DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

APR 2 6 2017

Gretchen Hammer
Medicaid Director
Colorado Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Hammer:

The Centers for Medicare & Medicaid Services (CMS) is approving Colorado's evaluation design submitted for the section 1115 demonstration entitled, "Adult Prenatal Coverage in Child Health Plan *Plus*" (Project Number 21-W-00014/8).

Attached is an updated set of the Special Terms and Conditions (STCs) that includes the approved evaluation design as Attachment C. CMS will also post these STCs on Medicaid.gov.

Your CMS project officer, Ms. Joyce Jordan, is available to answer any questions concerning your section 1115 demonstration or to provide technical assistance as the state implements the evaluation design. Ms. Jordan can be reached at (410) 786-3413 or Joyce.Jordan@cms.hhs.gov.

Sincerely,

[redacted]

Amy Lutzky
Director
Division of State Coverage Programs

Enclosure

cc: Richard Allen, Associate Regional Administrator, CMS Denver Regional Office

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00014/8

TITLE: Adult Prenatal Coverage in Child Health Plan Plus (*CHP+*)

AWARDEE: Colorado Department of Health Care Policy and Financing

The following are the Special Terms and Conditions (STCs) for the Colorado Adult Prenatal Coverage in CHP+ section 1115(a) title XXI funded Children's Health Insurance Program (CHIP) and Medicaid demonstration (hereinafter "demonstration") to enable the Colorado (hereinafter "State") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities under section 2104 of the Social Security Act (Act), authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of August 1, 2015 unless otherwise specified. This demonstration is approved through July 31, 2020.

The STCs have been arranged into the following subject areas:

i. Preface
ii. Program Description And Objectives
iii. General Program Requirements
iv. Eligibility for the Demonstration
v. Benefits
vi. Delivery System
vii. General Reporting Requirements
viii. General Financial Requirements
ix. Monitoring Allotment Neutrality for the Demonstration
x. Evaluation of the Demonstration
xi. Schedule of State Deliverables During the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A.	General Financial Requirements
Attachment B.	Quarterly Report Content and Format
Attachment C.	Demonstration Evaluation Plan *[once approved]*

I. PROGRAM DESCRIPTION AND OBJECTIVES

Demonstration Description

The Colorado Adult Prenatal Coverage in CHP+ demonstration was initially approved on September 27, 2002 to provide coverage to uninsured pregnant women with family incomes from 133 to 185 percent of the federal poverty level (FPL) and to allow the state to receive title XXI funds for this population.

Historical Context

Initial Demonstration Application Submitted:	May 24, 2002
Demonstration Approved:	September 27, 2002
Implementation Date:	October 8, 2002
Original Expiration Date:	September 30, 2006
Amendment #1Submitted:	July 1, 2005
Amendment #1 Approved:	January 24, 2006
Amendment #1 Implementation Date:	January 24, 2006
First Extension Period:	October 1, 2006 – September 30, 2009
Temporary Extensions:	October 1, 2009 – July 31, 2012
Second Extension Period:	August 1, 2012 – July 31, 2015
Third Extension Period:	August 1, 2015 through July 31, 2020

Demonstration Purpose

Prior to the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states were only permitted to cover pregnant women with title XXI funds through an 1115 demonstration such as Colorado. CHIPRA made it possible to cover higher income pregnant women under the CHIP state plan as long as lower income pregnant women were covered under the Medicaid state plan. Given that Colorado already covered lower income pregnant women in the demonstration, CMS permitted the state to continue to use XXI funds rather than converting to the lower Medicaid FMAP rate under section 1115 authority. The state requested to extend its existing authority under this demonstration to receive title XXI funds for uninsured pregnant women with income above 141 percent through 195 percent of the Federal Poverty Level (FPL) (note these are the MAGI converted eligibility levels for the same population). The current demonstration period was set to expire on July 31, 2015.

The state's goals in renewing the demonstration are to:

- Decrease the uninsurance rate for pregnant women;
- Increase prenatal and postpartum care for pregnant women enrolled in the demonstration; and;
- Increase the number of healthy babies born to pregnant women enrolled in the demonstration.

This demonstration furthers the objectives of title XIX and XXI by providing necessary prenatal, delivery, and postpartum care to low-income pregnant women with incomes above 141 percent to through 195 percent FPL covered under the Medicaid state plan.

II. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact of Changes in Federal Law, Regulation, and Policy on the Demonstration.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified allotment neutrality agreement will be effective upon the implementation of the change.

    b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid or CHIP State Plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to demonstration features, such as eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing,

evaluation design, sources of non-Federal share of funding, allotment neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, amendments to the Medicaid or CHIP state plan may or may not require amendment to the demonstration as well. Amendments to the demonstration are not retroactive and federal financial participation (FFP) will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, required reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. *Public Notice.* The state does not need to comply with the state public notice and comment process outlined in 42 CFR §431.408 until such time that CMS issues policy guidance to the contrary. However CMS encourages the state to do so in the event it seeks to amend the demonstration that modifies benefits, cost sharing, eligibility, or delivery system changes. CMS will post and accept public comments on all amendments;

    b. *Tribal Consultation.* The state must provide documentation of the state's compliance with the tribal consultation requirements outlined in STC 14. Such documentation shall include a summary of the tribal comments and identification of proposal adjustments made to the amendment request due to the tribal input;

    c. *Demonstration Amendment Summary and Objectives.* The state must provide a detailed description of the amendment, including what the state intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary;

    d. *Waiver and Expenditure Authorities.* The state must provide a list waivers and expenditure authorities that are being requested or terminated for the amendment, accompanied with a justification that includes applicable federal citations, need, and programmatic description of the waiver and/or expenditure authority changes being requested.

e. *An allotment neutrality worksheet.* The state must provide an up-to-date CHIP (title XXI funding) allotment neutrality worksheet; and,

f. *Updates to existing demonstration reporting, quality and evaluation plans.* A description of how the evaluation design, quality strategy, and/or quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** No later than 12 months prior to the expiration date of the demonstration, the Governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.

    a. *Compliance with Transparency Requirements at 42 CFR §431.412(c).* As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements at 42 CFR §431.408 and 412 and the public notice and tribal consultation requirements outlined in STC 14.

    b. *Temporary Extension of Demonstration.* Upon application from the state or CMS determination that a temporary extension of the demonstration is necessary, CMS will temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Demonstration Transition and Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

    a. *Notification of Suspension or Termination.* The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

    b. *Transition and Phase-out Plan.* The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c. *Transition and Phase-out Plan Requirements.* The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid/CHIP eligibility prior to the termination of the program for the affected beneficiaries and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available.

d. *Phase-out Procedures.* The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid/CHIP eligibility under a different eligibility category.

e. *Exemption from Public Notice Procedures 42.CFR Section 431.416(g).* CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX or XXI would be served or under circumstances described in 42 CFR §431.416(g).

f. *Federal Financial Participation (FFP.* If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure**. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7, are proposed by the state.

    a. *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations*. In states with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    b. *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments*. In states with Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

    c. *Public Notice.* The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP**. No Federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or a later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

III. ELIGIBILITY FOR THE DEMONSTRATION

16. **Eligibility Groups Affected By the Demonstration**. Mandatory and optional state plan groups derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility

groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration.

This demonstration affects uninsured pregnant women with incomes from 141 percent through 195 percent FPL covered under the Medicaid state plan.

17. **Mandatory Eligibility Groups Included in the Medicaid State Plan.** Eligibility for all mandatory eligibility groups follow what is in the approved state plan. Should the state amend the state plan to make any changes to eligibility for Medicaid mandatory populations, upon submission of the state plan amendment, the state must notify CMS in writing of the pending state plan amendment. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Allotment Neutrality sections of the STCs will be updated upon approval of changes to State plan eligibility and will be considered a technical change to the STCs.

18. **Optional Eligibility Groups Included in the Medicaid State Plan.** Eligibility for all Optional eligibility groups follow what is in the approved State plan. Should the state amend the state plan to make any changes to eligibility for Medicaid optional populations, upon submission of the state plan amendment, the state must notify CMS in writing of the pending State Plan amendment. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Allotment Neutrality sections of the STCs will be updated upon approval of changes to State plan eligibility and will be considered a technical change to the STCs.

19. **Application of Modified Adjusted Gross Income (MAGI).** The state must maintain its converted eligibility standards and methodologies for all eligibility groups subject to MAGI through the state plan effective January 1, 2014.

IV. BENEFITS

20. **Demonstration Benefits.** Individuals enrolled in the Colorado Adult Prenatal Coverage in CHP+ demonstration will receive comprehensive benefits that are at least equal in amount, duration and scope as those described in the Medicaid State Plan and the alternative benefit plan.

21. **Minimum Essential Coverage.** Section 5000A(f)(1)(E) of the Internal Revenue Code grants the Secretary of Health and Human Services, in coordination with the Secretary of Treasury, the authority to recognize otherwise non-specified health benefits coverage as minimum essential coverage (MEC) for the purposes of purposes of section 5000A of the Internal Revenue Code. In accordance with this authority, CMS will inform the state of its determination of whether we recognize the health benefits coverage provided under this demonstration as MEC.

V. COST SHARING

22. **Cost Sharing.** There is no cost sharing imposed for services provided under this demonstration.

VI. DELIVERY SYSTEM

23. Delivery of Services. Pregnant women enrolled in the Colorado Adult Prenatal Coverage in CHP+ demonstration receive State Plan services through a combination of fee-for-service and managed care delivery systems which may vary by geographic area of the state. The service delivery systems are authorized under other managed care authorities, including section 1915(a), section 1915(b) and section 1932(a) of the Social Security Act.

VII. GENERAL REPORTING REQUIREMENTS

24. Monitoring Calls. CMS will convene monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, MCO operations and performance, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the state is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

25. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC 27, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 28.

26. Quarterly Progress Reports. The state must submit quarterly progress reports in accordance with the guidelines in Attachment B no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly and bi-annual reports must include the following, but are not limited to:

a. An updated allotment neutrality monitoring spreadsheet;

b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant

to the demonstration, pertinent legislative or litigation activity, and other operational issues;

c. Updates on the post award forums required under STC 27.

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Monthly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;

f. Information on beneficiary complaints, grievances and appeals filed during the quarter by type including; access to urgent, routine, and specialty services, and a description of the resolution and outcomes; and

g. Evaluation activities and interim findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; and status of study participant recruitment, if applicable.

27. **Demonstration Annual Report**. The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the Demonstration Year (DY) to CMS.

    a. All items included in the quarterly report pursuant to STC 28 must be summarized to reflect the operation/activities throughout the DY;

    b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and,

    c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration).

28. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments.

VIII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XXI expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

29. **General Financial Requirements.** The state must comply with all general financial requirements under title XXI, including reporting requirements related to monitoring allotment neutrality, set forth in Attachment A of these STCs.

30. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM".

31. **Extent of FFP for the Demonstration**. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS will provide FFP at the applicable Federal matching rate for the demonstration as outlined below, subject to the state's title XXI allotment limit:

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

    c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

32. **Sources of Non-Federal Share**. The state must certify that the matching non-Federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS may review the sources of the non-Federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

    c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

    d. State Certification of Funding Conditions. The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

i. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-Federal share of funds under the demonstration.
ii. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
iii. To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for Federal match.

e. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments.

f. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

33. **Title XXI Limits**. Colorado will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.

34. **Exhaustion of Title XXI Funds.** Uninsured pregnant women under the Medicaid state plan with incomes above 141 percent through 195 percent of the FPL under MAGI are funded with title XXI funds. The state is eligible to receive title XXI funds for expenditures for these uninsured pregnant women meeting the definition specified in section 2110(b)(1) of

the Social Security Act, up to the amount of its title XXI allotment. Title XIX funds for these uninsured pregnant women are available if the state exhausts its title XXI allotment. The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this demonstration population. The State must follow Medicaid State plan criteria for the beneficiaries unless specific waiver and expenditure authorities are granted through this demonstration.

IX. EVALUATION OF THE DEMONSTRATION

35. **Submission of an Updated Evaluation Design Subject to CMS Approval.** The state must submit to CMS for approval, within 120 days of the approval date of the renewal, a draft evaluation design that builds and improves upon their CMS approved evaluation design. The updated design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

36. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the evaluator selected by CMS. In addition, the state shall submit the required data to CMS or its contractor.

37. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. The state must submit a final design within 60-days of receipt of CMS comments and implement the evaluation design. The state must report evaluation activities in each of the quarterly and annual progress reports. The evaluation design may be revised during the demonstration approval period as needed or required by the STCs.

38. **Interim Evaluation Report.** The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration. The interim evaluation report will discuss evaluation progress and present findings to date.

39. **Final Evaluation Report.** The state must submit to CMS a draft of the evaluation final report within 60 days prior to the expiration of the demonstration. The state must take into consideration CMS' comments for incorporation into the final report. The final evaluation report is due to CMS no later than 60 days after receipt of CMS' comments.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

1. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the state Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver/CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

    a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

    b. The standard CHIP funding process will be used during the demonstration. Colorado must estimate matchable CHIP expenditures on the quarterly Form CMS-218. On a separate CMS-218, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

    c. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for my other Federal grant or contract, except as permitted by Federal law.

2. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan (CHP+) and those provided through the Colorado Adult Prenatal Coverage in CHP+ under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal Financial Participation (FFP) only for allowable Colorado demonstration expenditures that do not exceed the State's available title XXI funding.

3. Colorado will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment,

including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available.

4. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

5. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed ten percent of total title XXI net expenditures.

6. Premium contributions under the demonstration shall be reported to CMS on Form CMS-21 Waiver, line 29, in order to assure that the demonstration is properly credited with premium collections.

7. If the State exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State must continue to provide coverage to the approved title XXI State plan separate child health program population and the demonstration population with State funds.

ATTACHMENT B
QUARTERLY REPORT CONTENT AND FORMAT

Pursuant to STC 27 (Quarterly Progress Report) of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state.

NARRATIVE REPORT FORMAT:

Title Line One – [name of demonstration]
Title Line Two – Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period: [Example: Demonstration Year: 1 (1/1/2014-12/31/2014)

Federal Fiscal Quarter:

Footer: Date on the approval letter through December 31, 20xx]

Introduction
Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

Enrollment and Benefits Information
Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.
- Enrollment activity under the demonstration, including enrollment counts for the quarter and demonstration year to date.

Outreach/Innovative Activities to Assure Access
Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

Operational/Policy/Systems/Fiscal Developments/Issues
A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

Financial/Allotment Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting or allotment neutrality reporting for the current quarter. Identify the state's actions to address these issues.

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

Demonstration Evaluation
Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

Enclosures/Attachments
Identify any other attachments along with a brief description of what information the document contains.

State Contact(s)
Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT C
DEMONSTRATION EVALUATION PLAN

Objectives, Hypotheses and Evaluation Activities During the Extension Period
During the extension period, the following objectives of the demonstration include:

- Objective 1: Increase the percentage of pregnant women who receive prenatal and postpartum care for those enrolled in the demonstration.
- Objective 2: Increase the number of healthy babies born to pregnant women enrolled in the demonstration.

The CHP+ Demonstration Population Includes:
Pregnant Medicaid expansion clients who would have been covered under CHP+ if not for the expansion (142%-195% FPL).

To know if Colorado is achieving these objectives, the State will evaluate the following:

- Hypothesis 1: Pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in prenatal care visits and a statistically significant increase in postpartum care visits from SFY 2015 to SFY 2020.

  Methodology: Data to test the hypothesis comes from Medicaid claims data in our MMIS system. Total number of births is pulled from the claims for the previous calendar year. Three types of birth data are used: inpatient deliveries, global bills and antepartum/standalone care (other criteria are also assessed, per the specifications). Those data are used to identify the prenatal and postpartum care based on the numerator criteria for the measure (see specifications).

  Data are checked for completeness, accuracy and reasonableness via peer review of SQL code. Additionally, the code and data are reviewed by staff who work with birth and pregnancy data. Finally, a comparison is made between budget and other reports so as to assess reasonableness of the data.

  The statistical test used to evaluate these data is a year-to-year percentage change. The annual difference is calculated by subtracting the previous year's value from the current year's value. Then the annual difference is divided by the previous year's value to get a comparison. This figure is then multiplied by 100 to obtain the year-over-year percentage change. See the CHP+ 1115 Waiver Prenatal Care and CHP+ 1115 Waiver Postpartum Follow-Up Care documents.

  Accordingly, in performing analytics for these rates, Colorado will compare the numerators and denominators to those reported in previous years to see if the figures are similar or require further investigation. Colorado will strive for a statistically significant increase year-over-year to arrive at the projected increases. A deeper dive on the data will be taken if the projected significant increase is not realized. This deeper dive could include a geographic analysis, race and ethnicity analysis and input from current clients, case managers and providers. Colorado is also committed to further analyzing any significant improvement in order to identify and further share any best practices.

Baseline 2015 Data:

Pregnant Medicaid Expansion Clients (142-195% of FPL)		
Measure 1	***Rate of Pregnant Women With Prenatal Care***	**51.77 %**
Numerator	Number of Pregnant Women with Prenatal Care	1,637
Denominator	Number of Pregnant Women Eligible for Prenatal Care	3,162

Measure 2	***Rate of Pregnant Women With Postpartum Care***	***51.93%***
Numerator	Number of Pregnant Women with Postpartum Care	1,642
Denominator	Number of Pregnant Women Eligible for Postpartum Care	3,162

- Hypothesis 2: The proportion of babies born to women enrolled in the CHP+ demonstration and admitted to the NICU will decrease over the five years of the demonstration project. The proportion of babies born to women enrolled in the CHP+ demonstration that weigh under 2,500 grams will decrease by 10 percent from SFY 2015 to SFY 2020.

  Methodology: The methodology is a pre- and post-measurement to compare the number of babies born to pregnant women in the demonstration population weighing less than 2,500 grams during the waiver period. The data for Hypothesis 2 are taken from claims data from the Department's MMIS system and birth certificate data provided by our sister agency, the Colorado Department of Public Health and Environment (CDPHE). The claims data birth mother is joined to CDPHEs' birth mother, and the infant's birth weight is pulled from the birth certificate. Only infants with a birth weight of less than 2,500 grams is kept for the report.

  Data are checked for completeness, accuracy and reasonableness via peer review of SQL code. Additionally, the code and data are reviewed by staff who work with birth and pregnancy data. Finally, a comparison is made between budget and other reports so as to assess reasonableness of the data.

  The statistical test used to evaluate this data is a year-to-year percentage change. The annual difference is calculated by subtracting the previous year's value from the current year's value. Then the annual difference is divided by the previous year's value to get a comparison. This figure is then multiplied by 100 to obtain the year-to-year percentage change.

  Accordingly, in performing analytics for these rates, Colorado will compare the numerators and denominators to those reported in previous years to see if the figures are similar or require further investigation. Colorado will strive for a statistically significant decrease year-to-year to arrive at the projected decreases. A deeper dive on the data will be taken if the projected significant decrease is not realized. This deeper dive could include a geographic analysis, race and ethnicity analysis and input from current clients,

case managers and providers. Colorado is also committed to further analyzing any significant improvement in order to identify and further share any best practices.

Baseline 2015:

Pregnant Medicaid Expansion Clients (142-195% of FPL)		
Measure 3	***% of births weighing < 2,500 grams***	***17.68%***
Numerator	Babies weighing < 2,500 grams	559
Denominator	Pregnant moms between 14-54, in demonstration	3,162

CHP+ 1115 Waiver Prenatal Care

Measure Title	CHP+ 1115 Waiver Prenatal Care
Motivation	Prenatal care is the healthcare you receive while you are pregnant. This healthcare and consultation can positively impact the health of the infant. Therefore, we track the extent to which our population receives this care.
Denominator	All women between 142% - 195% FPL with a global bill or hospital delivery DRG. These clients are captured with the following APR-DRGs: 540, 541, 542, and 560.
Numerator	Clients in denominator with one of the following CPT codes (59400, 59510, 99201-99215 w/modifier TH, 59425, 59426, 59610, 59618, 59622) at any time prior to delivery.
Population Exclusions	• Clients who are dually eligible for the ACC Medicare Medicaid Program (MMP) • Clients with less than three months of eligibility • Clients eligible for both a Medicare and a Medicaid benefit • Clients who are defined as part of the Medicaid expansion population • Clients in the Working Adults with Disabilities Buy-in Eligibility Type (031) • Clients in the Children with Disabilities Buy-in Eligibility Type (032)
Time Period	Rolling 12 months
Claims Run Out	90 days run out, 30 days processing
References and Measure Origin	Proportion of pregnant women who receive early and adequate prenatal care (NQF 5684). **HHS Agency:** Office of the Assistant Secretary for Health (OASH) **Denominator:** • Number of live births in states that use the 2003 standard certificate of birth **Numerator:** • Number of pregnant females receiving adequate prenatal care by the Adequacy of Prenatal Care Utilization Index (APNCU) in states that use the 2003 standard certificate of birth Please refer to KPI White paper State Fiscal Year 2015 on Dashboard for further details.
Version Date	04/20/2016

CHP+ 1115 Waiver Postpartum Follow-Up Care

Measure Title	CHP+ 1115 Waiver Postpartum Follow-Up Care
Motivation	Mothers on CHP+ and Medicaid now account for greater than 40% of all births in Colorado. It is important that we track the care that is being delivered to this population.
Denominator	Clients will be counted in the denominator if they meet the following criteria: • Between 142% -195% FPL • All women on CHP+ with a global bill or hospital delivery DRG or delivery CPT codes: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 • Or ICD-9 Procedure Codes: 72.0-73.99, 74.0-74.2, 74.4-74.99 • Or DRG 370-375 • Or APR-DRG 540-542 and 560 Pregnancies not ending with a live birth are excluded from the denominator.
Numerator	Clients will be counted in the numerator if they meet the following criteria: • CPT codes: 59400, 59510, 59410, 59515, 59430, 59610, 59614, 59618, 59622 • Postpartum care that is delivered before the client is enrolled with the CHP+ is also counted.
Population Exclusions	• Clients who are dually eligible for the ACC Medicare Medicaid Program • Clients with less than three months of eligibility • Clients eligible for both a Medicare and a Medicaid benefit • Clients who are defined as part of the Medicaid expansion population • Clients in the Working Adults with Disabilities Buy-in Eligibility Type (031) • Clients in the Children with Disabilities Buy-in Eligibility Type (032)
Time Period	Rolling 12 months
Claims Run Out	90 days run out, 30 days processing
References and Measure Origin	**Prenatal and postpartum care: Postpartum Care Rate (NQF 1517):** **HHS Agency** - Centers for Medicare & Medicaid Services (CMS) **Measure Steward** - National Committee for Quality Assurance (NCQA) **Topic or Condition** Health Services Administration - Access Reproductive Health - Pregnancy **Measure Domain** - Process **Care Setting** - Ambulatory/Office-based Care **Denominator** Deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year *Multiple Births*: Women who had two separate deliveries (different dates of service) between November 6 of the year prior. **Numerator** Timeliness of Prenatal Care: A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy. Postpartum Care: A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. **Target Population Age** - Unspecified

	Data Source - Claims; Hybrid **Measure Maintenance** – Annually Please refer to KPI White paper State Fiscal Year 2015 on Dashboard for further details.
Version Date	03/30/2015