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State/Territory Name: Colorado
State Plan Amendment (SPA) #: 21-0043

This file contains the following documents in the order listed:
1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-l 2
Baltimore, Maryland 21244-1850

December 15, 2021

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Re: Colorado State Plan Amendment (SPA) 21-0043

Dear Ms. Bimestefer:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 21-0043. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID- 19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID- 19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.),* and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID- 19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Colorado also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

The State of Colorado also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Colorado's Medicaid SPA Transmittal Number 21-0043 is approved effective March 1, 2020. This SPA is in addition to Disaster Relief SPAs approved on April 21, 2020, May 6, 2020, May 20, 2020, October 1, 2020, April 15, 2021, April 20, 2021, May 28, 2021, July 21, 2021, August 11, 2021, October 1, 2021, and October 14, 2021.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Curtis Volesky at 303-844-7033 or by email at Curtis.volesky@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Colorado and the health care community.

Sincerely,

[redacted]

Digitally signed by Alissa M. Deboy -S
Date: 2021.12.15 08:43:27 -05'00'

Alissa Mooney DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938 0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **21–0043**

2. STATE: **COLORADO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **March 1, 2020**

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS A NEW PLAN | **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

Social Security Act, Title XIX and Section 1135

7. FEDERAL BUDGET IMPACT:

a. FFY 2021: $540,133
b. FFY 2022: $10,635,995

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 7 – General Provisions – Item 7.4 – Medicaid Disaster Relief for the COVID-19 National Emergency, pgs ~~1-18~~ *1-19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Section 7 – General Provisions – Item 7.4 – Medicaid Disaster Relief for the COVID-19 National Emergency, pgs 1-18 (TN# 21-0005, 21-0023, 21-0027)

10. SUBJECT OF AMENDMENT:

Requests waivers under SSA Section 1135 concerning SPA submission, tribal consultation, and public notice requirements. This SPA will: 1) cover COVID-19 drug treatment provided through Emergency Use Authorization regardless of rebate or language in current State Plan effective March 1, 2020, 2) increase the rate for procedure code 36561 from Ambulatory Surgical Center (ASC) grouper 3, $420.48, to ASC grouper 10, $1813.06, effective August 26, 2021, and 3) increase the reimbursement rate for administration of the first two doses of a COVID-19 vaccine to $61.77, and $41.18 for additional doses, and an additional $35 for administration within the member's home or residence effective September 1, 2021.

11. GOVERNOR'S REVIEW *(Check One)*:

GOVERNOR'S OFFICE REPORTED NO COMMENT | **X OTHER, AS SPECIFIED**

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | **Governor's letter dated 14 July, 2021**

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

[redacted]

13. TYPED NAME:
Tracy Johnson

14. TITLE:
Medicaid Director

15. DATE SUBMITTED: October 14, 2021

16. RETURN TO:

Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Amy Winterfeld

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
October 14, 2021

18. DATE APPROVED
December 15, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
March 1, 2020

20. SIGNATURE OF R [redacted]
Digitally signed by Alissa M. Deboy -S
Date: 2021.12.15 ~~08:43:58 -05'00'~~

21. TYPED NAME
Alissa Mooney DeBoy

22. TITLE
On Behalf of Anne Marie Costello, Deputy Director, CMCS

23. REMARKS *Pen & Ink changes authorized by the state on 12/9/21 and 12/10/21 including revising box 8 on 179 to show pages 1 19, changing the effective date to 3/1/2020 on pages 1 and 2, adding the missing already approved February Interim Payment language at the end of Section E, and update page numbers in header.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here. The changes identified below are implemented for the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), unless a shorter period has been identified elsewhere in the below amendment for specific items.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X___The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X___Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X___Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in the Colorado Medicaid state plan, as described below:

Please describe the modifications to the timeline. The Department is requesting flexibility in modifying its tribal consultation timeframe, by conducting consultation within ninety (90) days after submission of the SPA.

Section A – Eligibility

1. __X___The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard. The state elects to cover all uninsured individuals as defined under 1902(ss) of the Act pursuant to Section 1902(a)(10)(A)(ii)(XXIII) of the Act effective March 18, 2020.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agencyis unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ___X The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g). The State waives cost-sharing for testing services (including in vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies, for any quarter in which the temporary increased FMAP is claimed.

2. __X___ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

b. __X___The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations. Waive premiums for the Buy-In program for Working Adults with Disabilities and the Buy-In program for Children with Disabilities

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similarchargesfor undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. __X___The agency makes the following adjustments to benefits currently covered in the state plan:

Supplement to Attachment 3.1-A, Item 6.d, Other Practitioner Services, Part 5, Services provided by licensed Pharmacists (TN# 18-0019), Add Subpart 5.c: In accordance with state law, the State covers the ordering of COVID-19 vaccines by licensed pharmacists, and the administration of COVID-19 vaccines by licensed pharmacists, pharmacy interns, and pharmacy technicians. In addition, the State covers ordered and administered COVID-19 tests by licensed pharmacistsand COVID-19 tests administered by pharmacy interns and technicians.

Supplement to Attachment 3.1-A, Item 19, Targeted Case Management: Persons with a Developmental Disability, Page 4 of 4 (TN 19-0005), limits the total number of units per client to 240 units per fiscal year per person for each state fiscal year (July 1 through June 30). Supplement to Attachment 3.1-A, Item 19.b, Targeted Case Management: Transition Services, Page 6 of 6 (TN# 18-0021), limits the total number of Targeted Case Management: Transition Services per client to 240 units per service year. Long-Term Care Case Management. The Department authorizes providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19 until termination of the COVID-19 public health emergency.

Supplement to Attachment 3.1-A, Item 7, Home Health Services, A. Service Limitations, Subpart 3 (TN# 11-0012), requires all services provided by a home care agency must be medically necessary and under a physician's order as part of a written plan of care, reviewed every 60 days, indicating the amount, duration and scope of the home care service the client can receive. Aligning with Center for Medicare and Medicaid Services guidance concerning Medicare flexibilities to fight COVID-19 for home health agencies, issued March 30, 2020, the Department allows a client to be under the care of a nurse practitioner or clinical nurse specialist (as such terms are defined in Social Security Act §1861(aa)(5)) who is working in accordance with Colorado law, and for such practitioner to: (1) order home health services; (2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care), and (3) certify and re-certify that the patient is eligible for Medicaid home health services until termination of the COVID-19 public health emergency.

Attachment 3.1-D, Methods of Assuring Transportation (TN# 14-011), requires that Non-Emergent Medical Transportation (NEMT) be utilized for trips to Medicaid covered services at covered places of service. Covered places of service are those enrolled with the Department. The Department authorizes NEMT services to non-enrolled locations if those locations have been identified as alternative care or surge locations set up in response to COVID-19. Authorization will end upon termination of the COVID-19 public health emergency.

3. __X__ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __X___ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. __X The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. __X___The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe. Allow Medicaid members to receive telemedicine services and for providers to bill for telemedicine services with no restrictions, including lifting the restriction that telemedicine services include a visual component so that the telemedicine service can be performed via telephone or through Live Chat functionality. In addition, the Department is requesting to allow Medicaid members to receive telemedicine services between a member and qualified professional without first establishing a relationship through a face-to-face visit. Waive requirements that physicians and other health care professionals providing Telemedicine services be licensed in Colorado, so long as they have equivalent licensing in another state.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. __X___Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. __X___The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. __X___The agency increases payment rates for the following services:

Please list all that apply.
Effective April 1, 2020, and ending June 30, 2020, and again effective January 1, 2021, and ending June 30, 2021, for Nursing Facilities and ICF/IIDs under Attachment 4.19-D.
Effective August 26, 2021, increase the rate for procedure code 36561 from Ambulatory Surgical Center (ASC) grouper 3, $420.48, to ASC grouper 10, $1813.06.

   a. ___x Payment increases are targeted based on the following criteria:

Please describe criteria.
Facilities facing atypical staffing shortages and infection control related expenses due to a public health emergency or declared state of emergency
Hospitals have postponed/delayed-indefinitely all non-urgent surgeries, including procedure code 36561. ASCs can do the procedure but not for their current reimbursement rate. The temporary increase is to make ASCs financially whole while they temporarily absorb the 36561 procedures not performed at hospitals.

   b. Payments are increased through:

      i. __x A supplemental payment or add-on within applicable upper payment limits:

Please describe.
Addendum to Attachment 4.19-D
Emergency supplemental payments and/or rate increases

1. Emergency lump sum and/or per diem add-on during a public health emergency or declared state of emergency.

ii. __x An increase to rates as described below.

Rates are increased:

__x_Uniformly by the following percentage: 8% increase from current rates for SNFs and ICF/IIDs; 431% increase for procedure code 36561 from ASC grouper 3 to grouper 10 _____

___x Through a modification to published fee schedules –

Effective date (enter date of change):____April 1, 2020 to June 30, 2020 and January 1, 2021 to March 31, 2021; procedure code 36561 increase effective August 26, 2021_____

Location (list published location): SNFs, ICF/IIDs; ASC_____

_____ Up to the Medicare payments for equivalent services.

__x___By the following factors:

Please describe.

Facility specific time-limited expenses to ensure the safety, health and welfare of residents during a public health emergency or declared state of emergency. Facility specific time-limited expenses are limited to purchase of materials/equipment to prevent the spread of COVID-19, temporary increased staffing costs, and/or increased on-boarding costs to hire new staff.

Hospitals have postponed/delayed-indefinitely all non-urgent surgeries, including procedure code 36561. ASCs can do the procedure but not for their current reimbursement rate. The temporary increase is to make ASCs financially whole while they temporarily absorb the 36561 procedures not performed at hospitals.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. ____ Are not otherwise paid under the Medicaid state plan;

b. ____ Differ from payments for the same services when provided face to face;

c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

d.

Describe telehealth payment variation.

e. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealthis incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. x___Other payment changes:

Attachment 4.19, Payment for Services, 66(b), 4.19(m) Medicaid Reimbursement for the Administration of Vaccines under the Pediatric Immunization Program (TN# 16-0007), requires that pediatric immunizations be provided specifically through the Vaccines for Children (VFC) program, by providers enrolled as VFC providers. The Department authorizes all providers licensed to administer vaccines to administer pediatric immunizations if the vaccine product used was provided free of cost by the federal government, outside of the VFC program. Authorization will end upon termination of the COVID-19 public health emergency.

Attachment 4.19, Payment for Services, 66(b), 4.19(m) Medicaid Reimbursement for the Administration of Vaccines under the Pediatric Immunization Program (TN#16-0007) also sets a reimbursement rate of $18.93 per vaccine administration, plus or minus any approved physician rate adjustments, with the exception of those services and providers subject to the minimum payments described at 42 CFR 447.405. Effective September 1, 2021, the Department authorizesa payment of $61.77 for administration of the first two doses of COVID-19 vaccine, $41.18 for additional doses, and an additional $35.00 for vaccine administration within the member's home or residence.

The Department will issue a one-time per member per month COVID-19 increased workload payment for intellectual and developmental disabilities targeted case management payment for the month of June 2021. The Department identified the services listed below to develop a rate of $78.00 per adult waiver member and $64.47 per children's waiver member. This rate takes into account the existing per member per month rate the case management agency received for the member and is a payment for the additional workload that is above and beyond the per member per month scope of work. Members are active on 1915c Medicaid waiver programs but the tasks below are reflective of state plan targeted case management tasks.

- Tracking and operationalizing multiple policy changes, including more than fifty operational memos, implemented by the Department related to COVID.
- Obtaining member paperwork that would have previously been completed in person. Case managers are now sending paperwork for physical and digital signatures and tracking the receipt of paperwork. This requires multiple attempts to obtain needed signatures and the member must be tracked for potential closure at the end of the PHE

due to missing documents:

- Maintaining tracking documents to know who has submitted physical or digital and those who have not.
- Increased volume and costs associated with mailing of forms and providing pre-paid return envelopes
- Purchase and implementation of computer software to support digital signatures

- Increased caseloads and tracking for Maintenance of Effort
  - Colorado is requiring CCB's to maintain member eligibility for their waiver program during the public health emergency under the Maintenance of Effort. This action is creating increased caseloads for case management agencies for the duration of the PHE. and requires additional tracking for the CCB on the member who may no longer be eligible for their program but still needs engagement and support outside of the waiver program.
- Rate increases for HCBS services outside of standard annual rate adjustments
  - Prior authorization request (PAR) correction related to the temporary rate increases for residential services
  - Retainer payment authorization
    - Case manager was required to call the member to discuss whether the member wanted other services, coordinate any service changes and receive the member's approval to issue the retainer payment to the provider.
  - Service modality changes
- Service Plan and prior authorization revisions for Day Habilitation. Required member outreach, service plan and PAR revisions.
  - Retainer payment authorization
    Service modality changes - implementation of the individualized 1:1 service option and tiered service flexibility.

The Department amends allowable health care costs for nursing facility cost reports to accommodate emergency workforce changes and efficient distribution:

Attachment 4.19-D, Nursing Facility Benefits, Page 3, Item 14(b) amended to: Non-prescription drugs ordered by a physician; excluding COVID-19 vaccines where Medicaid reimbursement is available directly to a 3rd party.

Attachment 4.19-D, Nursing Facility Benefits, Page 3, Item 14, add new Subpart i.
Effective April 1, 2020 and ending June 30, 2020, salaries, taxes and benefits for unlicensed workers performing healthcare tasks during a public healthcare emergency or declared state of emergency.

Attachment 4.19-D, Nursing Facility Benefits, Class I Health Care State-Wide Maximum

Allowable Per Diem Reimbursement Rates(Limit), Page 22, add new Subpart 7. *Effective April 1, 2020 and ending June 30, 2020, salaries, taxes and benefits for unlicensed workers performing healthcare tasks during a public healthcare emergency or declared state of emergency.*

Attachment 4.19, Payment for Services, Subpart (a), Page 57 (TN# 92-1), describes the methods and standards used to determine rates for payment for inpatient hospital services. The "Inappropriate level of care days are not covered" box is checked. This amendment unchecks that box and checks the box indicating "Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act." The rate will be equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State Plan.

Effective March 1, 2020, COVID-19 drug treatment provided through Emergency Use Authorization are reimbursed at the published Medicare Average Sales Price (ASP) Drug Pricing File minus 3.3 percent for drugs included in that file. EUA drugs that are not included in the Medicare ASP Drug Pricing File will be reimbursed at Wholesale Acquisition Cost (WAC). Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid the 340B purchase price. No professional dispensing fee is applied.

Colorado Medicaid COVID-19 July 2021 Interim Payment to Primary Care Medical Providers Who Provide Integrated Services (July 2021 Interim Payment)

Provider Qualifications

To receive a payment under the July 2021 Interim Payment, the Health Care Provider must meet the following Criteria:

1) A Health Care Provider (Provider) that is any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Colorado Medicaid members and has an active Provider ID that is established as a Primary Care Medical Provider (PCMP) in the Department's MMIS;

2) Enrolled with the Colorado Medicaid Program enrolled as a Physician, Osteopath, School Health Clinic, Family/Pediatric Nurse Practitioner, Clinic – Practitioner, Non-Physician Practitioner, Rural Health Clinic, Indian Health Service – Federally Qualified Health Center, or Federally Qualified Health Center;

3) A Provider that voluntarily contracts with a Regional Accountable Entity (RAE) as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home;

4) Provide services through an integrated services approach that includes physical health and dental services; physical health and behavioral health services, OR another integrated services model approved by the Department;

5) Received payment from Colorado Medicaid (as paid through the Department's MMIS as a Fee-For-Service payment) that was less than $425,000 for Calendar Year 2020 for Claims with Dates of Service and Dates of Payment Between 1/1/2020 – 12/31/2020);and

6) Completes and submits the specified application issued by Colorado Medicaid and attests to the following on that application (only one application per PCMP enrolled Provider ID will be accepted):

    a. The Providers serves a designated Colorado rural area and Colorado Medicaid enrollees make up at least 30% of the Provider's overall patient visits in Calendar Year 2019 OR serves a Colorado urban area and Colorado Medicaid enrollees make up at least 40% of the Providers overall patient visits in Calendar Year 2019;

    b. The Provider will continue to serve through July 1, 2021 through September 30, 2021 at least the same number of Medicaid patients as it did in October 1, 2019 through December 31, 2019;

    c. If the Provider has received COVID-19 relief funding through the federal government, they must attest that the received COVID-19 relief funding does not exceed the providers expected revenue for July 1, 2021 through September 30, 2021;

    d. The Provider will not lay off staff during July 1, 2021 through September 30, 2021; and

    e. The Provider will maintain wages during July 1, 2021 through September 30, 2021 at the existing levels as of date of the application.

Payment Calculation and Reconciliation Process

1) The July 2021 Interim Payment will be made in advance during July 2021 for medical services care that would be expected to be paid during July 1, 2021 through September 30, 2021.

    a. The July 2021 Interim Payment will be calculated as an AVERAGE of four quarterly payments from Colorado Medicaid (as paid through the Department's MMIS as a Fee-For-Service payment) during the period of January-December 2020 (calculated as (2020 Q1 Payments + 2020 Q2 Payments + 2020 Q3 Payments + 2020 Q4 Payments)/4 for claims with Dates of Service 1/1/2020 – 12/31/2020 AND Dates of Payment Between 1/1/2019 – 12/31/2020).

    b. The July 2021 Interim Payment will not exceed $105,000.00 per provider.

    c. If the total of all July 2021 Interim Payments to Providers exceed the total funds available of $1.2 million for the July 2021 Interim Payments, then all July 2021 Interim Payments will be reduced an equal percentage to match the total funds available.

2) The July 2021 Interim Payment will be paid through the Department's MMIS as a Fee-For-Service, lumpsum payment at Colorado's State Plan Rate.

a. One July 2021 Interim Payment will be made to a Provider through their Provider ID that is established as a Primary Care Medical Provider (PCMP) in the Department's MMIS. Providers are prohibited from receiving more than one Interim Payment.

3) During the period July 2, 2021 through September 24, 2021 (adjusted to match the Department's MMIS financial cycle that occurs on a Friday) the Provider will still submit claims but will not receive any fee-for-service payments through the Medicaid Agency (as paid through the Departments MMIS and Fiscal Agent once the July 2021 Interim Payment is made). All claims submitted by the Provider between July 2, 2021 through September 24, 2021 will be processed but all payments will be withheld.

   a. Payments for claims processed but not paid July 1, 2021 through September 30, 2021 will be released on the first MMIS financial cycle in October 2021.

   b. The July 2021 Interim Payment will be reconciled to the Colorado Medicaid payments for services actually provided during the period July 1, 2021 through September 30, 2021.

   c. The reconciliation will be calculated in November 2021 using dates-of-service between July 1, 2021 through September 30, 2021 and for claims paid between July 2, 2021 through October 29, 2021.

   d. The reconciliation process will calculate the difference in federal funds paid to the Provider through the July 2021 Interim Payment and the amount of federal funds that the Provider should have received for dates-of-service between July 1, 2021 through September 30, 2021 and for claims paid between July 2, 2021 January 1, 2021 through October 29, 2021.

   e. The reconciliation process will take into consideration the federal funds paid through the July 2021 Interim Payment calculated at Colorado's State Plan Rate, excluding any enhanced federal fund match authorized through the Family First Act, and the federal match rate that should have been paid based on the patient's eligibility category.

4) The Department will begin in December 2021 the process to recoup any federal funds paid to Providers in excess of what they should have received for dates-of-service between July 1, 2021 through September 30, 2021 and for claims paid between January 1, 2021 through October 29, 2021.

   a. Provider will receive notice of the Department's reconciliation process and calculation in November or December 2021.

   b. Provider will have a 30-day opportunity to appeal any the calculation and federal funds owed.

5) Providers will begin the repayment plan for any federal funds owed in December 2021. The repayment plan will have three options:

a. Providers may submit a check to repay the difference, either as a lump sum (due prior to December 31, 2021) or in four equal quarterly installments with the last payment due by August 31, 2022.

b. The Department will withhold a percentage of the Provider's weekly payment issued through the Department's MMIS such that the federal funds owed will recouped by August 31, 2022.

c. For any amount due but not recouped by August 31, 2022 the Department will take all necessary actions to return the federal funds by September 30, 2022.

6) The July 2021 Interim Payment will be reported on the Department's CMS-64, with the reconciliation performed and federal funds recouped reported no later than the Department's Quarter End September 30, 2022 CMS-64.

***Colorado Medicaid COVID-19 February 2021 Interim Payment to Primary Care Medical ProvidersWho Provide Integrated Services (February 2021 Interim Payment)**

Provider Qualifications

To receive a payment under the February 2021 Interim Payment, the Health Care Provider must meet the following Criteria:

1) A Health Care Provider (Provider) that is any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Colorado Medicaid members and has an active Provider ID that is established as a Primary Care Medical Provider (PCMP) in the Department's MMIS;

2) Enrolled with the Colorado Medicaid Program enrolled as a Physician, Osteopath, School Health Clinic, Family/Pediatric Nurse Practitioner, Clinic - Practitioner, Non-Physician Practitioner, Rural Health Clinic, Indian Health Service - Federally Qualified Health Center, or Federally Qualified Health Center;

3) A Provider that voluntarily contracts with a Regional Accountable Entity (RAE) as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home;

4) Provide services through an integrated services approach that includes physical health and dental services; physical health and behavioral health services; OR another integrated services model approved by the Department.

5) Received a payment from Colorado Medicaid (as paid through the Department's MMIS asa Fee-For-Service payment) that was less than $105,000 for the quarter during the period of October - December 2019 (Claims with Dates of Service 1/1/2019 - 12/31/2019 AND Dates of Payment Between 10/1/2019 - 12/31/2019); and

6) Completes and submits the specified application issued by Colorado Medicaid and attests to the following on that application (only one application per PCMP

enrolled Provider ID will be accepted):

a. The Providers serves a designated Colorado rural area and Colorado Medicaid enrollees, Child Health Plan Plus, and uninsured persons make up at least 30% ofthe Provider's overall patient visits in Calendar Year 2019 OR serves a Colorado urban area and Colorado Medicaid enrollees, Child Health Plan Plus, and uninsured persons make up at least 40% of the Providers overall patient visits inCalendar Year 2019;

b. The Provider will continue to serve through February 1, 2021 through April 30, 2021 at least the same number of Medicaid patients as it did in October **1,** 2019 through December 31, 2019;

c. If the Provider has received COVID-19 relief funding through the federal government, they must attest that the received COVID-19 relief funding does notexceed the providers expected revenue for February 1, 2021 through April 30, 2021;

d. The Provider will not lay off staff during February 1, 2021 through April 30,2021;and

e. The Provider will maintain wages during February **1,** 2021 through April 30,2021 at the existing levels as of date of the application.

Payment Calculation and Reconciliation Process

1) The February 2021 Interim Payment will be made in advance during February 2021 for medical services care that would be expected to be paid during January **1,** 2021 through March 31, 2021.

a. The February 2021 Interim Payment will be calculated as a quarterly payment from Colorado Medicaid (as paid through the Department's MMIS as a Fee-For- Service payment) during the period of January 1, 2021 through March 31, 2021 (estimated as claims with Dates of Service 1/1/2019 - 12/31/2019 AND Dates ofPayment Between 10/1/2019 - 12/31/2019).

a. The February 2021 Interim Payment will not exceed $105,000.00 per Provider.

b. If the total of all February 2021 Interim Payments to Providers exceed the total funds available of $3 million for the February 2021 Interim Payments, then all February 2021 Interim Payments will be reduced an equal percentage to match the total funds available.

2) The February 2021 Interim Payment will be paid through the Department's MMIS as aFee-For-Service, lumpsum payment at Colorado's State Plan Rate.

a. One February 2021 Interim Payment will be made to a Provider through their Provider ID that is established as a Primary Care Medical Provider (PCMP) in the Department's MMIS . Providers are prohibited from receiving more than one Interim Payment, such that they can only receive an October

2020 Interim Payment or a February 2021 Interim Payment.

3) During the period January 1, 2021 through March 31, 2021 the Provider will still submit claims but will not receive any fee-for-service payments through the Medicaid Agency (as paid through the Departments MMIS and Fiscal Agent) once the February 2021 Interim Payment is issued. All claims submitted by the Provider between January **1,** 2021 through March 31, 2021 will be processed but all payments will be withheld once the February 2021 Interim Payment is issued.

   a. Payments for claims processed but not paid during January **1,** 2021 through March 31, 2021 will be released on the first MMIS financial cycle in April 2021.

   b. The February 2021 Interim Payment will be reconciled to the Colorado Medicaid payments for services actually provided during the period January 1, 2021 through March 31, 2021;

   c. The reconciliation will be calculated in August 2021 using dates-of-service between January 1, 2021 through March 31, 2021 and for claims paid between January 1, 2021 through August 6, 2021.

   d. The reconciliation process will calculate the difference in federal funds paid to the Provider through the February 2021 Interim Payment and the amount of federal funds that the Provider should have received for dates-of-service between January 1, 2021 through March 31, 2021 and for claims paid between January 1, 2021 through August 6, 2021.

   e. The reconciliation process will take into consideration the federal funds paid through the February 2021 Interim Payment calculated at Colorado's State Plan Rate, excluding any enhanced federal fund match authorized through the Family First Act, and the federal match rate that should have been paid based on the patient's eligibility category.

4) The Department will begin in September 2021 the process to recoup any federal funds paid to Providers in excess of what they should have received for dates-of-service between January **1,** 2021 through March 31, 2021 and for claims paid between January **1,** 2021 through August 6, 2021.

   a. Provider will receive notice of the Department's reconciliation process and calculation in September 2021.

   b. Provider will have a 30-day opportunity to appeal any the calculation and federal funds owed .

5) Providers will begin the repayment plan for any federal funds owed in the quarter beginning October 2021. The repayment plan will have the following options:

   a. Providers may submit a check to repay the difference, either as a lump sum (due prior to December 31, 2021) or in four quarterly installments with the

last payment due by August 31, 2022.

b. The Department will withhold a percentage of the Provider's weekly payment issued through the Department's **MMIS** such that the federal funds owed will recouped by August 31, 2022.

c. For any amount due but not recouped by August 31, 2022 the Department will take all necessary actions to return the federal funds by September 30, 2022 .

6) The February 2021 Interim Payment will be reported on the Department 's CMS-64, with the reconciliation performed and federal funds recouped reported no later than the Department's Quarter End September 30, 2022 CMS-64.

Section F – Post-Eligibility Treatment of Income

1. ____The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. ____The individual's total income

   b. ____300 percent of the SSI federal benefit rate

   c. ____Other reasonable amount:

2. ____The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needsand the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

The state will provide demonstration that Medicaid (nursing facility) payments for the state fiscal year are within the applicable fee-for-service upper payment limits as defined in 42 CFR 447.272, when the upper payment limit demonstrations are due for the fiscal year. If the demonstration shows that payments for any category have exceeded the upper payment limit, the state will take corrective action as determined by CMS.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of

information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.