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State/Territory Name: CO

State Plan Amendment (SPA) #: 25-0020

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
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604



Financial Management Group/ Division of Reimbursement Review

April 30, 2026

Adela Flores-Brennan,
State Medicaid Director
Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Suite 1100
Denver, CO 80203

RE: TN 25-0020

Dear Director Flores-Brennan,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Colorado State Plan Amendment (SPA) to Attachment 4.19-B TN: #25-0020, which was submitted to CMS on August 28, 2025. This plan amendment removes the 16% increase to the partial prospective rate for Principal Accountable Provider (PAP) that receive 25% or more of their reimbursement through the Alternative Payment Methodology 2 (APM 2).

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 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 July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Matthew Klein at 214-767-4625 or matthew.klein@cms.hhs.gov

Sincerely,



Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

1. TRANSMITTAL NUMBER <u>2 5</u> — <u>0 0 2 0</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, 2025
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5. FEDERAL STATUTE/REGULATION CITATION Social Security Act, Section 1905(a)(2)(A) / 42 CFR 440.20	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2025</u> \$ <u>(5,312,010)</u> b. FFY <u>2026</u> \$ <u>(5,416,167)</u>
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7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-B -- Methods and Standards for Establishing Payment Rates -- Other Types of Care -- Item 5.a Physician Services, Page 12	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-B -- Methods and Standards for Establishing Payment Rates -- Other Types of Care -- Item 5.a Physician Services, Page 12 of 20 (TN 24-0038)
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9. SUBJECT OF AMENDMENT
Removes the 16% increase to the partial prospective rate for Principal Accountable Provider (PAP) that receive 25% or more of their reimbursement through the physician services Alternative Payment Model 2 (APM 2).

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:

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO Colorado Department of Health Care Policy and Financing 303 E. 17th Avenue, Suite 1100 Denver, CO 80203 Attn: Jessica Farnen
12. TYPED NAME Bettina Schneider	
13. TITLE Chief Financial Officer	
14. DATE SUBMITTED August 28, 2025	

FOR CMS USE ONLY

16. DATE RECEIVED August 28, 2025	17. DATE APPROVED April 30, 2026
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2025	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL Todd McMillion	21. TITLE OF APPROVING OFFICIAL Director, Division of Reimbursement Review

22. REMARKS
10/14/25 update: Updated box 6 to include \$0 for FFY2026 and FFY2027, rather than leaving those amounts blank (this SPA is budget neutral). Changed box 15 street address from "1570 Grant Street" to "303 E. 17th Avenue, Suite 1100", zipcode from "80203-1818" to just "80203", and Attn: from "Alex Lyons" to "Jessica Farnen"; 2/12/26 update: Updated box 6 to reflect budget impact of \$(5,312,010) for FFY 2025 and \$(5,416,167) for FFY 2026

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM STATE OF COLORADO

Attachment 4.19-B
Page 12 of 20

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

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.
- ii. 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.
- iii. 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