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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 24-0034

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

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

Financial Management Group

January 6, 2025

Adela Flores-Brennan
State Medicaid Director
Colorado Department of Health Care
Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

RE: TN 24-0034

Dear Adela Flores-Brennan:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Colorado state plan amendment (SPA) to Attachment 4.19-A and 4.19-B, CO 24-0034, which was submitted to CMS on December 9, 2024. This plan amendment adds authority for the state to negotiate higher reimbursement rates with certain out of state providers.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 and 1923 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of December 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan page.

If you have any additional questions or need further assistance, please contact Fred Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

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: 24 — 0034

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. § 447.201(b)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att 4.19-A - I. Methods and Stand. for Est. Prosp. Pay. Rates - IP Hosp.Serv. (pp. 8-9a)
Att 4.19-B - Item 2.a OP Hosp (p. 2d of 6) and Item 5.a Phys Serv (pp 1-20 of 20)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att 4.19-A - I. Methods and Stand. for Est. Prosp. Pay. Rates - IP Hosp.Serv. (pp 8-9, TN 21-0016, 23-0002)
Att 4.19-B - Item 2.a OP Hosp (p. 2d of 6, TN 23-0043) and Item 5.a Phys Serv (pp. 1-19 of 19, TN 24-0008)

9. SUBJECT OF AMENDMENT
Adds authority for the state to negotiate higher reimbursement rates, with out-of-state inpatient hospitals, outpatient hospitals, or physicians, through single case agreements for services not available in Colorado.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Governor's letter dated 5 April 2023

[redacted]

12. TYPED NAME
Adela Flores-Brennan

13. TITLE
Medicaid Director

14. DATE SUBMITTED
December 9, 2024

15. RETURN TO
Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Suite 1100
Denver, CO 80203

Attn: Russ Zigler

FOR CMS USE ONLY

16. DATE RECEIVED
12/9/2024

17. DATE APPROVED
January 6, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
12/1/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

f. Effective July 1, 2003 all adjustments outlined in number 2. of this section (Adjustments To The Payment Formula) are suspended.

3. Effective January 1, 2020, long-acting reversible contraceptive (LARC) devices, inserted following a delivery, will be excluded from the DRG relative weight calculation and will be paid according to Fee Schedule as determined by the Department of Health Care Policy and Financing. All rates can be found on the official website www.colorado.gov/hcpf.

4. Effective January 1, 2023, payment for take-home Naloxone (opioid antagonist) dispensed by a hospital upon discharge to members deemed at risk of opioid-related overdoses are excluded from the DRG relative weight calculation and will be paid according to the physician administered drugs payment methodology under subjection M of the Pharmaceutical Services reimbursement pages, at Attachment 4.19-B -- Methods and Standards for Establishing Payment Rates – Item 12.a.M -- Pharmaceutical Services. All rates can be found on the official Department website www.colorado.gov/hcpf.

E. Adjustments For Exempt Providers

1. Exempt hospitals will receive annual modifications to per diem rates based on inflationary adjustments as determined by the Medicare Economic Index. In no case shall the per diem rate granted to an exempt hospital exceed the facility's allowable Medicaid cost per day.

2. Effective October 1, 2001, government-owned mental health institutes shall receive annual modifications to the per diem rates. The rates shall be established to cover 100 percent of the total allowable cost to treat Medicaid clients. Payments are calculated using interim rates and later adjusted to a final rate, as described below:

a. Interim Rates. The Colorado Department of Human Services (CDHS) files by November 30 of each year (5 months before the end of the fiscal year) the Medicare cost report for the state mental health institutes. CDHS calculates the interim per diem rates using a 9-month cost report that is identical to the first portion of the Medicare cost report. CDHS divides the total allowable costs (contained in the report) by the number of patient days for each unit in the mental health institutes. Once the CDHS Director of Hospital Services approves this report, the rates are sent to the Department, where the educational component of the rate is "carved out" and the resulting interim rates are put into the MMIS with an effective date of July 1.

b. Final Rates and Reconciliation. A Medicare audit is initiated after the Medicare cost report is submitted. Once the Medicare audit is complete, CDHS files the Medicaid cost report, a state-developed report based on the 2552 with some minor adjustments. The state mental health institutes must file the Medicaid cost report four months after the Medicare audit is finalized. The Department initiates the Medicaid audit once the Medicaid cost report has been filed and the Department

c. has access to the necessary expenditure summary data from the MMIS. After the Medicaid audit has been completed, the Department calculates retroactive per diem rates for each of the units in the mental health institutes. These are the state's final rates and are used to compete the cost settlements.

3. Exempt hospitals are eligible for the Major Teaching Hospital and Disproportionate Share Payments.

F. Adjustments For In-State and Out-of-State Providers

1. Out-of-State Providers

a. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid patient must be prior authorized by the Department, based upon review and recommendation by the Peer Review Organization (PRO).

b. Payment for out-of-state and non-participating Colorado Hospital inpatient services shall be at a rate equal to 90% of the average Colorado Urban or Rural DRG payment rate. Out-of State urban hospitals are those hospitals located within the Metropolitan Statistical Areas (MSA) as designated by the U.S. Department of Health and Human Services.

c. Effective December 1, 2024, the Department may negotiate a higher reimbursement rate for out-of-state hospital services in accordance with single case agreements under the following circumstances:

i. The hospital services are not available in Colorado;

ii. The hospital services must be prior authorized;

iii. The member's physician may suggest where the member should be sent, but the medical consultant for the Department is responsible for making the final determination based on the most cost-effective institution consistent with quality of care

The reimbursement rate for out-of-state hospital services in accordance with single case agreements will be negotiated between the Department and the out-of-state facility providing the services. When negotiating the rate, the Department will take into consideration the following:

i. The actual costs of the facility;

ii. The Medicare rate for the same or similar services, if any; and,

iii. The Medicaid rate for the same or similar services in the state where the

facility is located, when available.

The reimbursement rate for out-of-state hospital services in accordance with single case agreements may not exceed the usual and customary charges of the facility for such services.

2. In-State Providers

a. The Department will negotiate a higher reimbursement rate—no greater than 100% of the costs anticipated by the hospital—for in-state inpatient hospital services regardless of ownership (public or private) where, as determined by the Department, all of the following conditions are fulfilled:

i. The in-state inpatient payment methodology insufficiently accounts for the level of acuity. Hospitals must provide evidence demonstrating the inpatient methodology is insufficient, including but not limited to an anticipated cost report for Department review. The Department will negotiate a higher reimbursement up to, but no more than, 100% of the hospital's anticipated costs.

ii. All other placement options have been exhausted.

iii. The service has been reviewed and prior authorized by the medical consultant for the Department

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

5.a. PHYSICIAN SERVICES

Physician services provided by physicians, podiatrists, and optometrists shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Physician services fee schedule as determined by the Department of Health Care Policy and Financing.

    a. The Health First Colorado fee schedule includes all services. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page.
    b. Alternative Payment Mode (APM) Code Set. Quality based adjustments to services in this code set are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page.
        i. Primary Care Medical Providers (PCMP) are identified as a billing entity at a single location for services, not individual providers.
        ii. Colorado Medicaid's Accountable Care Collaborative (ACC) divides the state into seven regions. Colorado's single State agency for administering Medicaid (the Department) contracts with a Regional Accountable Entity (RAE) in each region that is accountable for coordinating both physical health and behavioral health for its enrolled clients. Clients are mandatorily enrolled in the ACC and connected with a PCMP. The geographical location of a client's attributed PCMP determines the client's RAE assignment.
        iii. Provider Qualifications: Participating PCMPs are the subset of PCMPs having 500 or more attributed enrollees.
            1. A PCMP with fewer than 500 attributed enrolles may petition the Department to become a participating PCMP. The Department will grant the petition if it judges that there is sufficient baseline data to adequately measure quality performance.
            2. A PCMP having 500 or more attributed enrollees may petition the Department to not become a participating PCMP. The Department will grant the petition if it judges that there is insufficient baseline data to adequately measure quality performance. The Department

assumes that it will routinely grant petitions submitted by providers new to the practice of medicine or who are newly entering participation in the medical assistance program.

iv. Participating PCMPs will be paid in accordance with paragraph 5.a.2.b in the September to October timeframe following the completion of the performance period.

v. Effective October 2022, participating PCMPs will receive a rate adjustment based on measure and quality performance. However, that adjustment shall not result in rates less than Health First Colorado fee schedule less 4%.

vi. The APM Code Set Timeline. According to the following timeline, the Department will change payment for procedure codes in the APM Code Set based on a quality modifier determined by the PCMP's performance on quality measures in a completed program year. A program year is aligned with a calendar year.

1. The baseline for quality performance measures is defined as the most recent program year that has been completed prior to the start of the next program year.
2. PCMPs participating in the ACC, having 500 or more attributed ACC enrollees, or PCMPs with less than 500 ACC enrollees who have petitioned the Department to become a participating PCMP and such petition has been granted by the Department, will select quality measures through an online tool at https://hcpf.colorado.gov/value-based-payments. PCMPs may select their quality measures through January 31, 2022 and each January 31 thereafter; this deadline may be extended by the Department for good cause.
3. An APM quality modifier will be calculated by the Department of Health Care Policy and Financing no later than August 31 of each year for each PCMP based on the PCMP's performance on the selected quality measures in the previous calendar year.
4. Each PCMP will receive a letter with their quality modifier prior to October 1, 2022 and each October 1 thereafter. If the Department is delayed in calculating the quality modifier, or in sending notification to the providers, payment will follow the Health First Colorado fee schedule at paragraph 5.a.2.a.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

5. Effective October 1, 2022, a change in payment for procedure codes in the APM Code Set will be made for PCMPs that participated in program year 2021 (January 1 – December 31, 2021). Every October 1 thereafter a PCMP will be notified of a change in payment based on the previous program year.

vii. Effective for dates of service provided on or after October 1, 2022, and each October 1 thereafter, the quality modifier will adjust, for PCMPs participating in the APM, rates for services within the APM Code Set. The quality modifier may reduce rates for services within the APM Code Set to less than the Health First Colorado fee schedule. The quality modifier may increase payment for APM Code Set services relative to the Health First Colorado fee schedule; however, increases above the Health First Colorado fee schedule shall be, in aggregate, budget neutral relative to APM Code Set service rates for PCMPs that are adjusted to be below the Health First Colorado fee schedule. Increases or decreases in provider rates will be made annually each October 1, through provider specific changes.

1. The quality measures are available on the Department's website at https://hcpf.colorado.gov/value-based-payments.
2. Procedures for the APM are explained on the Department's website at https://hcpf.colorado.gov/value-based-payments.
3. The Department will provide a web-based tool at https://hcpf.colorado.gov/value-based-payments that PCMPs can use to determine the APM rate for each procedure code in the APM Code Set using the PCMP's quality modifier.

c. Prospective Payments and Incentive Payments to Non-Federally Qualified Health Center Primary Care Medical Providers. The payment methodologies described below are effective for services on or after January 1st, 2022.

i. Definitions

1. Alternative Payment Methodology Program Notification Letter (Notification Letter): A letter sent to an eligible PAP with the following factors: Fee for Service Percentage, Partial Prospective Payment, and the Commendable Threshold defined below. The Notification Letter shall also include rate effective beginning and end dates.
2. Alternative Payment Methodology Program Notification Letter Response (Response Letter): The written response from a PAP affirming the Participating Physicians that are part of that PAP will

receive payment pursuant to the calculations described in this Section 5.a.2.c of this Attachment to 4.19B of this state plan, instead of receiving payment for services as otherwise provided for in this State Plan under Section 5.a.2.a and 5.a.2.b of the Attachment. The Department will only make payment under this Section 5.a.2.c if it receives affirmation from that PAP through this Response. The Response must be received ten business days prior to the start of the Rate Effective Period by returning a copy of the Alternative Payment Methodology Program Notification Letter signed by the PAP representative.

3. Commendable Threshold: A prospectively determined, PAP specific, cost benchmark that must be met, as described below, in order for a PAP to earn an incentive payment.
4. Fee for Service Percentage: The percentage amount that is multiplied by the rate in the Health First Colorado fee schedule. This percentage is proposed by the PAP for each of its Participating Physicians. The Fee for Service Percentage, and the effective dates for that percentage, is memorialized in the Notification Letter sent by the Department to the PAP and must be affirmed by that PAP through the Response Letter. A PAP can change their Fee for Service Percentage by providing the Department with written notice via submission of a new Response Letter.
5. Historical Data Period: Effective January 1, 2024, claims experience from July 1, 2021 to June 30, 2022 will be used in the calculation of the Commendable Threshold. Partial Prospective Payments calculated before February 1, 2024 will utilize claims experience from the period of July 1, 2018 to June 30, 2019. Effective February 1, 2024, a blend of claims experience from July 1, 2018 to June 30, 2019 and July 1, 2021 to June 30, 2022 will be used in the calculation of the Partial Prospective Payment. To ensure that the historical data used in rate calculation is appropriate to the payment methodology used during the rate effective period, patients that are attributed to the PAP during the historical period, but that have eligibility for Medicare or who are geographically attributed, are excluded.
6. Incentive Payment: An upside only incentive payment made to PAPs to incentivize chronic care management. The methodology

for the payment is defined below.

7. Modified APM Code Set: The code set that is included in the Historical Data Period for setting the Prospective Partial Payment rate. Also, the Modified APM code set is subject to the Fee forService Percentage during the rate effective period. The Modified APM code set is identical to the APM code set that is considered in Section 5.a.2.b of Attachment 4.19B of this state plan, except services that are defined as family planning are excluded. The medical assistance program excludes Long Acting Reversible Contraceptive codes from the Partial Prospective Payment calculation out of an abundance of caution to ensure unambiguously that Qualified Patients have free choice of all qualified and willing providers of those Long Acting Reversible Contraceptive services as provided for in 42 CFR 431.51.
8. Participating Physician:
    a. A physician that both:
        i. Has a primary care taxonomy as listed here: https://hcpf.colorado.gov/alternative-payment-model-2-apm-2
        ii. Renders services under the Modified APM code set where the billing provider for those services has the same taxpayer identification number as the PAP.
    b. Advance Practice Providers, acting under physician supervision as provided for in Colorado licensing statute, are included in the provisions of these 5.a.2.c pages for the purposes of payment and quality measurement.
9. Principal Accountable Provider (PAP): A PAP is a Primary Care Medical Provider (PCMP) in a physician practice that meets the eligibility criteria established in section 5.a.2.c.ii below.
10. Partial Fee for Service Payment: For the services included in the Modified APM Code Set provided by the Participating Physician to Qualifying Patients, the Participating Physician will receive a discount (Fee for Service Percentage) to the allowable amounts that would have been paid under the Health First Colorado fee schedule, for the subset of those codes that are included in the Modified APM Code Set. The Fee for Service Percentage is included in the

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Alternative Payment Methodology Program Notification Letter. Codes that are in the APM Code Set as defined in 5.a.2.b but that are not part of the Modified APM Code Set are not subject to the Fee for Service Percentage.

11. Partial Prospective Payment: An advance payment for some or all of the fee-for-service revenue that a PAP would have received due to the reduction in payment due to the acceptance of a Fee for Service Percentage. The Partial Prospective Payment is equal to the prospectively calculated estimate of the cost of the Modified APM Code Set for Qualifying Patients, times 100% minus the Fee for Service Percentage. For example, if a PAP chooses a Fee for Service Percentage of 0% that would mean the PAP is taking 100% of their calculated Partial Prospective Payment. To compensate for the reduction in payment for the Modified APM Code Set as provided for in the Partial Fee for Service Payment, the PAP will receive a monthly payment for each of the PAP's Qualifying Patients. That payment is prospectively calculated to be an equitable replacement to the forgone revenue of the PAP due to the acceptance of the Partial Fee For Service Payment. However, as that Partial Prospective Payment is paid prospectively, it may be greater than, less than, or equal to the revenue foregone as compared to the payments that could have been made under the codes in the Modified APM Code Set as provided for in Section 5.a.2.b of this Attachment 4.19B of this State Plan. The Partial Prospective Payment amount is included in the Alternative Payment Methodology Program Notification Letter.
12. Performance Year: A calendar year containing one or more Rate Effective Periods, as provided for in one or more Response Letters.
13. Qualifying Patients: The subset of medical assistance beneficiaries that are attributed to the PAP (as described below), excluding those that are assigned to the PAP on the basis of geographical attribution and excluding those who are eligible for Medicare. The Participating Physician's Qualifying Patients will change on an ongoing basis because of new patient attribution to the PAP, removal of patients from the list of those attributed to the PAP, change in attribution reason, and either gain or loss of dual Medicare and Medicaid enrollment. Furthermore, any beneficiary who receives Modified APM Code Set services as a benefit

defined in a CMS approved risk contract is not a Qualifying Patient during periods of enrollment in that risk contract.

14. Quality Threshold: The quality score that must be achieved that allows the PAP to earn Incentive Payments. Also, comparison of the Quality Threshold to actual quality measured during the Performance Year is the first step in the Reconciliation Methodology.
15. Rate Effective Period: The period of time between the rate effective beginning and end dates, contained in the Alternative Payment Methodology Program Notification Letter, and affirmed by a PAP in an Alternative Payment Methodology Program Notification Letter Response, where the reimbursement methodology provided for in this Section 5.a.2.c of this Attachment 4.19B of the State Plan is in effect. The Rate Effective Period may be different for each PAP. Rate Effective Periods can begin each quarter within a Performance Year and will be effective until the PAP terminates their participation, or a new Rate Effective Period is outlined in a subsequent quarter. At the beginning of each Performance Year a new Rate Effective Period will begin, and a new Alternative Payment Methodology Program Notification Letter and Response will be generated. Also, a Rate Effective Period ends the day prior to a new Rate Effective Period begin date, as provided for in a subsequent Rate Effective Period and memorialized in a Response Letter. Reasons for a Rate Effective Period after the initial Rate Effective Period within a Performance Year may include, but are not limited to, changes provided for a CMS approved State Plan Amendment that include benefit or rate changes to the Modified APM Code Set.

ii. PAP Participation

1. A PAP must meet the criteria established in section 5.a.2.b.iii of this Attachment and participate in that quality measurement program. As described below, the Partial Fee for Service Payment and the Partial Prospective Payment are subject to adjustment based upon quality performance.

    a. A PAP must have 500 or more ACC attributed enrollees. If a PAP with less than 500 enrollees wishes to join the program, they must opt into the Alternative Payment model track one Quality

Threshold outlined in section 5.a.2.b in order to receive the Partial Prospective Payment and Incentive Payments.

b. A PAP must be an established PCMP in the ACC in the state of Colorado. This program is applicable statewide.

c. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are excluded from being eligible to participate.

d. A PAP can also be a group of PCMPs sharing a tax ID if the grouping together in a pool supports improved data quality or statistical credibility.

A Notification Letter Response must be signed by the PAP Representative for that PCMP to be qualified as a PAP. This Response Letter memorializes the PCMP's agreement to be a PAP and memorializes agreement with the terms of that Response Letter.

iii. Partial Prospective Payment

1. The PAP will receive a monthly payment for each Qualifying Patient for services rendered under the Modified APM Code Set.

a. The rate of payment is prospectively calculated by the Department's actuaries using Historical Data Period experience and the PAP's Qualifying Patients during that Historical Data Period that would have met the criteria for being a Qualifying Patient during that period. The calculation includes all services included in the Modified APM Code Set for all physician services where the billing provider shares a tax ID with the PAP and where the rendering provider has a primary care taxonomy.

b. This rate of payment will reflect an aggregate rate that is appropriate for the PAP's Qualifying Patients, indicative of the PAP's population mix and the expected utilization differences between the historical data period and the Rate Effective Period. The PAP's historical experience will be used to inform the actuarial modeling and to determine a reasonable estimate surrounding member distribution across the population cohorts resulting in the Partial Prospective Payment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

c. The rate calculated by the Department is effective for the Rate Effective Period and is agreed to by the PAP in the Notification Letter Response.
d. The Partial Prospective Payment will be recalculated for the PAP before the start of a new performance year and will be memorialized through a new Notification Letter Response which creates a new Rate Effective Period.
e. The rate calculation includes a proration based upon the Fee for Service Percentage. The rate calculation includes a step where the total amount is multiplied by 100% minus the Fee for Service Percentage. Choosing a Fee for Service Percentage of 0% would mean that the PAP will receive the full Partial Prospective Payment for their Qualifying Patients at the beginning of the month and will receive no fee for service payment. Choosing 100% would mean that the PAP will not receive a Partial Prospective Payment at the beginning of the month and therefore the PAP's Participating Physicians will continue to receive fee for service payments as provided for otherwise in this Attachment. However, in that case the PAP would still be eligible for an Incentive Payment, as described below.

2. Adjustments

a. Provider-Specific Adjustments. Historic claims data is used which comes from the Department's MMIS system, reflecting actual adjudicated and paid claims to providers. Historic detailed Medicaid eligibility files for the same time period as the claims data are also used to ensure the member was eligible at the time of service, and to determine their final eligibility group for purposes of the Partial Prospective Payment development and Incentive Payment thresholds. The populations excluded are those members who are dually eligible for both Medicaid and Medicare, and members who are geographically attributed to a provider based on the Department's attribution methodology. The data is first adjusted to account for any additional incurred but not reported (IBNR) services to ensure a fully completed dataset was used as the starting point. The IBNR adjustments were calculated using data

from the Historical Data Period, employing standard actuarial reserve setting techniques. This approach results in IBNR factors for each incurred month based on the number of months of claims runout related to that incurred month. These factors are applied at the monthly level to each provider's historic data and aggregated based on their actual historic utilization of Modified APM Code Set services. The final base rate for each PAP is then categorized into separate rates for six demographic categories of aid (COA), based on age, sex, and health status. These include: healthy adult female, healthy adult male, disabled adult female, disabled adult male, healthy child, disabled child and the final rate is a weighted average based on the most recent available distribution of a PAP's Qualifying Patients prior to the start of a Performance Year. The base data Partial Prospective Payment is then trended forward to account for anticipated changes in service mix and utilization levels. Trend factors will be developed consistent with generally accepted actuarial principles and practices. The prospective trend factors will be calculated based on the same historic detailed fee for service data underlying the development of the Partial Prospective Payment. This data will be stratified by the same six categories of aid (COA) and split between utilization and unit cost which make up the two components of the overall Partial Prospective Payment. The data will then be arrayed such that 3-month moving averages (MMA), 6 MMA, and 12 MMA could be calculated. These resulting averages will be evaluated and weighted to best reflect the expected prospective annual trend. There is not a pre-determined algorithm related to the weighting; it was based on each data extracts' results and varied depending on particular nuances within each year and population. The trended Partial Prospective Payment is then adjusted for any changes in fee schedule that were effective from the base period, to the Performance Year.

b. Statistical Credibility and Adjustment Using Statewide

Pooled Data. The statistical credibility of each PAP's specific attributed membership volume was considered before calculating a final aggregated Partial Prospective Payment. This was done by first calculating a minimum threshold for full credibility, using the standard full credibility formula. This formula is widely accepted for use in actuarial credibility analytics. This threshold was determined to be 1,600 members for the initial year, based on the Historical Data Period data used for the Partial Prospective Payment development. Any PAP that had attributed membership below 1,600 members in aggregate was blended with a statewide Partial Prospective Payment calculation. A partial credibility formula was then used, which assigns credibility percentages to PAP's historic Partial Prospective Payment data equal to the square root of the ratio of the PAP's members to the full credibility number of 1,600 members. This means that a PAP with 500 members will have a lower statistical credibility percentage than a PAP with 1,500 members. In that example, the PAP with 500 members would therefore receive a higher proportion of the statewide average blended with their historic data than the PAP with 1,500 members. The blending used is based on the partial credibility percentage for that provider applied to their historic Partial Prospective Payment data, and the compliment of the providers partial credibility percentage, relative to 100%, is applied to the statewide Partial Prospective Payment. If a PAP was above 1,600 members in aggregate, no credibility adjustment was necessary. The statewide Partial Prospective Payment was developed using the same methodology as the provider specific Partial Prospective Payment, to ensure they are on a comparable basis prior to blending.

c. Future Fee Schedule Adjustments. When the Department receives CMS approval for future State Plan Amendment changes to the fee schedule for the Modified APM Code Set, the Partial Prospective Payment will be adjusted commensurately.

3. The Partial Prospective Payment will be received by the PAP on the Friday following the first Tuesday of the month. The Partial Prospective Payments are processed on the first Thursday after the

first Tuesday and are received by that Friday. This schedule is subject to be delayed based on holidays or unforeseen operational issues.

4. The PAP's Partial Prospective Payment amounts will be made via the Department's MMIS.
5. Partial Prospective Payments are subject to a positive or negative percentage quality adjustment based upon performance in the model described above in 5.a.2.b.
6. Effective July 1, 2023, the partial prospective payment rate is increased 16% for all PAP that receive 25% or more of their reimbursement through the APM 2. For PAP that receive less than 25% of their reimbursement through the APM 2, they will receive a pro-rated increase relative to their percentage of APM 2 reimbursement.

iv. Partial Fee for Service Payment

1. A PAP will receive a Partial Fee for Service Payment for services included in the Modified APM code set for Qualifying Patients. The Partial Fee for Service amount will be determined by the Fee for Service Percentage a PAP elected in their Notification Letter Response to the Department prior to the start of a Rate Effective Period.
2. If a PAP selects a Fee for Service Percentage of 0% and receives no fee for service payment, but only Partial Prospective Payment, then the PAP's Participating Physicians must shadow bill through the Department's MMIS to provide for the necessary data to perform the Reconciliation, as described below.
3. Partial Fee for Service Payments are subject to a positive or negative percentage quality adjustment based upon performance in the model described above in 5.a.2.b.

v. Attribution Methodology for Qualifying Patients

1. This attribution of Qualifying Patients applies to the payment and rate calculations described for Partial Prospective Payment, Partial Fee for Service, and the Incentive Payment. All full-benefit Medicaid eligible beneficiaries who are enrolled in the Accountable Care Collaborative and are attributed to a PAP are considered Qualifying Patients, with the exceptions of the groups of excluded beneficiaries described in the Qualifying Patients definition, above.
2. At least every six months, Qualifying Patient attribution is

reprocessed to potentially reattribute Qualifying Patients. The attribution process below applies to all PCMPs including, but not limited to, PCMPs that have become PAPs through the submission of a Response Letter. Qualifying Patients who have received services delivered by other PCMPs may be reattributed. If reattributed, payments under these 5.a.2.c pages will be only be made to the PAP's Participating Physicians for dates of service within the attribution period. Only Qualifying Patients are used to calculate or pay the Partial Prospective Payment. For those beneficiaries that are reattributed to a PCMP that is not a PAP, no Partial Prospective Payment will be made. Each month, the Department generated PAP attribution lists will be made available to the PAP. Partial Prospective Payments to PAPs will change based on the number of attributed Qualifying Patients each month. Furthermore, Qualifying Patients may choose a new PCMP at any time. Attributions will be done using a hierarchical process as follows:

a. Qualifying Patient's choice of a PCMP made with the enrollment broker.
b. Qualifying Patient's utilization with a PCMP, which assigns a Qualifying Patient to a PCMP based on his/her claims or service utilization records during the most recent 18 months.
c. Qualifying Patient's family connection, in which a Qualifying Patient of the same household has a claims history with a PCMP that is appropriate for the Qualifying Patient.
d. Geographical attribution, when a member cannot be attributed based on utilization or family connection. The beneficiary will be attributed to the closest appropriate PCMP. Members that are geographically attributed to a PAP are however not Qualifying Patients for the purposes of this section 5.a.2.c of this Attachment.

3. A Qualifying Patient is attributed to only one PAP at a time. This eliminates the possibility of duplication of Partial Prospective Payments to multiple PAPs for the same Qualifying Patient.

vi. Incentive Payments Based Upon Episodes (Incentive Payments)

1. Purpose:

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a. Support Colorado's shift to value-based purchasing by rewarding high quality care and outcomes;
b. Encourage clinical effectiveness;
c. Encourage referral to providers who deliver high-quality care, when provider referrals are necessary;
d. Use episode-based data to evaluate the costs and quality of care delivered and to apply incentive payments; and
e. Establish a PCMP as a PAP for Chronic Condition Episodes of Care.

2. Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive payments are available at the Colorado Medicaid Primary Care Payment Reform website at (https://hcpf.colorado.gov/alternative-payment-model-2-apm-2)and are effective for the Performance Year.

3. Notice: PAPs will receive at least 30 days written notice of changes to Episode-Based Payments.

4. Episodes: A defined group of related Medicaid covered services provided to a specific patient over a specific period of time. The characteristics of an episode will vary according to the medical condition for which a patient has been treated. Detailed descriptions and definitions for each episode are found in the Department's Primary Care Payment Reform website located at (https://hcpf.colorado.gov/alternative- payment-model-2-apm-2).
5. PAPs: A PAP is held accountable for both the quality and cost of care delivered to a Qualifying Patient for an entire episode.
6. Payments: Subject to the incentive payments described below, providers, including PAPs, deliver care to QualifyingPatients and are paid in accordance with the Medicaid payment methodology in effect on the date of service.
7. Thresholds: Thresholds are the upper and lower incentive benchmarks for an episode of care and are established prior to the beginning of a performance period. If provider specific data is unavailable the Department will use a statewide average. Outliers above the 95th percentile will be removed from the threshold calculations. The Commendable Threshold for positive incentive payments includes a minimum savings rate of 2 percent applied to

ensure PAPs are lowering costs and improving the quality of care delivered. The thresholds will be updated prior to the final episodes of care calculation to account for any CMS approved policy changes that are effective during the performance period that impact fee for service reimbursement levels. This adjustment will ensure that the final threshold is on the same fee schedule basis as the actual expenditures the provider will be measured against.

8. Episode Risk Adjustment: Chronic condition episodes will be risk adjusted from a statewide baseline to reflect the risk of each PAP's Qualifying Patients. The risk adjustment methodology is based on observed variation in episode cost due to category of aid, gender, number of co-morbid chronic conditions, and the number of and presence of behavioral health conditions. The risk adjustment methodology is described on the Colorado Primary Care Payment Reform Payment website at (https://hcpf.colorado.gov/bundled-payments).

9. Incentive Payments Based Upon Episodes (Incentive Payments) promote efficient and economic care utilization by making incentive payments based on the aggregate valid and paid claims across a PAP's episodes of care ending during the twelve-month performance period specified for chronic condition episodes. After the conclusion of the full performance period, eligibility for a positive incentive payment is determined on an annual basis. Payments are made no earlier than three months after the end of the performance period. Payments equal 50% of the difference between the actual cost per qualifying chronic condition and the Commendable Threshold, if the actual cost is less than that Threshold. The Commendable Threshold will be calculated using the average cost for 12 qualifying conditions over the Historical Data Period. The comparison between the Commendable Threshold and the actual incurred claims will include a modification of the Commendable Threshold to account for any CMS approved rate changes that are effective between the acceptance of the Commendable Threshold by the provider and the end of the performance period. Because the incentive payments are based on aggregated and averaged claims data for a performance period, payments cannot be attributed to specific provider claims. Performance reports will be sent to providers on a quarterly basis.

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10. Timing of Incentive Payments: Each PAP that is eligible for a positive incentive payment and meets the performance requirements set out in this section shall receive any earned performance payment no later than 180 days after provider receipt of its prior-year performance report.

11. No Incentive Payments: If the average episode reimbursement is higher than the commendable threshold, the PAP will not receive an incentive payment.

12. Episodes: Effective for those specific episodes with an end date on or after January 1st, 2022, the defined scope of services within the following episodes of care are subject to incentive adjustments. Definitions and additional information about each episode are available on the Colorado Primary Care Payment Reform website available at (https://hcpf.colorado.gov/alternative-payment-model-2-apm-2).

    a. Asthma
    b. Chronic Obstructive Pulmonary Disease
    c. Coronary Artery Disease
    d. Hypertension
    e. Arrythmia/Heart Blockage
    f. Heart Failure
    g. Gastro-Esophageal Reflux Disease
    h. Crohn's Disease
    i. Ulcerative Colitis
    j. Low Back Pain
    k. Osteoarthritis
    l. Diabetes

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vii. Reconciliation

1. After the conclusion of each Performance Year, the Department will perform a reconciliation for each PAP. Typically, this process will occur no more than nine months after the end of the Performance Year. In no case will the Department request federal matching for services administered, eight quarters after original service date. The Department will allow a six-month run-out period before conducting the reconciliation process.
2. The data used for that reconciliation will include all Partial Fee for Service Payments and Partial Prospective Payments, all of which are made via the Department's MMIS, for each particular Performance Year. These sets of payments are only made on behalf of Qualifying Patients. Other payments made to PAPs are not included in this reconciliation.
3. Next, the Department will determine the amounts that would have been paid to PAPs in absence of these 5.a.2.c state plan pages during that particular Performance Year. These amounts are from the fee schedule in place at actual dates of service for Modified APM Code Set services provided to Qualifying Patients during the Performance Year, without reduction from the application of a Fee For Service Percentage.
4. For those PAPs that have a Fee for Service Percentage at 0%, and therefore have no Partial Fee for Service Payments, the Department will instead use the mandatorily required shadow billing to the MMIS of actual utilization of services priced at the fee schedule in effect at the date of service. Any and all changes in a PAP's Fee for Service Percentage during a Performance Year will be accounted for in the in the reconciliation process.
5. The Department will compare the amount that would have been paid to the PAP under the Health First Colorado Fee

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Schedule, as modified on a provider specific basis by the quality model defined in section 5.a.2.b, to the actual amounts paid to the PAP calculated by summing the Partial Fee For Service Payments and the Partial Prospective Payments for dates of service during the Performance Year.

6. If the Health First Colorado Fee Schedule, as modified on a provider specific basis by the quality model defined in section 5.a.2.b is higher, in the aggregate, than the actual amounts paid to the PAP, then the Department will recover the actual amounts made to the PAP and will replace them with the fee schedule payments, leading to an aggregate increase in payments, but only if the PAP met the Quality Threshold. The Quality Threshold is effective for each Performance Year and is posted at (https://hcpf.colorado.gov/alternative-payment-model-1-apm-1) and as provided for in this attachment at 5.a.2.b
7. If the Health First Colorado Fee Schedule, as modified on a provider specific basis by the quality model defined in section 5.a.2.b is lower, in the aggregate, than the actual amounts paid to the PAP, then the Department will recover the actual amounts made to the PAP and will replace them with the fee schedule payments, leading to an aggregate decrease in payments, but only if the PAP did not meet the Quality Threshold, and only subsequent to a PAP's first Performance Year. During the first Performance Year of a PAP, there is no downside risk. The Department will return the federal share of any overpayment which is remitted when a PAP does not meet the Quality Threshold in accordance with the requirements of 42 CFR 433 Subpart F.
8. In all other cases, there is no adjustment to payment as a result of the reconciliation.

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Telemedicine Services

Distant Site Transmission Fee: Physician services provided via telemedicine by physicians, podiatrists, and optometrists located at eligible distant sites shall be reimbursed a distant site transmission fee of $5.00 in addition to the fee for the procedure code billed.

Originating Site Facility Fee: Eligible originating sites hosting, transmitting, or facilitating physician services provided via telemedicine shall be reimbursed an originating site facility fee, according to the Department's fee schedule. An originating site may not bill for assisting the distant site provider with an examination.

Asynchronous Electronic Consultation: To be reimbursed for asynchronous electronic consultation, primary care medical providers (PCMPs) must use HCPCS code T1014, and specialists must use CPT code 99446.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page.

3. Effective December 1, 2024, the Department may negotiate a higher reimbursement rate for out-of-state physician services in accordance with single case agreements under the following circumstances:

    a. The physician services are either:
        i. Included in an approved single case agreement with a hospital under the authority granted in Attachment 4.19-A, Paragraph I.F.1.c (inpatient hospital) or in Attachment 4.19-B, Item 2.a., Paragraph 4 (outpatient hospital); or

        ii. Provided by an out-of-state physician rendering services not available in Colorado.

    b. The member's physician may suggest where the member should be sent, but the medical consultant for the Department is responsible for making the final determinations based on the most cost-effective physician consistent with quality of care.

    The reimbursement rate for out-of-state physician services in accordance with single case agreements will be negotiated between the Department and the out-of-state physician

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providing the services. When negotiating the rate, the Department will take into consideration the following:

a. The actual costs of the facility or physician;

b. The Medicare rate for the same or similar services, if any; and,

c. The Medicaid rate for the same or similar services in the state where the facility or physician is located, when available.

The reimbursement rate for out-of-state physician services in accordance with single case agreements may not exceed the usual and customary charges for the facility or physician for such services.