergent, urgent and routine services on a quarterly basis. For both fiscal years, compliance with Department standards consistently ranges from 97 to 100%, with average scores in the 98-99% range.*

***Problems identified:***

*No problems were identified. (Note that the Department reviews access to care reports at the end of each quarter, and follows up with each PIHP about areas of concern.)*

***Corrective action (plan/provider level):***

*No corrective actions were implemented.*

***Program change (system-wide level):***

*For FY 09/10, the Department worked with PIHPs to create a new reporting template to standardize and streamline reporting. This format allows the Department to note running totals and running averages for a two year period.*

*The Mental Health Statistics Improvement Program (MHSIP) survey and the Youth Services Survey for Families (YSSF) are used to assess the level of satisfaction enrollees have with the PIHPs, Quality of Care, and Timeliness of Access. The Department provides results of these surveys to all PIHPs for use in their quality programs.*

*Please see the below results of the most recent MHSIP and YSSF surveys processed for FY08/09 and FY 09/10.*

*Results from a MHSIP survey administered from August 15, 2008 to February 2, 2009 indicate the following average satisfaction rates across all five BHOs:*

- *Access – 71.9%*
- *Perception of Appropriateness and Quality – 69.3%*
- *Perception of Outcomes – 61.9%*
- *Perception of Participation – 65.7%*
- *Perception of Satisfaction – 74.9%*

- *Doctor Contact Outside of Emergency Room – 83.7%*

*Results from a MHSIP survey administered in September 2010 indicate the following average satisfaction rates across all five BHOs:*

- *Access – 84.9%*
- *Perception of Appropriateness and Quality – 89.6%*
- *Perception of Outcomes – 66.8%*
- *Perception of Participation – 79.2%*
- *Perception of Satisfaction – 91.2%*
- *Doctor Contact Outside of Emergency Room – 66.8%*

*Results from a YSS-F survey administered from August 15, 2008 to February 2, 2009 indicate the following average satisfaction rates across all five BHOs:*

- *Access – 64.4%*
- *Perception of Appropriateness – 66.3%*
- *Perception of Outcomes – 52.5%*
- *Perception of Participation in Treatment – 75.4%*
- *Perception of Cultural Sensitivity – 85.1%*
- *Doctor Contact – 79.8%*

*Results from a YSS-F survey administered in September 2010 indicate the following average satisfaction rates across all five BHOs:*

- *Perception of Access – 81.4%*
- *Perception of Appropriateness – 85.4%*
- *Perception of Outcomes – 62.5%*
- *Perception of Participation in Treatment – 91.8%*
- *Perception of Cultural Sensitivity – 96.6%*
- *Doctor Contact – 76.5%*

### ***Identify Problems***

*Note that results for the April 2009 calculation are based on the old methodology, and the methodology for the new survey process changed slightly from the implementation year to the preceding year. When methodology changes occur, caution is used when comparing results. As the above survey results note, rates have improved for the majority of domains. The Outcomes Domains continues to rate lower, as in previous years. The primary care doctor contact domain rated lower for the new survey.*

### ***Describe Plan/Corrective Actions***

*None*

### ***Describe System-level program changes***

*For FY 2009, the Division of Behavior Health (DBH) had set up a task force to improve response rates for both surveys. They implemented the new survey process in September 2009.*

*Due to errors with data collection by DBH's contracted data collection vendor, the Department was not able to use the September 2009 survey results. Before the September 2010 survey was implemented, DBH followed up with training for their vendor to ensure the Department would have the Medicaid break out needed to calculate survey results. The training and follow up by DBH was successful and the Department received the survey results as scheduled.*

**Strategy: Data Analysis (non-claims)**

**Confirmation it was conducted as described:**

**Yes**

**No. Please explain:**

**Summary of results:**

*Analysis of Program Integrity data and other standards is conducted when a report of potential abuse or fraud is reported to the Department by a Managed Care Organization (MCO) or Behavioral Health Organization (BHO/PIHP), and during site reviews. For fiscal year 2008/2009 and 2009/2010, the Department analyzed the BHO quarterly reports to identify issues, trends, adequate analysis by plan, evidence of appropriate investigations and follow up in regards to grievances, timely access and specialist capacity. See the following quarterly report criteria information to understand the Department's analysis process and findings from the compliance site audits for these years. Please note that health plans submit Network Adequacy, Grievance & Appeals, and Access to Care reports electronically to the Department on a fixed quarterly schedule.*

**The following criteria are used to identify issues with the BHO quarterly reports:**

**Access to Services**

- *Identify percentage met for
  - Emergency Services
  - Urgent Services
  - Routine Services*
- *Identify any outliers that affect ability to meet 100%*
- *Identify any plan of actions*

**Grievance and Appeal**

- *Identify number of grievances by
  - Adult
  - Child*
- *Identify largest category of complaints*
- *Identify "other" in all categories*
- *Identify the number of appeals/outcomes*
- *Identify any plan of actions*

**Network Adequacy (BHO and MCO)**

- Identify any additions/subtractions of providers
- Identify number of single case agreements
- Examine distance between provider and client and confirm they are within specified radius

**Problems identified:**

For Fiscal year 2008/2009, the Department's External Quality Review Organization audited all PIHPs for the following standards: Member Information, Notice of Actions, Appeals and Under-utilization. Corrective action plans were required in any areas that were Not Met or Partially Met.

For Fiscal year 2009/2010, the Department's External Quality Review Organization audited all PIHPs for the following standards: Emergency and Post-stabilization, Member Rights and Protections, the Grievance System, Provider Participation and Program Integrity, Credentialing and Re-credentialing, Subcontracts and Delegation, Quality Assessment and Performance Improvement. Corrective action plans were required in any areas that were Not Met or Partially Met.

**System-level program changes**

No programmatic changes were made at the systems level

**Strategy: Independent Assessment**

**Confirmation it was conducted as described:**

Yes

No. Please explain: This strategy was not included in the previous waiver renewal.

**Summary of results:**

Annual Technical Reports for FY2008-09 and FY2009-10 will be submitted to CMS under separate cover.

**Problems Identified**

Noted within the Technical Reports.

**Corrective Action**

The FY08 Technical Report reviewed the BHO FY06/07 Corrective Action Plans. For FY08, one BHO was required to submit an immediate CAP and 3 other BHOs submitted CAPs to address findings from the compliance site review.

**Program Changes**

None.

## ***Strategy: Network Adequacy Assurance by Plan***

***Confirmation it was conducted as described:***

**Yes**

**No. Please explain:**

### ***Summary of results:***

*The Department reviews Network Adequacy Reports on a quarterly basis for contractual compliance. The EQRO also reviews Network Adequacy as part of the compliance monitoring activity. Please see the narrative FY 08/09 and FY09/10 fourth quarter Network Adequacy Reports for all five BHOs. An example of the Department's comments follows below:*

### **Network Adequacy Report State Fiscal Year 2008-2009 Fourth Quarter**

Access Behavioral Care (ABC) is one of five Behavioral Health Organizations (BHOs) that manage Colorado's Medicaid Community Mental Health Services Program for the Department of Health Care Policy and Financing. This quarterly network adequacy report is a contractually required deliverable to the Department of Health Care Policy and Financing. The report format was developed in collaboration with the Department. This report provides information on the availability of behavioral health providers in Access Behavioral Care's network. Data is drawn from credentialing databases, Colorado Access's transaction system, member eligibility files, Provider Network Services records, and Mental Health Center of Denver reports. Each section provides an analysis of the data and, if indicated, any actions that Access Behavioral Care has taken or plans to take. Also included is any provider network activity of note in the reporting quarter.

#### **Network Practitioners**

The data table of individual practitioners that follows this report displays the number of behavioral health practitioners within the Mental Health Center of Denver (MHCD) and Denver service area Federally Qualified Health Centers (FQHCs), and other network individual practitioners by county. In addition to the number of providers by county, a three month average of unduplicated enrollment is identified for each county.

The Access Behavioral Care provider network includes 192 prescribers and 674 licensed mental health practitioners, for a total of 866 licensed practitioners. This is a 3.46 percent increase over the total licensed practitioners contracted in the third quarter of this year, with a net increase of 8 prescribers and 22 licensed mental health practitioners. ABC's network is more than adequate but we continue to recruit available providers to continue offering expanded options to our members. The graph below (*not shown*) illustrates quarterly volume trending; the provider network is dynamic, but ABC maintains a stable number of licensed practitioners with a quarterly average for the year of 652 licensed mental MH practitioners and 187 prescribers.

#### ***Problems Identified***

Department Follow up/ **Network Adequacy**

The data in the report identifies the addition and termination of providers, but does not provide any analysis. This was also evident when reporting the number of Organizational Providers, the report show 4 more RTCs outside of the BHO area from last quarter. Please submit an analysis of the items mentioned above by 9/11/2009.

***Corrective action***

*None required*

***Program change (system-wide level)***

*None*

***Strategy: Ombudsman***

***Confirmation it was conducted as described:***

Yes.  
 No. Please explain:

***Summary of results:***

***Program information***

In Colorado, Medicaid Managed Care includes physical health as well as mental health services. Mental health services are provided through the area Behavioral Health Organization (BHOs). Physical health services are provided through enrollment in a Managed Care Organization (MCO) or the Primary Care Physician Program (PCPP). Enrollment in a BHO is automatic and is based on county of residence. Enrollment in an MCO for Medicaid clients is by choice and is not mandatory.

The role of the Ombudsman for Medicaid Managed Care is to help members navigate the health care delivery system and to assist them with resolving problems encountered with accessing needed services. This requires coordination across health care delivery systems including mental health, physical health, and community-based care. The Ombudsman also provides a neutral process to facilitate fair and equitable resolutions to concerns. The Ombudsman helps inform and educate Medicaid managed care members of their rights and health plan benefits, and assists in comprehensive problem resolution, often resulting in improved and ongoing communication.

An “easy to use” grievance and appeals process is critical to assuring timely access to quality care. The Ombudsman program has proven to be effective in educating Medicaid members about the managed care process. In addition, the Ombudsman provides an effective resource to MCOs and BHOs by alerting them to member dissatisfaction, access to care and quality of care issues, or a need for provider education. This ensures members of a more positive managed care experience.

The Ombudsman Program provides Medicaid managed care members with information, referral, counseling, and assistance with problem resolution. The approach is to facilitate and foster communication among the involved parties, creating the most expeditious resolution of member concerns. Members often contact the Ombudsman with care needs of which the managed care plan may be unaware. Educating the member on how to work with the plan is an important role of the

Ombudsman program. Providing early intervention helps to alert the MCO and BHO to possible chronic care concerns or members with special needs. This provides a “win-win” approach to problem resolution.

The Ombudsman collects information to facilitate accurate reporting of issues, resolutions and referrals. The goal is to create reports that provide all involved parties with valuable data to be used to evaluate current trends, issues and processes. The following data is a sample of information entered into a tracking file, which can be accessed for reference and reporting purposes:

- Description of concern
- Diagnosis
- Date of grievance filed
- Date of Notice of Action
- Resolution / outcome summary

A summary of the issues, trends and complaints is reported to the Department on a quarterly and annual basis. The quarterly report summarizes the monthly case activity, services provided and trends in care issues. The annual report is a complete summary of care issues and trends, Ombudsman mediation, intervention and care coordination.

***Problems Identified***

*None*

***Corrective Action***

*None*

***Program change***

*Both long-time Ombudsman staff have resigned within the four months preceding this waiver application. New staff were hired in January-February 2011. The Department and the new Ombudsman staff are working together to further improve and enhance stakeholder relationships and awareness of the Ombudsman program.*

***Strategy: On-Site Review***

***Confirmation it was conducted as described:***

Yes  
 No.

***Summary of results:***

*Annual Technical Reports for FY2008-09 and FY2009-10 will be submitted to CMS under separate cover.*

**Strategy: Performance Improvement Projects**

**Confirmation it was conducted as described:**

- Yes
- No. Please explain:

**Summary of results:**

See the below chart for a list of performance improvement projects (PIPs) and Focused Studies that were in progress in process during FY08-09 and validated by the EQRO: (note that the one focused study listed was reviewed by the Department)

Plan Name	PIP Study/Focused Studies	Validation Year
<b>Access Behavioral (Colorado Access)</b>		
4/1/11	Coordination of Care	4
2/21/11	Coordination of Care between Psychiatric Emergency Facilities and Outpatient Providers	4
<b>BHI</b>		
4/1/11	Coordination of Care	4
9/1/2010	Focused Study/Investigative Review of Clients Simultaneously Prescribed Psychotropics and Analgesics	
<b>CHP</b>		
2/21/11	Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+	3
4/1/11	Coordination of Care	4
<b>Foothills</b>		
4/1/11	Coordination of Care	4
9/30/10	Reducing ED Utilization for Youth	2
<b>NBHP</b>		
4/1/11	Care Coordination Between Psychiatric Providers and Physical Health Providers	4
11/29/10	Therapy with Children and Adolescents: Increasing Caregiver Involvement	4

*“Each BHO was required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs was to achieve, through ongoing measurements and intervention, significant, sustained improvement in both clinical and nonclinical areas. This structured method of assessing and improving BHO processes was designed to have a favorable affect on health outcomes and consumer satisfaction... The Department contracted with (an EQRO) to meet this validation requirement.”*

*On an annual basis, the EQRO validates each PIP using the following 10 CMS protocol activities:*

- I. Review the Selected Study Topic
- II. Review the Study Question(s)

- III. Review the Selected Study Indicator(s)
- IV. Review the Identified Study Population
- V. Review Sampling Methods
- VI. Review Data Collection Procedures
- VII. Assess Improvement Strategies
- VIII. Review Data Analysis and Study Results
- IX. Assess for Real Improvement
- X. Assess for Sustained Improvement

**Problems identified:**

None

**Corrective action:**

None

**Program change (system-wide level)**

None

**Summary of results:**

See the below chart for a list of performance improvement projects (PIPs) and Focused Studies that were in progress in process during FY 09-10 and validated by the EQRO: (note that the one focused study listed was reviewed by the Department)

Plan Name	PIP Study
<b>Access Behavioral (Colorado Access)</b>	
4/2/10	Coordination of Care
2/23/10	Coordination of Care between Psychiatric Emergency Facilities and Outpatient Providers
<b>BHI</b>	
4/2/10	Coordination of Care
	Focused Study Antipsychotics(HSAG does not validate)
<b>CHP</b>	
2/23/10	Increasing Penetration Rate for Older Adult Medicaid Members Aged 60
4/2/10	Coordination of Care
<b>Foothills</b>	
4/2/10	Coordination of Care
9/29/09	Reducing ED Utilization for Youth
<b>NBHP</b>	
4/2/10	Care Coordination Between Psychiatric Providers and Physical Health Providers
11/30/09	Therapy with Children and Adolescents: Increasing Caregiver Involvement

*“Each BHO was required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs was to achieve, through ongoing measurements and intervention, significant, sustained improvement in both clinical and nonclinical areas. This structured method of assessing and improving BHO processes was designed to have a favorable affect on health outcomes and consumer satisfaction... The Department contracted with (an EQRO) to meet this validation requirement.”*

*On an annual basis, the EQRO validates each PIP using the following 10 CMS protocol activities:*

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- II. Review the Study Question(s)*
- III. Review the Selected Study Indicator(s)*
- IV. Review the Identified Study Population*
- V. Review Sampling Methods*
- VI. Review Data Collection Procedures*
- VII. Assess Improvement Strategies*
- VIII. Review Data Analysis and Study Results*
- IX. Assess for Real Improvement*
- X. Assess for Sustained Improvement*

***Problems identified:***

*None*

***Corrective action:***

*None*

***Program change (system-wide level)***

*None*

***Strategy: Performance Measures***

***Confirmation it was conducted as described:***

**Yes**

**No. Please explain:**

***Summary of results:***

*Noted below are the PIHP performance measures calculated and **validated** for FY07/08. Additional information is included in the FY08/09 Technical Report, which will be submitted separately to CMS.*

*Penetration Rates by Age Category*

*Penetration Rates by Service Category*

*Overall Penetration Rates*

*Hospital Recidivism*

*Hospital Average Length of Stay*

*Emergency Department Utilization*

*Inpatient Utilization*

*Follow-up After Hospitalization for Mental Illness  
(7 and 30-day follow up)*

*Consumer Perception of Access*

*Consumer Perception of Quality and Appropriateness (Consumer Perception of Quality/Appropriateness)*

*Consumer Perception of Outcomes of Services (Consumer Perception of Outcome)*

*Consumer General Satisfaction (Consumer Satisfaction)*

*Consumer Perception of Participation in Treatment Planning (Consumer Perception of Participation)*

*Consumers Linked to Physical Health (Consumers Linked to Primary Care)*

***Problems identified:***

*None identified. Note that the Department follows up with each PIHP after performance measure submissions are completed to identify areas of improvement with performance measure rates.*

***Corrective action:***

*None. Recommendations for improvement were noted in the Technical Report.*

***Program change (system-wide level)***

*None*

*Noted below are the PIHP performance measures calculated and **validated** for FY 08/09. Additional information is included in the FY09/10 Technical Report, which will be submitted separately to CMS.*

*Penetration Rates by Age Category*

*Penetration Rates by Service Category*

*Overall Penetration Rates*

*Hospital Recidivism*

*Hospital Average Length of Stay*

*Emergency Department Utilization*

*Inpatient Utilization*

*Follow-up After Hospitalization for Mental Illness (7 and 30-day follow-up)*

***Problems identified:***

*The Department and the Department's sister agency that administers the consumer satisfaction survey identified a data collection error with survey results for FY08/09 fiscal year. It was determined that the data could not be used, but follow up training was completed with the data collection vendor and new FY 09/10 survey rates are expected to be validated for FY2010/2011. Note that the Department follows up with each PIHP after performance measure submissions are completed to identify areas of improvement with performance measure rates.*

***Corrective action:***

*None*

***Program change (system-wide level)***

*Note that the Department is working with PIHPs to define a number of new performance measures for FY09/10 and they are expected to be reported in FY2010/2011.*

***Strategy: Utilization Review***

***Confirmation it was conducted as described:***

**Yes**

**No. Please explain:**

***Summary of results:***

As noted in the previous waiver submission, the Department reviewed utilization policy and procedures for all BHOs in calendar year 2008. Information already documented in this waiver report noted other utilization reviews by the Department and its EQRO (example, Access to Care reports, performance measures validation, site reviews standards (emergency and post-stabilization services)). For ongoing utilization policy changes, the PIHPs contact the Department and receive approval from the Department for those changes. For example, in calendar year 2009 the Department reviewed an approved PIHP changes to Notice of Action letters. The Department also discusses PIHP utilizations efforts in various topics during the Behavioral Health Quality Improvement Committee (BQuIC) Meeting.