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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 21-0023

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS Form 179
- 3) Approved SPA Pages

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



August 11, 2021

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

Re: Colorado State Plan Amendment (SPA) 21-0023

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) 21-0023. 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.

The State of Colorado 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 of the requirements related to 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 21-0023 is approved effective June 1, 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, May 28, 2021, and July 21, 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.

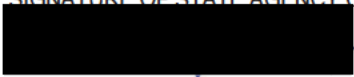
Sincerely,

**Alissa M.
Deboy -S**

 Digitally signed by Alissa
M. Deboy -S
Date: 2021.08.11
07:30 38 -04'00'

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

Enclosures

<p align="center">TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</p> <p>FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES</p>		1. TRANSMITTAL NUMBER: 21-0023	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: June 1, 2021	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS A NEW PLAN X AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Social Security Act Section 1905(a)(19) and Section 1135 / 42 CFR 440.169		7. FEDERAL BUDGET IMPACT: a. FFY 2021: \$628,235 b. FFY 2022: \$0	
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 –Pages 1-2 and Section E – Payments, Pages 10-18		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Section 7 – General Provisions – Item 7.4 – Medicaid Disaster Relief for the COVID-19 National Emergency –Pages 1-2 and Section E – Payments, Pages 10-17 (TN 21-0012)	
10. SUBJECT OF AMENDMENT: Requests waivers under SSA Section 1135 concerning tribal consultation and public notice requirements. This SPA provides a one-time per member per month COVID-19 workload targeted case management payment in consideration for additional workload imposed on case managers in response to the COVID-19 public health emergency above and beyond the usual per member per month scope of work. Case management agencies will receive an additional \$78 per adult waiver member and \$64.47 per children’s waiver member.			
11. GOVERNOR’S REVIEW (<i>Check One</i>): 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: 		16. RETURN TO: Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 Attn: Amy Winterfeld	
13. TYPED NAME: Tracy Johnson			
14. TITLE: Medicaid Director			
15. DATE SUBMITTED: May 14, 2021			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED May 14, 2021		18. DATE APPROVED August 11, 2021	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL June 1, 2021		20. SIGNATURE OF REGIONAL OFFICIAL Alissa M. Deboy -S <small>Digitally signed by Alissa M. Deboy -S Date: 2021.08.11 07:31:14 -04'00'</small>	
21. TYPED NAME Alissa Mooney DeBoy		22. TITLE On Behalf of Anne Marie Costello, Deputy Director, CMCS	
23. REMARKS State approved changes: Box 8 to correct pg numbers; box 9 to correct pg numbers and TN; box 10 to reflect 1135 waivers requested.			

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

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

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective dated during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. 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. 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. 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. 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 COVID-19 vaccine.

The Department will issue a one-time per member per month COVID-19 increased workload payment for intellectual and developmental disabilities targeted case management 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.

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;

TN: 21-0023

Supersedes TN: 21-0012

Approval Date: 08/11/2021

Effective Date: 06/01/2021

- 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
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Supersedes TN: 21-0012 Effective Date: 06/01/2021

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.

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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 Services – 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) Receive 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 on 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.