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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 22-0045

This file contains the following documents in the order listed:

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



February 24, 2023

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

Re: Colorado State Plan Amendment (SPA) CO-22-0045

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) 22-0045. 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.

These waivers or modifications of the requirements related to SPA submission timelines and public notice 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 22-0045 is approved effective July 1, 2022. This SPA is in addition to all previous approved Disaster Relief SPAs, 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,

Courtney L.
Miller -S

Digitally signed by
Courtney L. Miller -S
Date: 2023.02.24
08:06 07 -06'00'

Courtney Miller
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 2 — 0 0 4 5</u>	2. STATE <u>CO</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2022
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5. FEDERAL STATUTE/REGULATION CITATION Social Security Act, Section Title XIX and Section 1135	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2022</u> \$ <u>1,356,106</u> b. FFY <u>2023</u> \$ <u>0</u>
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7. 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 8-22 of 22	8. 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 8-20 of 20 (TN# 22-0013)
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9. SUBJECT OF AMENDMENT
Requests waivers under SSA Section 1135 concerning SPA submission and public notice requirements and would add a Nursing Facility Hospital Discharge Supplemental Payment payment.

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

OTHER, AS SPECIFIED:
Governor's letter dated 24 September 2022

12. TYPED NAME Bettina Schneider	15. RETURN TO Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 Attn: Amy Winterfeld
13. TITLE Chief Financial Officer	
14. DATE SUBMITTED November 29, 2022	

FOR CMS USE ONLY

16. DATE RECEIVED November 29, 2022	17. DATE APPROVED February 24, 2023
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2022	19. SIGNATURE OF APPROVING OFFICIAL Courtney L. Miller -S <small>Date: 2023.02.24 08:06:29 -06'00'</small>
20. TYPED NAME OF APPROVING OFFICIAL Courtney Miller	21. TITLE OF APPROVING OFFICIAL On Behalf of Anne Marie Costello, Deputy Director, CMCS

22. 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. 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.

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:

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.

Increase to state plan payment methodologies:

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

<i>Please list all that apply.</i>
Effective April 1, 2020, and ending June 30, 2020, for Nursing Facilities and ICF/IIDs; and again effective January 1, 2021, and ending June 30, 2021, for Nursing Facilities; and again effective April 1, 2022, and ending June 30, 2022 for Nursing Facilities 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, \$ \$1831.06.
Attachment 4.19-B, Methods and Standards for Establishing Payment Rates – Other Types of Care, Outpatient Hospital Services, Page 2d of 6 (TN# 18-0039), Item 2, increase the net invoice cost the Department will pay providers for Outpatient Hospital Physician Administered Drugs from 72% to 90% of the net invoice cost, effective February 26, 2022.
The Department shall pay a one-time supplemental payment to Class 1 nursing facility providers (Nursing Facility Hospital Discharge Supplemental Payment) for costs incurred admitting individuals from hospitals or the Department of Corrections during the COVID-19 Pandemic.

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

<i>Please describe criteria.</i>
Facilities facing atypical staffing shortages and infection control related expenses due to a public health emergency or declared state of emergency
April 1, 2022 – June 30, 2022 Nursing Facility payments are for facility staffing supports, and facilities with high Medicaid utilization rates and disproportionately high complex care populations.
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.

This change allows the Department to increase reimbursement to hospitals for select Outpatient Hospital Drugs in order to not exacerbate any financial strains resulting from the public health emergency.

Nursing Facility Hospital Discharge Supplemental Payment--the per-Medicaid discharge rate will equal an amount such that the total payment made to all Class 1 nursing facility providers will equal \$2,413,000. The per-Medicaid discharge rate for complex discharges will be increased by a multiplier.

Medicaid discharges are equal to Medicaid residents discharged from a hospital or the Department of Corrections during the period May 1, 2022 through June 30, 2022.

A complex discharge is a discharge for a Medicaid resident with a PASRR II designation and/or Medicaid resident deemed too difficult to place.

b. Payments are increased through:

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

One-time payments based on Medicaid utilization. For April 1, 2022 – June 30, 2022 Nursing Facility payments: one time payments based on Medicaid utilization, and facilities with high Medicaid utilization rates and disproportionately high complex care populations.

Specifically, the Department will make a one-time payment totaling \$17,588,000 to facilities proportionally based on Medicaid utilization. Each facility's share will be calculated by dividing their total Medicaid patient days from January 1, 2021-December 31, 2021 by the Statewide total Medicaid days from January 1, 2021- December 31, 2021. Payments will be limited to the available room under the Upper Payment Limit.

Additionally, the Department will make a one-time payment totaling \$7,000,000 to qualifying facilities. Qualifying facilities must meet both of the following conditions:

1. Medicaid resident count is equal to or greater than 90% of total resident count. Medicaid resident count and total resident count determined using the most recently finalized quarterly case mix index (CMI) report.
2. Preadmission Screening & Resident Review (PASRR) II Medicaid resident count is greater than the statewide average PASRR II Medicaid resident count, plus one standard deviation. PASRR II Medicaid resident count determined using the most recently completed comprehensive minimum data set (MDS) resident assessment for calendar year 2021.

Each qualifying facility will receive a payment equal to \$7,000,000 divided by the total number of qualifying facilities. Payments will be limited to the available room under the Upper Payment Limit.

The Nursing Facility Hospital Discharge Supplemental Payment will only be made if there is available federal financial participation under the Upper

Payment Limit after all other nursing facility provider MMIS and supplemental payments are considered

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. An increase to rates as described below.

Rates are increased:

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; increase payment from 72% of net invoice cost for Outpatient Hospital Physician Administered Drugs to 90% of the net invoice cost. _____

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.

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. This change allows the Department to increase reimbursement to hospitals for select Outpatient Hospital Drugs in order to not exacerbate any financial strains resulting from the public health emergency.

Payment for services delivered via telehealth:

TN: 22-0045
Supersedes TN: 22-0013

Approval Date: 02/24/2023
Effective Date: 07/01/2022

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.
- e.

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 telehealth is 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. 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 authorizes a payment of \$61.77 for administration of the COVID-19 vaccine, for each of the initial doses and for subsequent boosters, and an additional \$35.00 for vaccine administration within the member's home or residence.

Attachment 4.19-B – Methods and Standards for Establishing Payment Rates – Federally Qualified Health Center (FQHC) Services, Pages I-A to I-I, establishes the reimbursement methodology for FQHCs. Effective with dates of service starting February 21, 2021 through the end of the Public Health Emergency, through this APM, the Department authorizes FQHCs to receive an additional reimbursement at the fee schedule amount for the administration of COVID-19 vaccines by staff who have authority under state law to administer the COVID-19 vaccine and are covered under Colorado Medicaid's State Plan. Payments under this APM are to cover the additional costs associated with the administration of COVID-19 vaccines by FQHCs, as the PPS cost base for FQHCs did not include these costs. The supplemental amount paid under this APM for COVID-19 vaccine-only visits is the CO Fee Schedule rate for COVID-19 vaccine administration and PPS plus the CO Fee Schedule rate when COVID-19 vaccine administration is provided alongside a PPS eligible service. This alternative payment methodology will be agreed to by the Department and the FQHC and will reimburse, in total, an amount that is no less than what would be paid under PPS.

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.

Effective December 23, 2021, Remdesivir treatment provided in the outpatient setting shall be reimbursed at the published Medicare Average Sales Price (ASP) Drug Pricing File minus 3.3 percent for drugs included in that file. If remdesivir is not included in the Medicare ASP Drug Pricing File, we will reimburse 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;

Provide services through an integrated services approach that includes physical health

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Approval Date: 02/24/2023

Supersedes TN: 22-0013

Effective Date: 07/01/2022

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:

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- 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 be 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 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).
 - 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 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 FamilyFirst 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 be 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

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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.