DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

March 23, 2022

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

Re: Colorado State Plan Amendment (SPA) 21-0012

Dear Ms. Bimestefer:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Disaster Relief Medicaid State Plan Amendment (SPA) submitted under transmittal number CO 21-0012. This amendment was submitted to add temporary policies, which were different from those policies and procedures otherwise applied under your Medicaid State Plan, during the period of the Presidential and Secretarial emergency declarations related of the COVID-19 outbreak (or any renewals thereof).

During a quality review being conducted by CMS it was discovered that the original approval package sent to Colorado in July 2021 contained an error. The footers on the approved SPA pages showed the SPA was approved July 21, 2121, which was incorrect. CO 21-0012 was approved on July 21, 2021. The enclosed corrected package contains the original signed letter and CMS-179 and the updated SPA pages reflecting the correct approval date.

If you have any questions, please contact Curtis Volesky at (303) 844-7033, or via email at Curtis.Volesky@cms.hhs.gov.

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2022.03.23 18:30:54 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 21, 2021

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

Re: Colorado State Plan Amendment (SPA) 21-0012

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) 21-0012. 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), 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 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 21-0012 is approved effective March 16, 2021. 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, and May 28, 2021, and does not supersede anything approved in those SPAs."

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: 2021.07.21 08:37:27 -04'00'

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: **21–0012**

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 16, 2021**

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: $25,035,317
b. FFY 2022: $8,432,052

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 1-2 and Section E – Payments, pgs 10-17

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 1-2 and Section E – Payments, pgs 10-17 (TN# 21-0005)

10. SUBJECT OF AMENDMENT:

Requests waivers under SSA Section 1135 concerning SPA submission, tribal consultation, and public notice requirements. This SPA will set a reimbursement rate of $41.18 for administration of a dose of a COVID-19 vaccine for the duration of the COVID-19 national emergency.

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 11 October, 2019**

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:
May 4, 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: May 4, 2021

18. DATE APPROVED: July 21, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
March 16, 2021

20. SIGNATURE OF REGIONAL OFFICIAL

[redacted]

21. TYPED NAME
Alissa Mooney DeBoy

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

23. REMARKS

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 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:

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. The Department authorizes a payment of $41.18 for administration of a COVID-19 vaccine.

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

Colorado Medicaid COVID-19 October 2020 Interim Payment to Primary Care Medical Providers Who Provide Integrated Services (October 2020 Interim Payment)

Provider Qualifications

To receive a payment under the October 2020 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 OR physical health and behavioral health services, as documented through claims submitted to the Colorado Medicaid Agency;

5) Received a payment from Colorado Medicaid (as paid through the Department's MMIS as a Fee-For-Service payment) that was less than $70,000 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 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 October 1, 2020 through December 31, 2020 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 October 1, 2020 through December 31, 2020;

d. The Provider will not lay off staff during October 1, 2020 through December 31, 2020; and

e. The Provider will maintain wages during October 1, 2020 through December 31, 2020 at the existing levels as of date of the application.

Payment Calculation and Reconciliation Process

1) The October 2020 Interim Payment will be made in advance during October 2020 for medical services care that would be expected to be paid during October 1, 2020 through December 31, 2020.

    a. The October 2020 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 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)

    b. The October 2020 Interim Payment will not exceed $70,000.

2) The October 2020 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 October 2020 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 October 2020 Interim Payment.

3) During the period October 5, 2020 through December 31, 2020 (adjusted to match the Department's MMIS financial cycle) 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). All claims submitted by the Provider between October 5, 2020 through December 31, 2020 will be processed but all payments will be withheld.

4) Payments for claims processed but not paid during October 5, 2020 through December 31, 2020 will be released on January 8, 2021 MMIS financial cycle.

5) The October 2020 Interim Payment will be reconciled to the Colorado Medicaid payments for services actually provided during the period October 5, 2020 through December 31, 2020.

    a. The reconciliation will be calculated in August 2021 using dates-of-service between October 5, 2020 through December 31, 2020 and for claims paid between January 1, 2021 through August 6, 2021.

    b. The reconciliation process will calculate the difference in federal funds paid to the Provider through the October 2020 Interim Payment and the amount of

federal funds that the Provider should have received for dates-of-service between October 5, 2020 through December 31, 2020 and for claims paid between January 1, 2021 through August 6, 2021.

c. The reconciliation process will take into consideration the federal funds paid through the October 2020 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.

6) 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 October 5, 2020 through December 31, 2020 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.

7) Providers will begin the repayment plan for any federal funds owed in October 2021. The repayment plan will have two 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.

Colorado Medicaid COVID-19 February 2021 Interim Payment to Primary Care Medical Providers Who 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 as a 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% of the 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 in Calendar 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 not exceed 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 of Payment Between 10/1/2019 - 12/31/2019).

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

c. 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 a Fee-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 needs and 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.