

Revision: HCFA-PM-91-4 (BPD)

OMB No. 0938-

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

State/Territory: Colorado

Citation As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

42 CFR Colorado Department of Health Care Policy and Financing
430.10 (Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

TN No. 94-029

Supersedes

TN No. 92-1

Approval Date 10/06/94

Effective Date 7/1/94

HCFA ID: 7982 E

Revision: HCFA-AT-80-38 (BPP)

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

State/Territory: Colorado

Section 1 SINGLE STATE AGENCY ORGANIZATION

Citation 1.1 Designation and Authority

42 CRF 431.10
AT-79-29

- (a) The Colorado State Department of Health Care Policy and Financing
is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is the certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

TN No. 94-029

Supersedes

TN No. 77-9

Approval Date 10/06/94

Effective Date 7/1/94

Revision: HCFA-AT-80-38 (HPP)
May 22, 1980

State of Colorado

Citation
Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is _____

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☒ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

TN # 77-9
Supersedes
TN # _____

Approval Date 4/21/77

Effective Date 4/1/77

Revision: HCFA-AT-80-38 (BFP)
May 22, 1980

State of Colorado

Citation
Intergovernmental
Cooperation Act
of 1968

1.1(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

- ☐ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.
- ☐ Not applicable. Waivers are no longer in effect.
- ☒ Not applicable. No waivers have ever been granted.

TN # 79-14
Supersedes
TN # _____

Approval Date 6/12/79 Effective Date 7/1/79

Revision: HCFA-AT-80-38 (BPP)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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<u>Citation</u>	1.1(d) <u>/ /</u>	The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
	<u>/x/</u>	Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in <u>ATTACHMENT 2.2-A.</u> There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

TN No. 99-254

Supersedes

TN No. 79-14

Approval Date 04/27/99

Effective Date 04/01/99

Revision: HCFA-AT-80-38 (HPP)
May 22, 1980

State of Colorado

Citation
42 CFR 431.10
AT-79-29

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

TN # 79-14
Supersedes
TN #

Approval Date 6/12/79 Effective Date 7/1/79

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The State Department of Health Care Policy and Financing is the single State agency responsible for:

☒ Administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis are Sections 25.5-1-104(4) and 25.5-4-104, C.R.S. (2014)

☒ Supervising the administration of the plan by local political subdivisions and Department eligibility technicians.

The legal authority under which the agency supervises the administration of the plan on a statewide basis is contained in

Sections 25.5-1-104(4), 25.5-1-201, 25.5-4-104, 25.5-4-106, and 25.5-4-205, C.R.S. (2014)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan are is Sections 25.5-4-104(1), C.R.S. (2014).

January 16, 2015
DATE

Cynthia H. Coffman
Cynthia H. Coffman, Attorney General

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

State of Colorado

WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED UNDER THE
INTERGOVERNMENTAL COOPERATION ACT OF 1968

Waiver #1.^{1/} Not Applicable

- a. Waiver was granted on _____
(date)
- b. The organizational arrangement authorized, the nature and extent of repsonsibility for program administration delegated to _____, and
(name of agency)
the resources and/or services of such agency to be utilized in administration of the plan are described below:
- c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

^{1/} (Information on any additional waivers which have been granted is contained in attached sheets.)

TRANSMITTAL # 94-019
APPROVAL DATE 8/8/94
EFFECTIVE DATE 7/1/94
SUPERSEDES TRANSMITTAL NEW

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Organization for Administration

<u>Citation</u> 42 CFR 431.11, AT 79-29	1.2	Organization for Administration
	(a)	Attachment 1.2-A contains a description of the Organization and functions of the Department of Health Care Policy and Financing and an organizational chart of the Department.
	(b)	Within the State agency, Medical and Child Health Plan Plus Administration Office, has overall management and administrative responsibility for the Medicaid Program. Attachment 1.2-B contains a description of the organization and functions, and an organizational chart of Medical and Child Health Plan Plus Administration Office.
	(c)	Attachment 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.
	(d)	Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). Attachment 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

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STATE OF COLORADO

**ORGANIZATION AND FUNCTIONS OF THE STATE AGENCY
HEALTH CARE POLICY AND FINANCING**

Executive Director

The Executive Director is responsible for establishing such divisions, sections and other units within the Department of Health Care Policy and Financing (the Department) as are necessary for the proper and efficient discharge of the powers, duties and functions of the Department. The Department administers the Colorado Medical Assistance Program.

The Executive Director of the Department is responsible for developing the overall goals and objectives for the Colorado Medicaid Assistance Program. This position coordinates the activities of the Medical and Child Health Plan Plus Administration Office, Agency Administration and Operations Office, Client and Community Relations Office, Budget Division, and Human Resources Section to assure consistent management and coordinated program directions.

TN No. 07-011

Effective Date: July 1, 2007

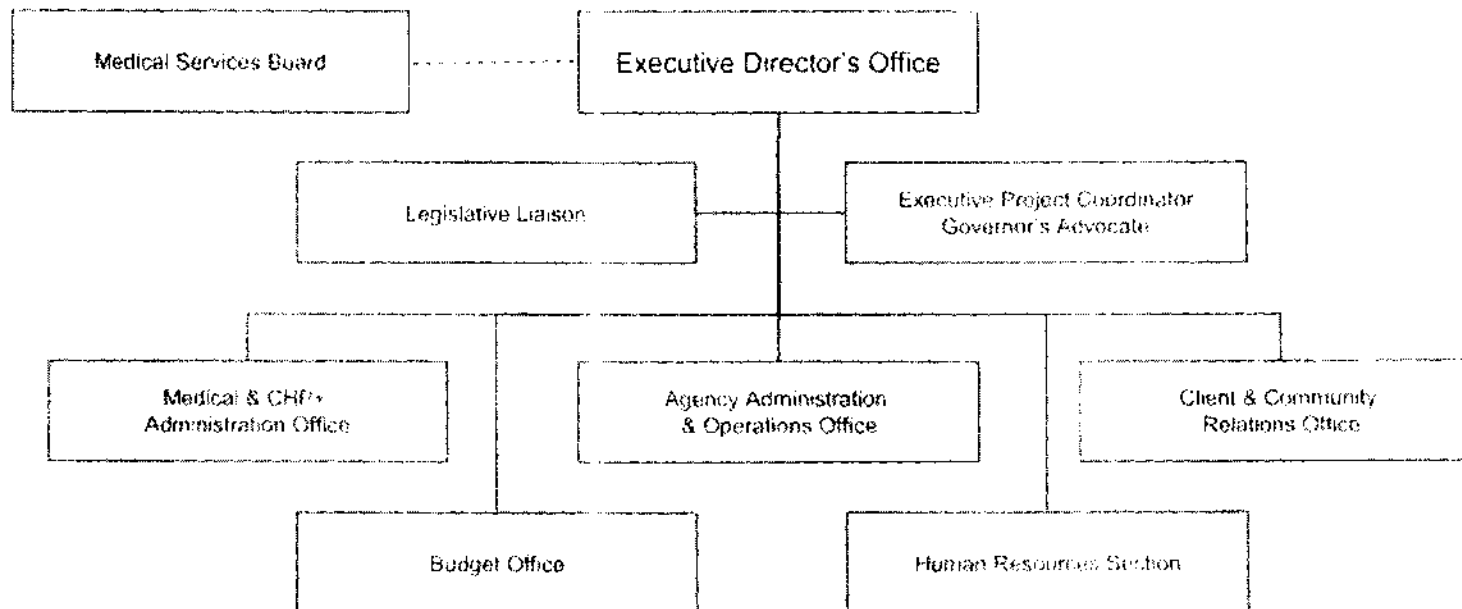
Supersedes TN No. 03-037

Approval Date 10/19/07

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MEDICAL ASSISTANCE ACT**

STATE OF COLORADO

**ORGANIZATION AND FUNCTIONS OF THE STATE AGENCY
HEALTH CARE POLICY AND FINANCING**



TN No. 07-011

Supersedes TN No. 03-037

Effective Date: July 1, 2007

Approval Date 10/19/07

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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**ORGANIZATION AND FUNCTIONS OF THE MEDICAL AND CHILD
HEALTH PLAN PLUS ADMINISTRATION OFFICE**

Medical and Child Health Plan Plus Administration Office

The Director of the Medical and Child Health Plan Plus Administration Office has management and administrative responsibility for Medicaid including the provision of delivery of services and resolving conflicts between the State, Providers, Counties and Recipients and must ensure appropriate implementation of all Federal, State and Departmental rules, regulations and procedures. This Director provides direct supervision to the Benefits Division, the Child Health Plan Plus Division, the Long Term Benefits Division, the Pharmacy Section, the Quality Improvement Section and the Rates Section.

Benefits Division

The Benefits Division is comprised of two sections: the Acute Care Benefits and the Managed Care Benefits sections. The Division is responsible for administering Medicaid's acute care benefits and programs and managing contracts with the enrollment broker and managed care organizations which provide services in both the physical health care and behavioral health care arenas.

The Acute Care Benefits Section administers a range of individual acute care benefits and several specialty programs. The specialty programs include programs for pregnant women, teen pregnancy prevention and breast and cervical treatment programs. Individual benefits include, but are not limited to: durable medical equipment, rural health clinics, federally qualified health clinics, non-emergent medical transportation, occupational, physical and speech therapy, dental and orthodontia services and physician and non-physician services. Benefits administration responsibilities include activities such as, policy analysis and medical benefit definition, development and implementation of benefit rules and billing guidelines, ad hoc education and outreach activities, and program monitoring of utilization and expenditures.

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Approval Date 10/19/09

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**ORGANIZATION AND FUNCTIONS OF THE MEDICAL AND CHILD
HEALTH PLAN PLUS ADMINISTRATION OFFICE**

The Managed Care Benefits Section is responsible for the oversight and management of the continuum of Medicaid Managed Care Programs including a primary care case management (PCCM) program, contracted health maintenance organizations (HMO) and prepaid inpatient health plans (PIHP). The Section also manages the contract for Medicaid's enrollment broker. Section responsibilities include program development and implementation, rule development, procurement activities, contract monitoring and stakeholder interface.

Child Health Plan Plus Division¹

The Child Health Plan Plus Division is responsible for the implementation and oversight of the Children's Basic Health Plan program. The Division is responsible for managing contracts with vendors to provide services. The vendors are responsible for determining eligibility and enrollment, providing customer service and outreach, and providing health care to clients through HMOs and the Child Health Plan Plus Network. The Division sets policy, manages contracts, solves high level problems, and coordinates issues and policies between vendors.

Long Term Benefits Division

The Division is comprised of the Community Based Long Term Care Section, including the Systems Change unit, and the Nursing Facility Section. This Division is responsible for determining the health care policy and benefits for the Medicaid long-term care programs and is responsible for establishing the rates, auditing, and overseeing the issuance of provider agreements for nursing facilities and community-based care providers. The Systems Change unit serves to implement legislative initiatives related to consumer direction, writing the amendments to existing home and community based

¹ The Child Health Plan Plus program is also known as the State Children's Health Insurance Program. Benefits for this program are provided pursuant to Title XXI of the Social Security Act. As such, they are not Title XIX State Plan benefits.

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HEALTH PLAN PLUS ADMINISTRATION OFFICE**

services waivers to include consumer direction as a delivery method. The Long Term Benefits Division is responsible for the single entry point system that provides assessment for and access to Medicaid long-term care programs and services, and for skilled home health services.

Pharmacy Section

The Pharmacy Section manages the pharmacy benefit for fee-for-service Medical Assistance Program clients. This includes but is not limited to drug coverage issues, prior authorizations and limitations. The Pharmacy Section also handles federal rebates on drugs.

Quality Improvement Section

The Quality Improvement Section is responsible for administering a quality assessment and performance improvement program for the Medicaid program. The Section's work encompasses all external quality review activities, including monitoring health plans for contract and regulation compliance, validating health plan performance improvement projects, validating health plan performance measures and producing an annual technical report summarizing the results of external quality review activities.

Rates Section

The Rates Section is responsible for the calculation and implementation of a variety of payment rates for providers contracted to provide health services to Medicaid clients.

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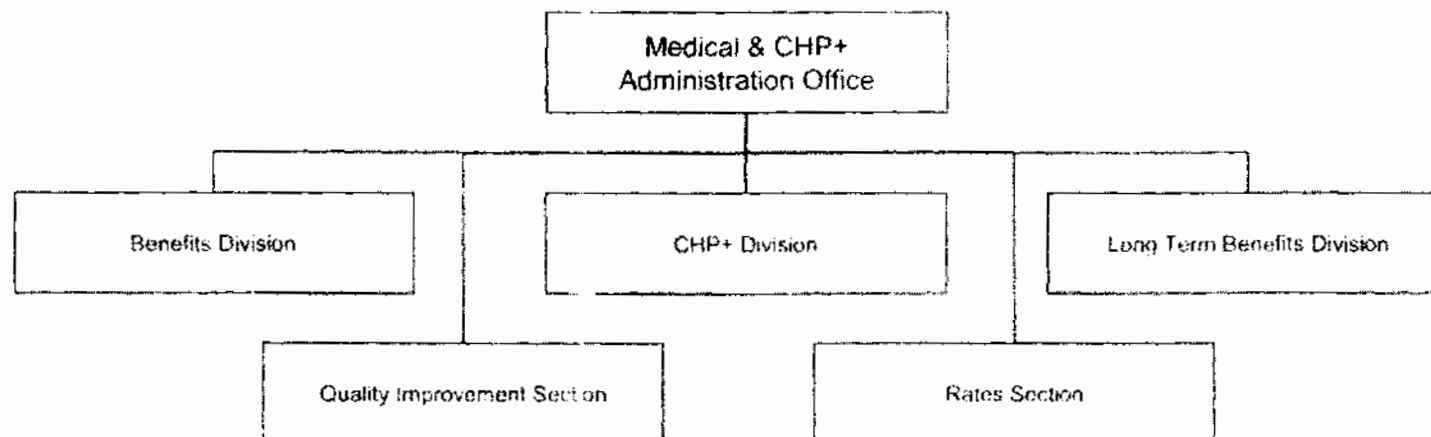
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**ORGANIZATION AND FUNCTIONS OF THE MEDICAL AND CHILD
HEALTH PLAN PLUS ADMINISTRATION OFFICE**



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**ORGANIZATION AND FUNCTIONS OF THE
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

Executive Director

- I. Medical and Child Health Plan Plus Administration Office - Director - 1
 - A. General Professional IV - 1
 - B. Benefits Division - Director - 1
 - 1. Administrative Assistant III - 1
 - 2. Program Assistant I - 1
 - 3. Section Managers - 2
 - a) General Professional II - 3
 - b) General Professional III - 4
 - c) General Professional IV - 11
 - d) General Professional V - 2
 - C. Child Health Plan Plus Division - Director - 1
 - 1. Program Assistant I - 1
 - 2. Section Managers - 2
 - a) General Professional III - 1
 - b) General Professional IV - 6
 - c) General Professional VI - 1
 - d) Statistical Analyst III - 1
 - D. Long Term Benefits Division - Director - 1
 - 1. Program Assistant I - 1
 - 2. Section Managers - 2
 - a) General Professional II - 1
 - b) General Professional III - 3
-

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- c) General Professional IV - 13
- d) General Professional V - 3
- e) Auditor II - 1
- f) Auditor IV - 1

E. Quality Improvement Section - Section Manager - 1

- 1. General Professional II - 1
- 2. General Professional IV - 7

F. Rates Section - Section Manager - 1

- 1. Administrative Assistant II - 1
- 2. General Professional III - 1
- 3. Statistical Analyst I - 1
- 4. Statistical Analyst II - 1
- 5. Statistical Analyst III - 3
- 6. Rate/Financial Analyst II - 2
- 7. Rate/Financial Analyst III - 1

II. Administrative Services Unit

- A. Administrative Assistant II - 2
- B. Administrative Assistant III - 2
- C. General Professional II - 1
- D. General Professional IV - 1

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- III. General Professional VI - 1
 - IV. Human Resources Section - Section Manager - 1
 - A. General Professional III - 2
 - B. General Professional IV - 2
 - C. Technician III - 1
 - V. Budget Division - Director - 1
 - A. Program Assistant I - 1
 - B. Section Manager - 1
 - 1. Budget Analyst II - 5
 - 2. Budget/Policy Analyst III - 6
 - 3. Budget/Policy Analyst IV - 2
 - VI. Client and Community Relations Office - Director - 1
 - A. Program Assistant I - 1
 - B. General Professional IV - 1
 - C. General Professional V - 1
 - D. General Professional VI - 1
 - E. Program Eligibility and Improvement Division - Director - 1
-

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1. Administrative Assistant III - 2
 2. Section Manager - 4
 - a) General Professional II - 2
 - b) General Professional III - 7
 - c) General Profession IV - 10
 - d) General Professional V - 3
 - e) Technician III - 3
 - f) Accountant I - 1
 - g) Accountant II - 1
 - h) App Programmer - 1
 - i) Rate/Financial Analyst I - 1
 - j) Stat Analyst I - 4
 - k) Stat Analyst II - 2
 - l) Stat Analyst III - 2
- F. Client Services Division - Director 1
1. Administrative Assistant III - 1
 2. Section Manager - 2
 - a) Customer Support Intern - 5
 - b) Customer Support Coordinator I - 1
 - c) Customer Support Coordinator II - 1
 - d) General Professional II - 2
 - e) General Professional III - 3
 - f) General Professional IV - 1
 - g) General Professional V - 1
 - h) Pharmacy II - 2
 - i) Rate/Financial Analyst III - 1

TN No. 07-011

Effective Date: July 1, 2007

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**ORGANIZATION AND FUNCTIONS OF THE
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

VII. Agency Administration & Operations Office – Director 1

A. Audits Section – Section Manager - 1

1. General Professional II – 1
2. General Professional III – 3
3. General Professional IV – 2
4. Auditor IV – 1

B. Legal Division – Director - 1

1. Program Assistant I – 1
2. Administrative Assistant II – 1
3. Section Managers – 2
 - a) General Professional III - 3
 - b) General Professional IV - 9
 - c) General Professional V - 1

C. Controller Division – Controller III - 1

1. Administrative Assistant II – 1
2. Section Managers – 2
 - a) Accounting Technician III - 2
 - b) Accountant I – 2
 - c) Accountant II – 4
 - d) Accountant III - 3
 - e) General Professional II - 1
 - f) General Professional IV – 3
 - g) General Professional VI – 1

D. Information Technology Division – Director - 1

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1. Program Assistant I - 1
2. General Professional IV - 1
3. Section Managers - 5
 - a) Administrative Assistant III - 1
 - b) General Professional II - 4
 - c) General Professional III - 11
 - d) General Professional IV - 8
 - e) General Professional V - 6
 - f) Application Programmer III - 2
 - g) IT Professional I - 1
 - h) IT Professional II - 2
 - i) IT Professional III - 8
 - j) IT Professional IV - 2

TN No. 07-011

Effective Date: July 1, 2007

Supersedes TN No. 03-037

Approval Date 10/19/07

State of Colorado

Determinations of Eligibility by the Colorado County Departments of Social Services

The Colorado County Departments of Social Services are the agencies designated to make the determination of Medicaid eligibility for the Colorado Department of Health Care Policy and Financing. The staff designated to make such determinations are the eligibility technicians hired by the Colorado County Departments of Social Services to perform eligibility for Colorado State Medicaid programs.

An individual obtains Medicaid coverage by establishing eligibility under a particular Medicaid program eligibility category. A Colorado resident makes application at the local County Department of Social Services (or at a health care provider that offers an "outstationing" eligibility site), and a county eligibility technician verifies and processes the application using criteria established in state and federal rules that is handed down in policy by the Department of Health Care Policy and Financing.

TN No. 99-004

Supersedes

TN No. NEW

Approval Date 09/27/99

Effective Date 04/01/99

Revision: BCSA-AT-80-38 (BFP)
May 22, 1980

State of Colorado

Citation
42 C.R.
431.50 (b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 C.R. 431.50.

☐ The plan is State administered.

☒ The plan is administered by the political subdivisions of the State and is mandatory on them.

TN # 93-015

Supersedes

TN # 74-27

Approval Date 10/13/93

Effective Date 1-1-93

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

State of Colorado

CITATIONS

205.120
402(a)(1)

1.3 Statewide Operation

The plan is

☐ State-administered.

☒ State-supervised.

224.10
224.30
402(a)(19)(G)

1.4 Administrative Responsibility with
Regard to the Work Incentive Program

The Separate Administrative Unit is responsible for the providing, or arranging for the provision of optional services specified in the approved WIN Plan (State Operational Plan), to enable a registrant who is an AFDC recipient to accept employment or training for employment in accordance with 45 CFR 224.10 and 45 CFR 224.30.

☒ Yes

☐ No

TN # 93-015

Approval
Date 10/13/93

Effective
Date 1-1-93

Supersedes
TN # NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation

42 CFR 431.12(b)

1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

42 CFR 438.104

- x The State enrolls recipients in managed care organizations, prepaid inpatient health plans, and/or primary care case manager programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved:

The Department of Health Care Policy and Financing (the Department) intends to meet the requirements described above through execution of a formal consultation agreement

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with American Indian health programs in Colorado. The consultation agreement will be fully executed by representatives from all parties prior to official implementation. The parties to the consultation agreement include the Southern Ute Indian Tribe, the Ute Mountain Ute Tribe, Denver Indian Health and Family Services, the Colorado Department of Public Health and Environment, the Office of the Lieutenant Governor of Colorado, and the Department. The Department intends to use the following process, as described in the consultation agreement, to seek advice on a regular, ongoing basis from the parties:

Programmatic Action Log Update:

On a bi-monthly basis (approximately every sixty days) each State Agency [the Department of Public Health and Environment and the Department of Health Care Policy and Financing] shall distribute to the Tribes and the UIHO [Urban Indian Health Organization] a Programmatic Action Log Update. The Update shall contain a continuous list/log of Programmatic Actions being developed and/or initiated by each State Agency. The Update shall provide a short description of each Programmatic Action, any clearly foreseeable Tribal Implications, important dates or implementation timeframes, and if the Programmatic Action is considered an Actionable Item. The Update shall indicate a date by which additional consultation must be requested by a Tribe or the UIHO (thirty days from receipt of the Update). The Update shall also contain an area to track whether additional consultation was requested and by whom, and to update current status/resolution of Programmatic Actions.

Additional Consultation:

A Tribe or UIHO may request additional consultation on any Actionable Item on the Update or on any question, concern, policy, practice, or issue within the scope of the State Agencies' responsibilities relating to the health of American Indians/Alaska Natives living in Colorado. Actionable Items on the Update shall indicate a date by which a Tribe or the UIHO must request additional consultation (thirty days from receipt of the Update). Additional consultation shall be initiated by written notice (may be in the form of an email) from a designated Tribal or UIHO Liaison(s) and directed to a designated Indian Health Liaison(s). Consultation may include but shall not be limited to meetings (face-to-face or via teleconference), written correspondence including emails, presentations, and discussions at the Colorado Commission of Indian Affairs' Health and Wellness Committee meetings. When consultation is completed, a written response from one or both State Agencies to the Party that requested the consultation shall be sent describing the final determination

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or outcome regarding the topic of consultation. This information shall also be included on the Programmatic Action Log Update.

Meetings:

Face-to-Face and Remotely

The State Agencies, Tribes, and UIHO, all together or individually, shall meet face-to-face no less than once per fiscal year and as resources allow. As necessary, the State Agencies, Tribes, and UIHO, all together or individually, shall meet remotely via teleconference or videoconference to discuss outstanding issues and/or hold consultations as described above.

This State Plan Amendment contains language from the consultation agreement the Department intends to execute to seek advice on a regular, ongoing basis from the involved parties. The consultation agreement was developed through a collaborative process beginning in January 2010:

- January 2010 – Colorado Commission of Indian Affairs (CCIA) Health and Wellness Committee Meeting (face-to-face) – Discussed establishing channels for better communication between state agencies and the Tribes. (Included, among others: the chairman, the vice-chairman, and the tribal health director of the Ute Mountain Ute Tribe; a councilman from Southern Ute Indian Tribe; staff from the Office of the Lieutenant Governor; and state agency staff.)
- February 2010 – Department staff consulted with the Utah Indian Health Liaison and the Director of the Utah Division of Indian Affairs regarding their experience with consultation agreements.
- March 2010 – CCIA Health and Wellness Committee Meeting (face-to-face) – Developed list of specific contacts from each agency and Tribe to facilitate effective communication. Discussed need for written consultation agreement. (Included, among others: the vice-chairman of the Ute Mountain Ute Tribe; a councilman from the Southern Ute Indian Tribe, and state agency staff.)
- April 2010 – CCIA Health and Wellness Committee Meeting (conference call) – Spoke more in depth about a written consultation agreement. Reviewed consultation agreements from several other states. (Included, among others: the vice-chairman and the tribal health director of the Ute Mountain Ute Tribe; the director of the Ute Mountain Ute Health Center (an IHS facility); a councilman from the Southern Ute Indian Tribe; the director of the Southern Ute Health Center (a 638 facility); staff from the Office of the Lieutenant Governor; and state agency staff.)
- May 2010 – Department staff made an on-site visit to the Colorado reservations. Met individually with each Tribe to discuss their preferences regarding potential content and processes for the consultation agreement. (Included, among others: the tribal health

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director and a councilman from the Ute Mountain Ute Tribe; the director and office staff of the Ute Mountain Ute Health Center; the executive officer, the co-executive officer, a councilman, and legal representation for the Southern Ute Indian Tribe; the director of the Southern Ute Health Center; and Department staff.)

- June 2010 – First written draft of the consultation agreement was distributed via email and subsequent conference call was held to discuss the draft during which participants agreed to share draft with others in their organizations and get additional feedback. (Recipients of the initial email included: the chairman, the vice-chairman, the tribal health director, and a councilman of the Ute Mountain Ute Tribe; the chairman, the executive officer, the co-executive officer, and a councilman of the Southern Ute Indian Tribe; staff from the Office of the Lieutenant Governor; and state agency staff.)
- August 2010 – Second draft was distributed reflecting requested changes. Requested any additional changes before participants seek approval of the agreement from management and leadership. (Recipients included: a councilman from the Southern Ute Indian Tribe; the director of the Southern Ute Health Center; the vice-chairman and the tribal health director of the Ute Mountain Ute Tribe; the director of the Ute Mountain Ute Health Center; the director of the UIHO; staff from the Office of the Lieutenant Governor; and state agency staff.)
- September 2010 – Discussed at the quarterly CCIA meeting. Awaiting final comments from one of the Tribes.
- November 2010 – Having received no response from the UIHO, additional communication was sent to other representatives of the UIHO requesting advice and feedback on the draft.
- December 2010 – Discussed at quarterly CCIA meeting. Still awaiting final comments from one of the Tribes. It was decided that the Office of the Lieutenant Governor would send a written communication to the Tribes and request that the draft be reviewed by Tribal Councils for final changes prior to execution. Awaiting approval from Tribal Councils and agency management. Also awaiting feedback and approval from the UIHO.

Revision: HCFA-PM-94-3 (MB)

APRIL 1994

State/Territory: ColoradoCitation1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.
 - a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.
 - b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.
 - c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.
 - d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.
 - e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.
 - f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.
 - g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the

TN No. 95-001

Supersedes

TN No. New

Approval Date 1/10/95Effective Date 10-1-94

Revision: HCFA-PM-94-3 (MB)
APRIL 1994

State/Territory: Colorado

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.
3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.
4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

☐ State Medicaid Agency

☒ State Public Health Agency

No. 95-001

Supersedes

TN No. New

Approval Date

1/10/95

Effective Date

10-1-94

TN

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State: Colorado

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and
Furnishing Medicaid

- (a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

TN No. 92-1

Supersedes

TN No. 79-23

Approval Date

4/9/92

Effective Date

10/1/91

HCFA ID: 7982E

COLORADO MEDICAID STATE PLAN

11

Revision: HCFA-PM- (MB)

STATE OF COLORADO

Citation

42 CFR 435.914	2.1(b)(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(a)(34) of the Act		
1902(e)(8) and 1905(a) of the Act	2.1(b)(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47)	<u> X </u> 2.1(b)(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
	2.1(c)	Deleted 2003 due to Medicaid managed care BBA regulations.

TN No: 05-004

Approval Date 7/05/05

Effective Date 7/1/05

Supersedes TN No. 04-003

Revision: HCFA-PM-91-8 (MB)
October 1991

OMB No.

State/Territory: COLORADOCitation

1902(a)(55) of the Act 2.1(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

TN No. 92-9

Supersedes

Approval Date 6/16/92TN No. 91-22Effective Date 10/1/91

HCFA ID: 7985E

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

STATE OF COLORADO

Page 11b

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid

1902(e)(13) of the Act ☒ (e) Express Lane Option. This option is effective through September 30, 2017. If the statutory authority for express lane eligibility is reauthorized, this option will continue under the new authority provided that it continues to meet the statutory requirements. The Medicaid State agency elects the option to rely on a finding from an Express Lane of the agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013.

- (1) The Express Lane option is applied to:
 ☒ Initial determinations ☐ Redeterminations ☐ Both
- (2) A child is defined as younger than age:
 ☒ 19 ☐ 20 ☐ 21
- (3) The following public agencies are approved by the Medicaid State Agency as Express Lane agencies:

The Supplemental Nutritional Assistance Programs (SNAP) and Temporary Assistance for Needy Families Program (TANF) are authorized to approve eligibility for the Medicaid State Agency.

- (4) The following component/components of Medicaid eligibility are determined under the Express Lane option Also specify any differences in budget unit deeming income exclusions income disregards or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

Income declared to other agencies will be used to determine Medicaid eligibility clients will not be required to provide additional income verification under the Express Lane option.

Income disregards outlined in Supplement 8a to Attachment 2.6-A will not be used to determine financial eligibility.

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

STATE OF COLORADO

Page 11c

SECTION 2 – COVERAGE AND ELIGIBILITY

Citations(s)

**2.1 Application, Determination of Eligibility and Furnishing Medicaid
(continued).**

The eligibility findings from SNAP and TANF will be used to determine state residency, household size, and gross household income. All other eligibility requirements such as citizenship and identity will be verified through the standard verification process (SSA data match).

SNAP and TANF ELE Process:

When an application for SNAP and/or TANF (cash assistance) is approved for a child, the state uses SNAP and/or TANF findings for income and eligibility household size for Medicaid and CHIP eligibility determinations for children who apply via these methods. With this process, no additional eligibility determinations are required. The only requirement is for the family to provide affirmative consent for the child to receive Medical Assistance. The state also uses SNAP and/or TANF findings for verification of SSN and state residency. The state then verifies citizenship and obtains any supplemental health insurance information.

(5) Check off and describe the option used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXL.

[X] (a) Screening threshold established by the Medicaid agency as:

[X] (i) percentage of the Federal poverty level which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points:

Children under age 6, accepted with gross income up to 133% of the FPL plus 30 percentage points for family size from the Supplemental Nutritional Assistance Program (SNAP).

Children over age 6 and under age 19, accepted with gross income up to 100% FPL plus 30 percentage point for family size from the Supplemental Nutritional Assistance Program (SNAP).

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

STATE OF COLORADO

Page 11d

SECTION 2 – COVERAGE AND ELIGIBILITY

Citations(s)

**2.1 Application, Determination of Eligibility and Furnishing Medicaid
(continued).**

Children under age 6, accepted with gross income up to 133% of the FPL plus 30 percentage points for family size from the Temporary Assistance for Needy Families Program (TANF).

Children over age 6 and under age 19, accepted with gross income up to 100% FPL plus 30 percentage point for family size from the Temporary Assistance for Needy Families Program (TANF).

or

☐ (ii) percentage of the FPL (describe how this reflects the value of any differences between income methodologies of Medicaid and the Express Lane agency:

or

☐ (b) Temporary enrollment pending screen and enroll.

☐ (c) State's regular screen and enroll process for CHIP.

☒ (6) Check off if the State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

☐ (7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State: Colorado

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in
ATTACHMENT 2.2-A.

- ☐ Mandatory categorically needy and other required special groups only.
- ☐ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- ☒ Mandatory categorically needy, other required special groups, and specified optional groups.
- ☐ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

TN No. 92-1

Supersedes

TN No. 87-14

Approval Date

4/9/92

Effective Date

10/1/91

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups

42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

- ☒ Families with an unemployed parent for the mandatory 6-month period and an optional extension of ___ months.
- ☒ Pregnant women with no other eligible children.
- ☒ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115

2. Deemed Recipients of AFDC

- a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

*Agency that determines eligibility for coverage are Colorado County Departments of Social Services.

TN No. 92-2
Supersedes
TN No. 87-5

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7983E

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

2. Deemed Recipients of AFDC.

1902(a)(10)(A)(i)(I)
of the Act

b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.

402(a)(22)(A)
of the Act

c. Individuals whose AFDC payments are reduced to zero reason of recovery of overpayment of AFDC funds.

and
1902(a)(10)(A)
(i)(I) of the Act

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

1902(a) of
the Act

e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage are Colorado County Departments of Social Services.

TN No. 92-2
Supersedes
TN No. 90-11

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7983F

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

407(b), 1902
(a)(10)(A)(i)
and 1905(m)(1)
of the Act

3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

☐ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

1902(a)(52)
and 1925 of
the Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

*Agency that determines eligibility for coverage. Colorado County Dept of Social Service

TN No. 92-2
Supersedes NEW
TN No.

Approval Date 6/11/92

Effective Date 10/1/91

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

42 CFR 435.113

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:
- a. Families denied AFDC solely because of income and resources deemed to be available from--
 - (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
 - (2) Grandparents;
 - (3) Legal guardians; and
 - (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);
 - b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.
 - c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

Colorado County Dept. of Social Services

TN No. 92-2
Supersedes
TN No. 88-1

Approval Date 6/11/92

Effective Date 10/1/91

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

X Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

X Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

— Not applicable with respect to intermediate care facilities; State did or does not cover this service.

1902(a)(10)
(A)(i)(III)
and 1905(n) of
the Act

7. Qualified Pregnant Women and Children.

- a. A pregnant woman whose pregnancy has been medically verified who--

- (1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

*Agency that determines eligibility for coverage.

Colo. County Dept. of Social Services

TN No. 92-2
Supersedes
TN No. 87-5

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

1902(a)(10)(A)
(i)(III) and
1905(n) of the
Act

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

— Children born after

(specify optional earlier date)
who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Agency that determines eligibility for coverage: Colorado County Department of Social Services.

TN No. 93-015

Supersedes

TN No. 92-14

Approval Date 10/13/93 Effective Date 1-1-93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1902(a)(10)(A)
(i)(IV) and
1902(1)(1)(A)
and (B) of the
Act

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(1)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

— The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children:

1902(a)(10)(A)
(i)(VI)
1902(1)(1)(C)
of the Act

- a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

1902(a)(10)(A)(i)
(VII) and 1902(1)
(1)(D) of the Act

- b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.

Agency that determines eligibility for coverage: Colorado County Department
of Social Services.

TN No. 93-015

Supersedes

TN No. 92-14

Approval Date 10/13/93 Effective Date 1-1-93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(a)(10) (A)(i)(V) and 1905(m) of the Act	10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

Agency that determines eligibility for coverage: Colorado
County Department of Social Services.

TN No. 93-015
Supersedes
TN No. 92-14
Approval Date 10/13/93 Effective Date 1-1-93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1902(e)(4)
of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

☒ a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

- ☒ Aged
☒ Blind
☒ Disabled

*AGENCY THAT DETERMINES ELIGIBILITY FOR COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-013

Supersedes

TN No. 02-14

Approval Date 10/13/93 Effective Date 1-1-93

sion: HCFA-PM-91- (BPD)
1991

ATTACHMENT 2.2-A
Page 6a
OMB NO.: 0938-

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

435.121

13. ☒

b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

1619(b)(1)
of the Act

☐ Aged
☐ Blind
☐ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

Colo Department of Social Services - County

TN No. 92-2

Approval Date 6/11/92

Effective Date 10/1/91

Supersedes

TN No. 87-14

HCFA ID: 7983EHCFA ID: 7983.

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1902(a)
(10)(A)
(i)(II)
and 1905
(q) of
the Act

14. Qualified severely impaired blind and disabled individuals under age 65, who--
- a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
 - b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
 - (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
 - (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
 - (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

TN No. 92-2
Supersedes
87-14

Approval Date 6/11/92

Effective Date 10/1/91

State: Colorado

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

Effective Date 10/1/91

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1619(b)(3)
of the Act



The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage

County Dept of Social Services

TN No. 92-2

Approval Date 6/11/92

Effective Date 10/1/91

Supersedes

TN No. 87-14

State: Colorado

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1634(c) of the Act	15.	Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. <input type="checkbox"/> c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. <input type="checkbox"/> d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
42 CFR 435.122	16.	Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
42 CFR 435.130	17.	Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

Effective Date 10/1/91

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

☒ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

☒ Aged ☒ Blind ☒ Disabled

☐ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

County Dept of Social Services

TN No. 92-2

Approval Date 6/11/92

Effective Date 10/1/91

Supersedes

TN No. 87-14

Revision: HCFA-PM-91- (BPD)
1991

ATTACHMENT 2.2-A
Page 6g
OMB NO.: 0938-

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

- | | | |
|----------------|-----|--|
| 42 CFR 435.132 | 19. | Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--

a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

b. Remain institutionalized; and

c. Continue to need institutional care. |
| 42 CFR 435.133 | 20. | Blind and disabled individuals who--

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria. |

*Agency that determines eligibility for coverage.

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7983E

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

- | | | |
|----------------|-------------------------------------|--|
| 42 CFR 435.134 | 21. | Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. |
| | <input checked="" type="checkbox"/> | Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). |
| | <input type="checkbox"/> | Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan). |
| | <input type="checkbox"/> | Not applicable with respect to intermediate care facilities; the State did or does not cover this service. |

*Agency that determines eligibility for coverage.

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92 Effective Date 10/1/91

County Dept of Social Services

State: Colorado

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135

22. Individuals who --

- a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
- b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

Effective Date 10/1/91

County Dept of Social Services

State: Colorado

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1634 of the
Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

- ☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.
- ☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

TN No. 92-2
Supersedes
TN No. 87-14

County Dept. of Social Services
Approval Date 6/11/92 Effective Date 10/1/91

State/Territory: Colorado

Agency* Citation(s) Groups Covered

1634(d) of the
Act

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

_____ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

X In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of the income than would reduce the individual's income to the SSI income standard.

_____ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in § 1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to be disregarded is specified in Supplement 4 to Attachment 2.6-A.

_____ • In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.

*Agency that determines eligibility for coverage.

TN No. 42-15
Supersedes
TN No. NEW

Approval Date 4/22/92

Effective Date 1/1/92

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

ATTACHMENT 2.2-A
Page 9b
OMB NO.: 0938-

State: Colorado

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1902(a)(10)(E)(i)
and 1905(p) of
the Act

25. Qualified Medicare beneficiaries--

- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income does not exceed 100 percent of the Federal poverty level; and
- c. Whose resource standard is equal to the amount defined under Section 1905(p)(1)(C) of the Act

(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

1902(a)(10)(E)(ii),
1905(s) and
1905(p)(3)(A)(i)
of the Act

26. Qualified disabled and working individuals--

- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;
- b. Whose income does not exceed 200 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI-
- d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

*Agency that determined eligibility for coverage

TN No. 10-009
Supersedes
TN No. 93-008

Approval Date. June 7, 2010 Effective Date January 1, 2010

HCFA ID: 7983E

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

ATTACHMENT 2.2-A
Page 9b1
OMB NO.: 0938-

State: Colorado

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) under of thb Act	27.	<p>Specified low-income Medicare beneficiaries--</p> <p>a. Who are entitled to hospital insurance benefits</p> <p>Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</p> <p>b. whose income for calendar years 1993 and 1994 exceeds the income level in 25.b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and</p> <p>c. Whose resource standard is equal to the amount defined under Section 1905(p)(1)(C) of the Act</p> <p>(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)</p>
	28.	<p>Qualifying Individuals</p> <p>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</p> <p>b. whose income for calendar years 1993 and 1994 exceeds the income level in 25.b., but is less than 120 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 135 percent of the Federal poverty level; and</p> <p>c. Whose resource standard is equal to the amount defined under Section 1905(p)(1)(C) of the Act</p> <p>(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)</p>

*Agency that determined eligibility for coverage

TN No. 10-009
Supersedes
TN No. 93-008

Approval Date June 7, 2010 Effective Date January 1, 2010

HCFA ID: 7983E

Revision: HCFA-PM-95-2 (MB)
APRIL 1995

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Page 9b2
OMB NO.: 0938-

State: Colorado

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1634(e) of
the Act

29. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

- b. The State applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

*Agency that determined eligibility for coverage

TN No. 10-009

Approval Date June 7, 2010 Effective Date January 1, 2010

Supersedes

TN No. 93-008

HCFA ID: 7983E

State: Colorado

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR
435.210
1902(a)
(10)(A)(ii) and
1905(a) of
the Act

☐ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

☐ The plan covers all individuals as described above.

☐ The plan covers only the following group or groups of individuals:

- ☐ Aged
- ☐ Blind
- ☐ Disabled
- ☐ Caretaker relatives
- ☐ Pregnant women

42 CFR
435.211

☒ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

Agency that determines eligibility for coverage.

County Dept of Social Services / Social Security

N No. 01-CC8

Approval Date 10/12/01

Effective Date 07/01/01

Supersedes

N No. 92-2

State/Territory: Colorado

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 &
1902(e)(2) of the
Act, P.L. 99-272
(section 9517) P.L.
101-508 (section
4732)

3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in section 1903(m)(2)(B)(iii), (E) or (G) of the Act, or a Competitive Medical Plan (CMP) with a Medicare contract under section 1876 of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in section 1905(a)(4)(C).

☒ The State elects not to guarantee eligibility.

☐ The State elects to guarantee eligibility. The minimum enrollment period is months.

The State measures the minimum enrollment period from:

☐ The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

☐ The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

☐ The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (a new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

*Agency that determines eligibility for coverage

TN No. 02-004

Supersedes

TN No. 00-018

Approval Date 04/26/02

Effective Date 01/01/02

HCFA ID: 798E

State: Colorado

Agency*	Citation(s)	Groups Covered
<u>1932(a)(4) of Act</u>	B.	<u>Optional Groups Other Than the Medically Needy (Continued)</u>

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56

This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

X Disenrollment rights are restricted for a period of 12 months (not to exceed 12 months).

During the first three months of each initial enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

 No restrictions upon disenrollment rights.

1903(m)(2)(H),
1902(a)(52) of
the Act P.L. 101-
508 42 CFR
438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity has a contract.

X The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become ineligible, into the same entity in which they were enrolled at the time eligibility was lost.

 The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

TN No.
Supersedes
TN No.

04-001
94-018

Approval Date

5/25/04

Effective Date

01/01/04

Revision: HCFA-PM-91-10 (MB)
December 1991

STATE/TERRITORY: COLORADO

<u>Agency</u>	<u>Citation(s)</u>	<u>Groups Covered</u>
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
42 CFR 435.217	<u>X</u> 4.	A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR, Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
	<u>X</u> 5.	PACE Enrollees.

*Agency that determines eligibility for coverage.

TN# 13-043
Supersedes TN # 92-015

Effective Date: October 1, 2013
Approval Date: 1/21/14

State: Colorado

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)
(A)(ii)(VII)
of the Act

☒ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☐ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

- ☐ Aged
- ☐ Blind
- ☐ Disabled
- ☐ Individuals under the age of--
 - ☐ 21
 - ☐ 20
 - ☐ 19
 - ☐ 18
- ☐ Caretaker relatives
- ☐ Pregnant women

*Agency that determines eligibility for coverage.

County Dept of Social Services
TN No. 92-2 Approval Date 6/11/92 Effective Date 10/1/91
Supersedes
TN No. 87-5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.220

☒

6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

☒

The State covers all individuals as described above.

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

☐

The State covers only the following group or groups of individuals:

Individuals under the age of--
____ 21
____ 20
____ 19
____ 18
____ Caretaker relatives
____ Pregnant women

42 CFR 435.222
1902(a)(10)(A)
(ii) and 1905(a)
(i) of the Act

7. ☒

a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below.

☒ 20
____ 19
____ 18

*AGENCY THAT DETERMINES ELIGIBILITY FOR COVERAGE: COLORADO COUNTY DEPARTMENT OF SOCIAL SERVICES.

TN No. 93-015
Supersedes
TN No. 92-2

Approval Date 10/13/93

Effective Date 1-1-93

Revision: HCFA-PM-91-
1991

(BPD)

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State: COLORADO

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.222

/X/ b. Reasonable classifications of individuals described in (a) above, as follows:

X (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

X (a) In foster homes (and are under the age of 21).

X (b) In private institutions (and are under the age of 21).

 (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of).

X (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).

X (3) Individuals in NFs (who are under the age of 21). NF services are provided under this plan.

X (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 21).

*AGENCY THAT DETERMINES ELIGIBILITY:
COLORADO COUNTY DEPARTMENT OF SOCIAL SERVICES.

TN No. 93-015
Supersedes

Approval Date 10/13/93

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1-1-93

92-2

HCFA ID: 7983E

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1991

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State: COLORADO

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | |
|----------|-----|---|
| <u>X</u> | (5) | Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of <u>21</u>). Inpatient psychiatric services for individuals under age 21 are provided under this plan. |
| <u>X</u> | (6) | Other defined groups (and ages), as specified in Supplement 1 of <u>ATTACHMENT 2.2-A</u> . |

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015

Supersedes

Approval Date = 10/13/93

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92-2

1-1-93

HCFA ID: 7983E

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)
COLORADO

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State: _____

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10) ☒
(A)(ii)(VIII)
of the Act

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

- a. Was eligible for Medicaid under the State's approved Medicaid plan; or
- b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

☒ 21
— 20
— 19
— 18

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes
TN No. 92-2

Approval Date 10/13/93

Effective Date 1-1-93

HCFA ID: 7983E

ion: HCFA-PM-91- (BPD)
1991

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OMB No.: 0938-

State: COLORADO

Agency*	Citation (s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.223 / 9. Individuals described below who would be eligible
for AFDC if coverage under the State's AFDC plan
were as broad as allowed under title IV-A:

1902(a)(10)
(A)(ii) and
1905(a) of
the Act

___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes

Approval Date 10/13/93

Effective Date
1-1-93

TN No. 92-2

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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State: _____

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.230 ☒ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.
 - ☒ (1) All aged individuals.
 - ___ (2) All blind individuals.
 - ___ (3) All disabled individuals.

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes
TN No. 92-2

Approval Date 10/13/93

Effective Date 1-1-93

HCFA ID: 7983E

sion: HCFA-PM-91- (BPD)
1991

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State: COLORADO

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.230	— (4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	— (5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	— (6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	— (7)	Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	— (8)	Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	— (9)	Individuals in additional classifications approved by the Secretary as follows:

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes

Approval Date 10/13/93

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1-1-93

92-2

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1991

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State: COLORADO

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

 Yes.

 x No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes

Approval Date

10/13/93

Effective Date
1-1-93

92-2

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.230
435.121
1902(a)(10)(A)
(ii)(XI) of the Act

☒ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:

- (1) All aged individuals.
- (2) All blind individuals.
- (3) All disabled individuals.

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes
T: 92-2

Approval Date 10/13/93

Effective Date 1-1-93

State: COLORADO

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | |
|---|-----|---|
| — | (4) | Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (5) | Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (6) | Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (7) | Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (8) | Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (9) | Individuals in additional classifications approved by the Secretary as follows: |

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes

Approval Date 10/13/93

Effective Date
1-1-93

92-2

HCFA ID: 7983E

tion: HCFA-PM-91- (BPD)
1991

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State: COLORADO

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes

☐ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes

Approval Date 10/13/93

Effective Date
1-1-93

Supersedes 92-2

HCFA ID: 7983E

State: COLORADO

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.231 ☒
1902(a)(10)
(A)(ii)(V)
of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☐ The State covers all individuals as described above.

☒ The State covers only the following group or groups of individuals:

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

☒ Aged
☒ Blind
☒ Disabled
— Individuals under the age of--
— 21
— 20
— 19
— 18
— Caretaker relatives
— Pregnant women

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes
TN No. 92-2

Approval Date 10/13/93

Effective Date 1-1-93

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.2-A
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OMB NO.: 0938-

State/Territory Colorado

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | | |
|---|-----|-----|--|
| 1902(e)(3)
of the Act | // | 13. | Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. <u>Supplement 3 to ATTACHMENT 2-A</u> describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home. |
| 1902(a)(10)
(A)(ii)(IX)
and 1902(1)
of the Act | /X/ | 14. | The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6--A</u> :

X a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
b. Infants under one year of age. |

TN No 13-002
Supersedes TN No. 93-015

Approval Date 3/26/13
Effective Date 01/01/2013

State: Colorado

<u>Citation</u>	<u>Condition or Requirement</u>
1902(a)(10)(E)(iii) of the Act	<p>k. <u>Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act--</u></p> <p>The agency uses the same method as in 5.h. of <u>Attachment 2.6-A.</u></p> <p>l. <u>Qualifying Individuals covered under section 1902(a)(10)(E)(iii) of the Act-</u></p> <p>The agency uses the same method as in 5.h. of <u>Attachment 2.6-A.</u></p>
6.	<p>Resource standard - Categorically Needy</p> <p>a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:</p> <p>— Same as SSI resource standards.</p> <p>— More restrictive.</p> <p>The resource standards for other individuals are the same as those in the related cash assistance program.</p> <p>b. Non-1902(f) States (except as specified under items 6.c. and d. below)</p> <p>The resource standards are the same as those in the related cash assistance program.</p> <p><u>Supplement 8 to ATTACHMENT 2.6-A</u> specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.</p>

TN No: 10-009
2010

Supersedes

TN No. 00-009

Approval Date June 7, 2010

Effective Date January 1,

HCFA ID: 7985E

State: COLORADO

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a) ☒ 15.
(10)(A)
(11)(IX)
and 1902(1)(1)
(D) of the Act

The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--

☐ 7 years of age; or

☒ 8 years of age.

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT OF SOCIAL SERVICES.

TN No. 93-015

Supersedes 92-2

TN No. 92-2

Approval Date

10/13/93

Effective Date 1-1-93

HCFA ID: 7983E

F sion: HCFA-PM-91- (BPD)
1991

ATTACHMENT 2.2-A
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OMB NO.: 0938-

State: COLORADO

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a) ☒
(ii)(X)
and 1902(m)
(1) and (3)
of the Act

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supersedes

Approval Date

10/13/93

Effective Date
1-1-93

TN No. 92-2

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Colorado

Citation(s)

1902(a)(47) and 1920 of the Act

Groups Covered

B. Optional Groups Other Than the
Medically Needy (Continued)

X 17. Pregnant women who are determined by a "qualified provider" (as defined in Section 1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with Section 1920 of the Act.

TN No: 05-004

Approval Date 7/05/05

Effective Date 7/1/05

Supersedes TN No. 04-003

State/Territory: COLORADO

Citation

Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1906 of the
Act

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of ____ months.

1902(a)(10)(F)
and 1902(u)(1)
of the Act

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

*AGENCY THAT DETERMINES ELIGIBILITY COVERAGE: COLORADO COUNTY DEPARTMENT
OF SOCIAL SERVICES.

TN No. 93-015
Supercedes
TN No. 92-9

Approval Date 10/13/93

Effective Date 1-1-93
HCFA ID: 7982E

October 1991

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OMB No.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

Citation(s)

Groups Covered

B. Optional Coverage Other Than the Medically Needy (Continued):

1902 (a) (10) (A)
(ii) (XVIII) of the
Act

X [20]. Women who:

- a. Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
- b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;
- c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and
- d. have not attained age 65.

1920B of the Act

X [21]. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) of the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does

TN# 07-008

APPROVAL DATE 12/14/07

SUPERSEDES TN# 02-008

EFFECTIVE DATE July 1, 2007

State:

Citation

Groups Covered

1920B of the Act

B. Optional Groups Other Than the Medically Needy
(Continued)

not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Sections 477,
1902(a)(10)(A)(ii)(XVII),
and 1905(w) of the Act

X 22. Independent Foster Care Adolescents.

An individual who is younger than age 21, who on the individual's 18th birthday was in foster care under the responsibility of a State, who meets the targeting criteria in a.) below, and whose income and resources do not exceed the level(s), if any, established in b.) below.

a. Individuals who meet the following criteria:

- 1) Are under the age of: X 21
— 20
— 19

2) Are: X

All such individuals.

— Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individual turned 18 years old.

— Other reasonable classifications:

October 1991

Page 23d
OMB No.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

Citation(s) Groups Covered

B. Optional Coverage Other Than the Medically Needy (Continued):

___ 3) Other (please describe):

a. Financial Requirements

1) Income test

X There is no income test for this group.

___ The income test for this group is

2) Resource test

X There is no resource test for this group.

___ The resource test for this group is

NOTE:

If there is an income or resource test, then the standards and methodologies used cannot be more restrictive than those used for the State's low-income families with children eligible under section 1931 of the Act as specified in Supplement 12 of Attachment 2.6-A.

TN# 07-008

APPROVAL DATE 12/14/07

SUPERSEDES TN# NEW

EFFECTIVE DATE July 1, 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Colorado

Citation(s)

1902(a)(47) and 1920A of the Act

Groups Covered

B. Optional Groups Other Than the
Medically Needy (Continued)

X 23. Children under age 19 who are determined by a "qualified entity" (as defined in Section 1920A(b)(3)(A) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with Section 1920A of the Act.

TN No: 07-018

Approval Date 6/30/08

Effective Date 1/1/08

Supersedes TN. No: NEW

Revision:

ATTACHMENT 2.2-A

PAGE 23f

OMB NO.:

State/Territory: Colorado

Citation

Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A)
(ii)(XIII) of the Act

[]

23. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of ATTACHMENT 2.6-A.

1902(a)(10)(A)
(ii)(XV) of the Act

[X]

24. TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State.
See page 12d of ATTACHMENT 2.6-A.

1902(a)(10)(A)
(ii)(XVI) of the Act

[]

25. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State.
See page 12h of ATTACHMENT 2.6-A.

NOTE: If the State elects cover this group, it MUST also cover the eligibility group described in No. 24 above.

TN No. 12-005
Supersedes TN No. New

Approval Date 3/22/12 Effective Date 03/01/2012
CMS ID:

State/Territory: Colorado

Citation

Groups Covered

B Optional Groups Other Than the Medically Needy
(Continued)1902(a)(10)(A)
(ii)(XIX) of the Act

[X] 26

Family Opportunity Act –
Children who have not attained 19 years of
age, who would be considered disabled under
Section 1614(a)(3)(C) of the Act, and whose
family income meets the standard described on
Page 12p of Attachment 2.6-A.

X Beginning with the effective date of its
plan amendment, the State covers all
children eligible under this group, as
described below

In the case of the second, third, and
fourth quarters of fiscal year 2007, the
State covers children who were born on
or after January 1, 2001, or who were
born on or after the following earlier date
_____.

In the case of each quarter of fiscal
year 2008, the State covers children
who were born on or after October 1,
1995, or who were born on or after the
following earlier date _____

In the case of each quarter of fiscal
year 2009 and each quarter of any
fiscal year thereafter, the State covers
children who were born after October 1,
1989

TN No 12-013

Supersedes

TN No _____

Approval Date 10/24/12 Effective Date 7/1/2012

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.2-A
Page 23h
OMB NO.: 0938-0193

State: Colorado

Citation	Groups Covered/Special Conditions of Coverage
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B. Optional Coverage Other Than the Medically Needy
(Continued)

1902(e)(12) 27. X Continuous Eligibility for Children

A child under age 19 (not to exceed age 19) who has been determined eligible under Section 1902(a)(10)(A) of the Act is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances, other than moving out of the state or attainment of the maximum age stated above, until the earlier of:

- a. The end of a period (not to exceed 12 months) of continuous eligibility; or
- b. The time that the individual exceeds that age.

TN No. 14-006
Supersedes NEW

Approval Date 11/18/14 Effective Date 3-01-2014

ion: HCFA-PM-91- (BPD)
1991

ATTACHMENT 2.2-A
Page 24
OMB NO.: 0938-

State: Colorado

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

C. Optional Coverage of the Medically Needy

42 CFR 435.301

This plan includes the medically needy.

☒ No.

☐ Yes. This plan covers:

1902(e) of the
Act.

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
2. Women who, while pregnant, were eligible for and have applied for Medicaid and received Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

1902(a)(10)
(C)(ii)(I)
of the Act

TN No. 92-2
Supersedes 87-14

Approval Date 6/11/92

Effective Date 10/1/91

F ion: HCFA-PM-91- (BPD)
1991

ATTACHMENT 2.2-A
Page 25
OMB NO.: 0938-

State: COLORADO -NONE

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of
the Act

4. Newborn children born on or after
October 1, 1984 to a woman who is eligible
as medically needy and is receiving
Medicaid on the date of the child's birth. The child
is deemed to have applied and been found eligible for
Medicaid on the date of birth and remains eligible
for one year so long as the woman remains eligible
and the child is a member of the woman's household.

42 CFR 435.308

5. a. Financially eligible individuals who are not
described in section C.3. above and who are
under the age of--
 21
 20
 19
 18 or under age 19 who are full-time
students in a secondary school or in the
equivalent level of vocational or
technical training

 b. Reasonable classifications of financially
eligible individuals under the ages of 21, 20,
19, or 18 as specified below:

 (1) Individuals for whom public agencies are
assuming full or partial financial
responsibility and who are:

 (a) In foster homes (and are under the age
of).

 (b) In private institutions (and are under
the age of).

TN No. 92-2
Supersedes

Approval Date 6/11/92

Effective Date

TN No. 87-14

10/1/91

HCFA ID: 7983E

ion: HCFA-PM-91- (BPD)
1991

ATTACHMENT 2.2-A
Page 25a
OMB NO.: 0938-

State: _____
COLORADO NONE

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

- (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).
- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).
- (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.
- (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____).
- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- (6) Other defined groups (and ages), as specified in Supplement 1 of. ATTACHMENT 2.2-A.

TN No. 92-2
Supersedes

Approval Date 6/11/92

Effective Date

TN No. 87-14

10/1/94

HCFA ID: 7983E

State: COLORADO NONE

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

C. Optional Coverage of Medically Needy (Continued)

- 42 CFR 435.310 ☒ 6. Caretaker relatives.
- 42 CFR 435.320 ☒ 7. Aged individuals.
and 435.330
- 42 CFR 435.322 ☒ 8. Blind individuals.
and 435.330
- 42 CFR 435.324 ☒ 9. Disabled individuals.
and 435.330
- 42 CFR 435.326 ☒ 10. Individuals who would be ineligible if they were
not enrolled in an HMO. Categorically needy
individuals are covered under 42 CFR 435.212 and
the same rules apply to medically needy
individuals.
- 435.340 11. Blind and disabled individuals who:
 - a. Meet all current requirements for Medicaid
eligibility except the blindness or disability
criteria;
 - b. Were eligible as medically needy in December
1973 as blind or disabled; and
 - c. For each consecutive month after December 1973
continue to meet the December 1973. eligibility
criteria.

Revision: HCFA-PM-91-8 (BPD)

October 1991

ATTACHMENT 2.2-A

Page 26a

OMB NO.: 0938-

State: COLORADO

Citation(s)

Groups Covered

C. Optional Coverage of Medically Needy
(Continued)

1906 of the
Act

12. Individuals required to enroll in
cost effective employer-based group
health plans remain eligible for a minimum
enrollment period of _____ months.

TN No. 92-9
Supersedes New

Approval 6/16/92

EFFECTIVE 10/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66)	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.	
42 CFR 423.774 and 423.904	<ol style="list-style-type: none">1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act.2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined.3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

TN No. 05-016 Approval Date 11/07/05 Effective Date July 1, 2005

Supersedes

TN No. NEW

Revision: HCFA-PM-91-4 (BPD)
August 1991

SUPPLEMENT 1 TO ATTACHMENT 2.2-A
Page 1
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER THE
AGE OF 21, 20, 19 AND 18

OTHER DEFINED GROUPS (AND AGES) 435.222

(6) Other Groups as Defined Below:

All individuals under age 21 for whom
public agencies are assuming full or
partial financial responsibility and
who are:

- a. Receiving services under the
State Board of Social Services
approved plans for Alternatives
as Foster Care Program.
- b. Are in independent living
situations.

TN No. 92-02
Supersedes 86-14 Approval Date 6/11/92 Effective Date 10/1/91
TN NO. 86-14

Revision: HCFA-AT-85-3 (BREC)
FEBRUARY 1985

SUPPLEMENT 2 TO ATTACHMENT 2.2A

State: _____

FOR 1902(f) STATES MORE RESTRICTIVE CATEGORICAL ELIGIBILITY CRITERIA
(NON-FINANCIAL CRITERIA)

NOT APPLICABLE

TN No. 85-8

Supersedes

TN No. _____

Approval Date MAY 30 1985

Effective Date

APR 1 1985

HCFA ID: 0004P/0102A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 3 TO ATTACHMENT 2.2-A
Page 1
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

Method for Determining Cost Effectiveness of Caring for
Certain Disabled Children At Home

Not applicable

TN No. 03-007 Approval Date 05/14/03 Effective Date 04/01/03
Supersedes
TN No. _____ HCFA ID: 7982E

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: COLORADO

Citation

435.10 and
435.403, and
1902(b) of the
Act, P.L. 99-272
(Section 9529)
and P.L. 99-509
(Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

TN No. 87-14
Supersedes
TN No. 87-5

Approval Date 8/21/87

Effective Date 4/1/87

HCFA ID: 1006P/0010P

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: COLORADO

Citation

42 CFR 435.530(b)

42 CFR 435.531

AT-78-90

AT-79-29

2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

TN No. 87-14

Supersedes

TN No. _____

Approval Date 9/21/87

Effective Date 4/1/87

HCFA ID: 1006P/0010P

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State: COLORADO

Citation

42 CFR
435.121,
435.540(b)
435.541

2.5 Disability

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

TN No. 92-1

Supersedes

TN No. 87-14

Approval Date

4/9/92

Effective Date 10/1/91

HCFA ID: 7982E

State: _____

COLORADO

Citation(s)

2.6 Financial Eligibility

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

- (a) The financial eligibility conditions for
Medicaid-only eligibility groups and for
persons deemed to be cash assistance
recipients are described in ATTACHMENT 2.6-A.

TN No. 92-14

Supersedes

Approval Date

6/11/92

Effective Date

7/1/92

TN No. _____

92-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
A. General Conditions of Eligibility	
Each individual covered under the plan:	
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

TN No. 92-14
Supersedes 92-02 Approval Date 6/11/92 Effective Date 11/1/92
TN No. _____

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AUGUST 1991

(MB)

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OMB No.: 0938-

State COLORADO

Citation(s)	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of thi Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.406	3. Is residing in the United States and-- a. Is a citizen or national of the United States; b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended; c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA; d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;

TN No: 11-011
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TN No. 09-036

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AUGUST 1991

(MB)

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State COLORADO

Citation(s)	Condition or Requirement
e.	<p>Is a qualified alien (QA) whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.</p> <p><u>X</u> State covers all authorized QAs. ___ State does not cover authorized QAs.</p>
f.	<p>State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women as specified below who are aliens lawfully residing in the United States; including the following:</p> <p>(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);</p> <p>(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;</p> <p>(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;</p> <p>(4) An alien who belongs to one of the following classes:</p> <p>(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);</p> <p>(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;</p> <p>(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);</p> <p>(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;</p> <p>(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;</p> <p>(vi) Aliens currently in deferred action status; or</p> <p>(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;</p>

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AUGUST 1991

(MB)

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OMB No.: 0938-

State COLORADO

Citation(s)	Condition or Requirement
(5)	A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
(6)	An alien who has been granted withholding of removal under the Convention Against Torture;
(7)	A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
(8)	An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9)	An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

X Elected for pregnant women.
_____ Elected for children.

g. X The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

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AUGUST 1991

(MB)

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State COLORADO

Citation(s)	Condition or Requirement
42 CFR 435.403 1902(b) of the Act	<p>4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.</p> <p>// State has interstate residency agreement with the following States:</p> <p>// State has open agreement(a).</p> <p>// Not applicable; no residency requirement.</p>

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Effective Date 1/1/11

HCFA ID: 7985E

State/Territory: COLORADO

Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. <input type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

TN No. 929
Supersedes

Approval Date 6/16/92

Effective Date 10/1/92

TN No. 92-2

HCFA ID: 7985E

State: COLORADO

Citation	Condition or Requirement
	<p>An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.</p> <p>An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.</p> <p><input checked="" type="checkbox"/> Assignment of rights is automatic because of State law.</p>
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number), except for aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) of the Social Security Act (Section 1137(f)).

TN No. 92-9
Supersedes 92-2 Approval Date 6/16/92 Effective Date 10/1/91
TN No. _____

ion: HCFA-PM-91- (BPD)
1991

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State: COLORADO

Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

TN No. 92-2
Supersedes
TN No. NEW

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Effective Date 10/1/91

HCFA ID: 7985

Revision: HCFA-PM-91-8
October 1991

(MB)

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Page 3c

State of Colorado

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).
<i>New York State Department of Social Services v. Dublino</i>	11. Is required to apply for Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for and subsequently enrolled in Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

TN# 05-012

SUPERCEDES TN# 92-9

APPROVAL DATE 3/03/06

EFFECTIVE DATE January 1, 2006

Revision: HCFA-PM-97-2
December 1997

ATTACHMENT 2.6-A
Page 4
OMB No.:0938-0673

State: Colorado

Citation	Condition or Requirement
B. Posteligibility Treatment of Institutionalized Individuals' Incomes	
1. The following items are not considered in the posteligibility process:	
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to \$90 per month under 38 U.S.C. 5503.

TN No. 99-005
Supersedes

Approval Date 12/09/99

Effective Date 07/01/99

TN No. NEW

Revision: HCFA-PM-97-2
December 1997

Attachment 2.6-A
Page 4a
OMB.: 0938-0673

State: Colorado

Citation

Condition or Requirement

1924 of the Act
435.725
435.733
435.832

2. The following monthly amount for personal needs is deducted from the total monthly income in the application of an institutionalized individual's income to the cost of care at a nursing facility or intermediate care facility for individuals with intellectual disabilities.

Beginning January 1, 2015, and on January 1 of each year thereafter, the basic minimum Personal Needs Allowance (PNA) of \$75 is increased for individuals by the same percentage as the increase in the nursing facility (NF) provider reimbursement rate that is detailed in Attachment 4.19-D.

- a. Aged, blind, disabled.
Individuals: \$75.00 + annually by the same percentage as the increase in the NF rate.
- b. TANF related:
Children: \$75.00 + annually by the same percentage as the increase in the NF rate.
Adults: \$75.00 + annually by the same percentage as the increase in the NF rate.
- c. Individuals under age 21 covered in the plan as specified in Item B.7 of Attachment 2.2-A.: \$75.00 + annually by the same percentage as the increase in the NF rate.

For the above persons with greater need:

Supplement 12 to Attachment 2.6.-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

TN No. CQ 14-041

Supersedes TN No. 2000-002

Approval Date 01/20/15

Effective Date: January 1, 2015

Revision: HCFA-PM-97-2
December 1997

State: Colorado

Citation(s)

1924 of the Act 3. In addition to the amounts under item 2, the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

- a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924(d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

 X The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

 The poverty level component is calculated using a percentage greater than the applicable percentage, equal to %, of the official poverty level (still subject to maximum maintenance needs standard.)

 The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

Revision: HCFA-PM-97-2
December 1997

ATTACHMENT 2.6-A
Page 4c
OMB No.: 0938-0673

State: Colorado

Citation	Condition or Requirement
	In determining any excess shelter allowance, utility expenses are calculated using: <input checked="" type="checkbox"/> the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or <input type="checkbox"/> the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.
b.	The monthly income allowance for other dependent family members living with the community spouse is: <input checked="" type="checkbox"/> one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income. <input type="checkbox"/> a greater amount calculated as follows: The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):
c.	Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to <u>ATTACHMENT 2.6-A.</u>)

TN No. 99-005
Supersedes

Approval Date 12/09/99

Effective Date 07/01/99

TN No. NEW

State: Colorado

Citation	Condition or Requirement
435.725 435.733 435.832	<p>4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</p> <ul style="list-style-type: none">o AFDC level; oro Medically needy level: <p>(Check one)</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> AFDC levels in Supplement 1-- Medically needy level in Supplement 1-- Other: \$ _____ <p>b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:</p> <p>(I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</p> <p>(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)</p>
435.725 435.733 435.832	<p>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:</p>

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

☐ No.

☒ Yes (the applicable amount is shown on page 5a.)

TN No. 99-003
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TN No. 99-001

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December 1997

State: Colorado

ATTACHMENT 2.6-A
Page 5a
OMB No.: 0938-0673

Citation	Condition or Requirement
<u> </u>	Amount for maintenance of home is: \$
<u> X </u>	<p>Amount for maintenance of home is the actual maintenance costs not to exceed the Individual Needs Standard less 105% of the Federal Poverty Level (according to the tables most recently published as of January 1st of the calendar year) for a household of 1. The Individual Needs Standard is determined as follows:</p> <p>1. HCPF will calculate an Individual Needs Standard by dividing the Federal Minimum Monthly Maintenance Needs Allowance maximum, by the Federal Minimum Monthly Maintenance Needs Allowance in place on January 1st of each Calendar Year; the result of this division will be multiplied by 150% of the Federal Poverty Level (according to the tables most recently published as of January 1st of the calendar year) for a household of 1.</p> <p>Claimable utility costs will be limited to the lessor of the following amounts:</p> <ul style="list-style-type: none">a. The standard utility allowance used by Colorado under 7 U.S.C. 2014(e) (2018)Or,b. The individual's actual utility expenses
<u> </u>	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
<u> </u>	Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.

TN# 18-0001

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Supersedes

TN# 01-001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p>C. <u>Financial Eligibility</u></p> <p>For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.</p> <p>For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.</p> <p>Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.</p>

TN No. 92-14
Supersedes 92-02 Approval Date 6/11/92 Effective Date 1/1/92
TN No. 92-02

State: Colorado

Citation	Condition or Requirement
<input checked="" type="checkbox"/>	<u>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.</u>
<input type="checkbox"/>	<u>Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.</u>
<input type="checkbox"/>	<u>Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.</u>
<input type="checkbox"/>	<u>Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.</u>
<input checked="" type="checkbox"/>	<u>Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.</u>
<input checked="" type="checkbox"/>	<u>Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.</u>
<input type="checkbox"/>	<u>Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.</u>

TN No. 00-010
Supersedes
TN No. 93-001

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	<p>1. <u>Methods of Determining Income</u></p> <p>a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u></p> <p>(1) In determining countable income for AFDC-related individuals, the following methods are used:</p> <p>— (a) The methods under the State's approved AFDC plan only; or</p> <p><u>X</u> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to <u>ATTACHMENT 2.6-A.</u></p> <p>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p>
1902(e)(6) the Act	<p>(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. <u>Aged individuals.</u> In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: <p><input type="checkbox"/> The methods of the SSI program only.</p> <p><input checked="" type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p>

TN No. 93-001
Supersedes
TN No. 92-14

Approval Date MAY 28 1993

Effective Date 10/1/92

State: COLORADO

Citation	Condition or Requirement
<input checked="" type="checkbox"/>	For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> ; and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
<input checked="" type="checkbox"/>	For institutional couples, the methods specified under section 1611(e)(5) of the Act.
<input type="checkbox"/>	For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> .
<input type="checkbox"/>	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- ____ SSI methods only. ____ SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> . ____ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> . In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

N No. 93-001
supersedes
N No. 92-2

Approval Date MAY 28 1993

Effective Date 10/1/92

State: COLORADO

Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	<p>c. <u>Blind individuals.</u> In determining countable income for blind individuals, the following methods are used:</p> <p>— The methods of the SSI program only.</p> <p><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>— For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>, and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p><u>X</u> For institutional couples, the methods specified under section 1611(e)(5) of the Act.</p> <p>— For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u></p> <p>— For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--</p> <p>— SSI methods only.</p> <p>— SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>— Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p>

TN No. 93-001
Supersedes
TN 92-2

Approval Date MAY 28 1993

Effective Date 10/1/92

State: COLORADO

Citation	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. <u>Disabled individuals.</u> In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used: <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program.<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u><input checked="" type="checkbox"/> For institutional couples: the methods specified under section 1611(e)(5) of the Act.<input type="checkbox"/> For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u><input type="checkbox"/> For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A;</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

TN No. 43-001
Supersedes
TN No. 92-2

Approval Date MAY 28 1993

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ion: HCFA-PM-91- (BPD)
1991

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OMB No.: 0938-

State: COLORADO

Citation

Condition or Requirement

— For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

— SSI methods only.

— SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

— Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

TN No. 92-2
Supersedes
TN No. 89-23

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7985E

State Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(E) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women, infants, and children.</u> For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act--</p> <p>(1) The following methods are used in determining countable income:</p> <p>___ The methods of the State's approved AFDC plan.</p> <p>___ The methods of the approved title IV-E plan.</p> <p><u>X</u> The methods of the approved AFDC State plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>___ The methods of the approved title IV-E plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. <u>Qualified Medicare beneficiaries.</u> In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: <u> </u> The methods of the SSI program only. <u> X</u> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u> <u> </u> For institutional couples, the methods specified under section 1611(e)(5) of the Act.

TN No. 93-001
Supersedes
TN No. 92-14

Approval Date MAY 28 1993

Effective Date 10/1/92

State: Colorado

<u>Citation</u>	<u>Condition or Requirement</u>
	<p>If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.</p> <p>For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.</p> <p>For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.</p>
1905(s) of the Act	<p>g. (1) <u>Qualified disabled and working individuals</u> In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.</p>
1905(p) of the Act	<p>(2) <u>Specified low-income Medicare beneficiaries.</u> In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.</p> <p>(3) <u>Qualifying Individuals</u> In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.</p>

TN No: 10-009
Supersedes
TN No. 93-008

Approval Date June 7, 2010 Effective Date January 1, 2010

HCFA ID: 7985E

State/Territory: COLORADO

Citation	Condition or Requirement
1902(u) of the Act	<p>(h) <u>COBRA Continuation Beneficiaries</u></p> <p>In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:</p> <ul style="list-style-type: none">_____ The disregards of the SSI program;_____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. <p>NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).</p>

TN No. 929
Supersedes

Approval Date 6/16/92

Effective Date 10/1/91

TN No. New

HCFA ID: 7985E

Revision:

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A)(ii) I. (i) (XIII) of the Act	<p><u>Working Individuals With Disabilities -BBA</u></p> <p>In determining countable income and resources for working individuals with disabilities under BBA, the following methodologies are applied:</p> <p>_____ The methodologies of the SSI program.</p> <p>_____ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and Supplement 5 (resources) to <u>ATTACHMENT 2.6-A</u>.</p> <p>_____ The agency uses more liberal income and/or resource than the SSI program. More liberal methodologies are described in Supplement 8a to attachment 2.6-A. More liberal resource methodologies are described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p>

TN No. 12-005
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Approval Date 3/22/12 Effective Date 03/01/2012
CMS ID:

Revision:

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
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1902(a)(10)(A)
(ii)(XV) of the Act

(ii) Working Individuals with Disabilities - Basic Coverage Group - TWWIIA

In determining financial eligibility for working individuals with disabilities under this provision, The following standards and methodologies are applied:

☐ The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

☒ The agency applies the following income and/or resource standard(s): 450% FPL is the income standard. There is no resource standard applied.

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p><u>Income Methodologies</u></p> <p>In determining whether an individual meets the income standard described above, the agency uses the following methodologies.</p> <p>_____ The income methodologies of the SSI program.</p> <p>_____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u>.</p> <p><u>X</u> The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p>

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p><u>Resource Methodologies</u></p> <p>In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p>All funds held in retirement funds and accounts are disregarded.</p> <p>Unless one of the following items is checked, the agency, under the authority of 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p> <p>_____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.</p> <p>_____ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p>

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Supersedes TN No. New

Approval Date 3/22/12 Effective Date 03/01/2012
CMS ID:

Revision:

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p>_____ The agency does not disregard funds in retirement accounts.</p> <p>_____ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p> <p>_____ The agency uses the resource methodologies of the SSI Program.</p> <p>_____ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u>.</p>

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act	<p>(ii) <u>Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIIA</u></p> <p>Not applicable</p> <p>In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:</p> <p>_____ The agency does not apply any income or resource standard.</p> <p>NOTE: If the above option is chosen, no further eligibility-related options should be elected.</p> <p>_____ The agency applies the following income and/or resource standard(s):</p>

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State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<p><u>Income Methodologies</u></p> <p>In determining whether an individual meets the income standard described above, the agency uses the following methodologies.</p> <p>_____ The income methodologies of the SSI program.</p> <p>_____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u>.</p> <p>_____ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p>

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<p><u>Resource Methodologies</u></p> <p>In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p>Unless one of the following items are checked, the agency, under the authority of 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p> <p>_____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.</p> <p>_____ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p>

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<p>_____ The agency does not disregard funds in retirement accounts.</p> <p>_____ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p>_____ The agency uses the resource methodologies of the SSI Program.</p> <p>_____ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in <u>Supplement 5 to ATTACHMENT 2.6-A.</u></p>

TN No. 12-005
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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act	<u>Definition of Employed – Employed Medically Improved Individuals – TWWIIA</u> —— The agency uses the statutory definition of “employed”, i.e., earning at least the minimum wage, and working at least 40 hours per month. —— The agency uses an alternative definition of “employed” that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency’s threshold criteria is described below:

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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII) (XV), (XVI), and 1916(g) of the Act	<p><u>Payment of Premiums or Other Cost Sharing Charges</u></p> <p>For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of <u>ATTACHMENT 2.2-A</u>:</p> <p>_____ The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:</p>

TN No. 12-005
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OMB No.:

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A)(ii) (XIII), (XV), (XVI), and 1916(g) of the Act (cont.)	<p>For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of <u>ATTACHMENT 2.2-A</u>.</p> <p>NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds \$75,000 pay 100 percent of premiums.</p> <p><u>X</u> The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.</p> <p>The premiums or other cost-sharing charges, and how they are applied are described on page 12o.</p>

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SupersedesTN No. New

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State/Territory: Colorado

Citation	Condition or Requirement
Sections 1902(a)(10)(A) (ii)(XV), (XVI), and 1916(g) of the Act (cont.)	<p><u>Premiums and Other Cost-Sharing Charges</u></p> <p>For the Basic Coverage Group, the agency's premium and other cost-sharing charges, and how they are applied, are described below.</p> <p>There are five income tiers:</p> <p>There is a no monthly premium amount for income which is at or below 40% of FPL A monthly premium of \$25 is applied to income above 40% FPL but at or below 133% FPL A monthly premium of \$90 is applied to income above 133% FPL but at or below 200% FPL A monthly premium of \$130 is applied to income above 200% FPL but at or below 300% FPL A monthly premium of \$200 is applied to income above 300% FPL but at or below 450% FPL</p> <p>Premiums are charged beginning the month after determination of eligibility.</p> <p>NOTE: The State may waive payment of any such premium in any case where the State determines that requiring payment would create an undue hardship.</p>

TN No. 15-0006
Supersedes TN 12-005

Approval Date 9/16/15
Effective Date 04/01/2015

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XIX) of the Act (cont.)	<p data-bbox="662 470 922 502"><u>Income Standards</u></p> <p data-bbox="662 544 1435 619"><u> X </u> The agency uses the family income standard of 300% of federal poverty level.</p> <p data-bbox="662 661 1435 736"><u> </u> The agency uses the family income standard of less than 300% of the federal poverty level.</p> <p data-bbox="760 768 1295 800">Specify the income standard <u> </u></p> <p data-bbox="662 842 1435 991"><u> </u> The agency uses a family income standard higher than 300% of the federal poverty level, (no federal financial participation is provided for benefits to families above 300% FPL)</p> <p data-bbox="760 1023 1295 1055">Specify the income standard <u> </u></p> <p data-bbox="662 1140 954 1172"><u>Resource Standards</u></p> <p data-bbox="662 1215 1317 1291">Under this provision agencies may not impose resource standards in determining eligibility</p>

TN No 12-013

Supersedes

TN No. _____

Approval Date 10/24/12 Effective Date 7/1/2012

State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XIX) of the Act (cont.)	<u>Income Methodologies</u> In determining whether a family meets the income standard described above, the agency uses the following methodologies. <input type="checkbox"/> The income methodologies of the SSI program <input type="checkbox"/> The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. <input checked="" type="checkbox"/> The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

TN No. 12-013

Supersedes

TN No. _____

Approval Date 10/24/12 Effective Date 07/01/2012
CMS ID:

State/Territory Colorado

Citation	Condition or Requirement
1902(cc) of the Act and 1903(a)	<p data-bbox="630 474 1406 510"><u>Interaction with Employer Sponsored Family Coverage</u></p> <p data-bbox="662 549 1425 619">For individuals eligible under the FOA eligibility group described in No. 26 on page 23e of Attachment 2.2-A.</p> <p data-bbox="662 661 1422 878">The agency requires parents to enroll in available group health plans through their employers if the plan qualifies under Section 2791(a) of the Public Health Service Act and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage.</p> <p data-bbox="662 921 1414 1215">If such coverage is obtained, the agency (subject to the payment of premiums described in Attachment 2.6-A, pages 12s and t) reduces any premium imposed by the State by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability, and treats such coverage as a third party liability.</p> <p data-bbox="753 1257 1430 1508">_____ The agency provides for payment of all or some portion of the annual premium for the employer-provided private family coverage that the parent is required to pay. Any payments made by the State are considered, for purposes of section 1903(a), to be payments for medical assistance.</p> <p data-bbox="753 1551 1393 1619">The agency pays _____ percent of the premium</p>

TN No. 12-013

Supersedes

TN No. _____

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State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIX), 1916(i) and 1902(cc)(2)(A)(ii)(I) of the Act	<p><u>Payment of Premiums</u></p> <p>For individuals eligible under the FOA eligibility group described in No. 26 on page 23e of Attachment 2.2-A.</p> <p><input type="checkbox"/> The agency does not require the payment of premiums for Medicaid coverage</p> <p><input checked="" type="checkbox"/> The agency requires payment of premiums on a sliding scale based on income. The premiums, and how they are applied are described below:</p> <p>NOTE. Amounts paid for premiums for Medicaid, required family coverage, and other cost-sharing may not exceed 5% of a family's income for families with income up to and including 200% FPL and 7.5% of a family's income for families above 200% and up to 300% FPL.</p>

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Supersedes

TN No. _____

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State/Territory: Colorado

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIX), 1916(i) and 1902(cc)(2)(A)(ii)(I) of the Act	<p data-bbox="667 537 980 606"><u>Payment of Premiums</u> (Continued)</p> <p data-bbox="667 648 1430 863">NOTE: A State may not require prepayment of premiums and may not terminate eligibility of a child for medical assistance on the basis of failure to pay a premium until the failure to pay continues for at least 60 days from the date on which the premium was past due.</p> <p data-bbox="667 905 1403 974">NOTE: Premiums are charged beginning the month after determination of eligibility.</p> <p data-bbox="573 1016 1373 1157">NOTE: The State may waive payment of any such premium in any case where the State determines that requiring payment would create an undue hardship.</p> <p data-bbox="573 1199 1040 1226">Premium amounts are as follows:</p> <ol data-bbox="573 1268 1419 1600" style="list-style-type: none"> There is no monthly premium for households with income at or below 133% of FPL. A monthly premium of \$70 is applied to households with income above 133% of FPL but at or below 185% of FPL. A monthly premium of \$90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL. A monthly premium of \$120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.

State: COLORADO

Citation	Condition or Requirement
1902(k) of the Act	<p>2. Medicaid Qualifying Trusts</p> <p>In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.</p> <p><input checked="" type="checkbox"/> The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes an undue hardship.</p>
1902(a)(10) of the Act	<p>3. Medically needy income levels (MNILs) are based on family size.</p> <p><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.</p>

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State: COLORADO

Citation	Condition or Requirement
42 CFR 435.732, 435.831	<p>4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only</p> <p>a. <u>Medically Needy</u></p> <p>(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either ____ or ____ month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.</p> <p>(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:</p> <p>(a) Health insurance premiums, deductibles and coinsurance charges.</p> <p>(b) Expenses for necessary medical and remedial care not included in the plan.</p> <p>(c) Expenses for necessary medical and remedial care included in the plan.</p> <p>____ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.</p> <p>1902(a)(17) of the Act</p> <p>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.</p>

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

Effective Date 10/1/91

State/Territory: COLORADO (NONE)

Citation	Condition or Requirement
1903(f)(2) of the Act	a. <u>Medically Needy (Continued)</u> — (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

TN No. 929
Supersedes
TN No. New

Approval Date 6/16/92

Effective Date

10/1/91

HCFA ID: 7985E/

ion: HCFA-PM-91- (BPD)
1991

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State: COLORADO

Citation	Condition or Requirement
	b. <u>Categorically Needy - Section 1902 (f) States</u>
42 CFR 435.732	<p>The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</p> <ol style="list-style-type: none">(1) Any SSI benefit received.(2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.(3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.(4) Other deductions from income described in this plan at <u>Attachment 2.6-A, Supplement 4.</u>(5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

TN No. 92-2
Supersedes 87-14

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7985E

Revision: HCFA-PM-91-8 (MB)
October 1991

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COLORADO

State/Territory: _____

Citation	Condition or Requirement
1903(f)(2) of the Act	4.b. <u>Categorically Needy - Section 1902(f) States</u> Continued ____ (6) Spenddown payments made to the State by the individual.

NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

TN No. 92-9
Supersedes
TN No. New

Approval Date 6/16/92

Effective Date 10/1/91

HCFA ID: 7985E/

STATE OF COLORADO

Citation

Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

/x/ (b) The method under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

ion: HCFA-PM-91- (BPD)
1991

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OMB No.: 0938-

State: COLORADO

Citation

Condition or Requirement

5. Methods for Determining Resources

1902(a)(10)(A),
1902(a)(10)(C),
1902(m)(1)(B)
and (C), and
1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

- ☐ The methods of the SSI program.
- ☒ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- ☐ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

TN No. 93-001
Supersedes
TN 92-2

Approval Date MAY 28 1993

Effective Date 10/1/92

HCFA ID: 7985E

ion: HCFA-PM-91- (BPD)
1991

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OMB No.: 0938-

State: COLORADO

Citation

Condition or Requirement

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

1902(a)(10)(A),
1902(a)(10)(C),
1902(m)(1)(B), and
1902(r) of the
Act

c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources:

— The methods of the SSI program.

X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

— Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

TN No. 93-001
Supersedes
TN No. 92-2

Approval Date MAY 28 1993

Effective Date 10/1/92

HCFA ID: 7985E

sion: HCFA-PM-91- (BPD)
1991

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OMB No.: 0938-

State: COLORADO

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <p><u>X</u> The methods of the SSI program.</p> <p>— SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>— Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(1)(3) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <p>— The methods of the SSI program only.</p> <p>— The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7985

State: COLORADO

Citation	Condition or Requirement
	<p>Methods that are more liberal than those of SSI. The more liberal methods are specified in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>
	<p><u>X</u> Not applicable. The agency does not consider resources in determining eligibility.</p>
	<p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(l)(3) and 1902(r)(2) of the Act	<p>f. <u>Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.</u></p> <p>The agency uses the following methods for the treatment of resources:</p>
	<p>Methods of the State's approved AFDC plan.</p>
1902(l)(3)(C) of the Act	<p>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u></p>
1902(r)(2) of the Act	<p>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>
	<p><u>X</u> Not applicable. The agency does not consider resources in determining eligibility.</p>
TN No. <u>92-2</u> Supersedes TN No. <u>87-14</u>	Approval Date <u>6/11/92</u> Effective Date <u>10/1/91</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 1. <u>Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act.</u> The agency uses the following methods for the treatment of resources: — The methods of the State's approved AFDC plan. — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u> — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u> — Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3)(C) of the Act	
1902(r)(2) of the Act	

TN No. 92-14
Supersedes 92-02 Approval Date 6/11/92 Effective Date 11/1/92
TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	<p>g. 2. <u>Poverty level children under section 1902(a)(10)(A)(i)(VII)</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <ul style="list-style-type: none">— The methods of the State's approved AFDC plan.— Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>— Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
1902(1)(3)(C) of the Act	
1902(r)(2) of the Act	<p><u>x</u> Not applicable. The agency does not consider resources in determining eligibility.</p> <p>In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>

Revision: HCFA-PM-91-8
October 1991

(MB)

ATTACHMENT 2.6-A
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OMB No.:

State: Colorado

<u>Citation</u>		<u>Condition or Requirement</u>
1905(p)(1) (C) and 1902(r)(2) of the Act	5. h.	<u>For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act</u> the agency uses the following methods for treatment of resources: <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program only.<input checked="" type="checkbox"/> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
1905(s) of the Act	i.	For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j.	For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program only.<input type="checkbox"/> More restrictive methods applied under section 1902(f) of the Act as described in <u>Supplement 5 to Attachment 2.6-A.</u>

TN No: 18-0032
Supersedes
TN No. 10-009

Approval Date 7/31/18

Effective Date April 1, 2018

HCFA ID: 7985E

State: Colorado

<u>Citation</u>	<u>Condition or Requirement</u>
1902(a)(10)(E)(iii) of the Act	<p>k. <u>Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act--</u></p> <p>The agency uses the same method as in 5.h. of <u>Attachment 2.6-A.</u></p> <p>l. <u>Qualifying Individuals covered under section 1902(a)(10)(E)(iii) of the Act-</u></p> <p>The agency uses the same method as in 5.h. of <u>Attachment 2.6-A.</u></p>
6.	<p>Resource standard - Categorically Needy</p> <p>a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:</p> <p>— Same as SSI resource standards.</p> <p>— More restrictive.</p> <p>The resource standards for other individuals are the same as those in the related cash assistance program.</p> <p>b. Non-1902(f) States (except as specified under items 6.c. and d. below)</p> <p>The resource standards are the same as those in the related cash assistance program.</p> <p><u>Supplement 8 to ATTACHMENT 2.6-A</u> specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.</p>

TN No: 10-009
2010

Supersedes

TN No. 00-009

Approval Date June 7, 2010

Effective Date January 1,

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	c.	<p>For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</p> <p>— Yes. <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><u>x</u> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (C) of the Act	d.	<p>For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</p> <p>— Yes. <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><u>x</u> No. The agency does not apply a resource standard to these individuals.</p>

ion: HCFA-PM-91- (BPD)
1991

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OMB No.: 0938-

State: COLORADO

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	<p>e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:</p> <p><u>X</u> Same as SSI resource standards.</p> <p>— Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).</p> <p><u>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.</u></p>

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92 Effective Date 10/1/91

HCFA ID: 7985E

State: Colorado

Citation	Condition or Requirement
1902(a)(10)(C)(i) of the Act	<p>7. Resource Standard - Medically Needy</p> <p>a. Resource standards are based on family size.</p> <p>b. A single standard is employed in determining resource eligibility for all groups.</p> <p>c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--</p> <ul style="list-style-type: none">— Aged— Blind— Disabled <p><u>Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.</u></p>
1905(p)(1)(D) and (p)(2)(B) of the Act	<p>8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals</p> <p>For qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act, specified low-income Medicare beneficiaries covered under Section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under Section 1902(a)(10)(E)(iv) of the Act, the resource standard is equal to the amount defined under Section 1905(p)(1)(C) of the Act.</p>
1905(s) of the Act	<p>9. Resource Standard - Qualified Disabled and Working Individuals</p> <p>For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.</p>

TN No: 10-009

Approval Date June 7, 2010

Supersedes

TN No. 00-009

Effective Date January 1, 2010

OMB ID: 7985E

State/Territory: COLORADO

Citation	Condition or Requirement
1902(u) of the Act	9.1 For COBRA continuation beneficiaries, the resource standard is: Twice the SSI resource standard for an individual. More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

TN No. 92-9
Supersedes _____ Approval Date 6/15/92 Effective Date 10/1/91
TN No. NEW
HCFA ID: 7985E

Revision: HCFA-PM-93-5
MAY 1993

(MB)

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State: Colorado

<u>Citation</u>	<u>Condition or Requirement</u>
1902(u) of the Act	<p>10. Excess Resources</p> <p>a. Categorically Needy, Qualified Beneficiaries, Qualified Disabled and Working Individuals, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals</p> <p>Any excess resources make the individual ineligible.</p> <p>b. Categorically Needy Only</p> <p>— This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.</p> <p>c. Medically Needy</p> <p>Any excess resources make the individual ineligible.</p>

TN No: 10-009
Supersedes
TN No. 00-009

Approval Date June 7, 2010 Effective Date January 1, 2010

HCFA ID: 7985E

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

STATE OF COLORADO

ATTACHMENT 2.6-A

Page 24

Citation

Condition or Requirement

42 CFR § 435.914 11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

- ☒ Aged, blind, disabled
☒ AFDC-related
☒ All other Title XIX populations

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

- ☐ Aged, blind, disabled
☐ AFDC-related
☐ All other Title XIX populations

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

- ☐ Aged, blind, disabled
☐ AFDC-related
☐ All other Title XIX populations.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

- ☒ Aged, blind, disabled
☒ AFDC-related.
☒ All other Title XIX populations

No. 13-041
ersedes TN No. 07-004

Approval Date 3/3/14
Effective Date 10/01/13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation

Condition or Requirement

1920(b)(1) of the Act

X (3) For a presumptive eligibility for pregnant women only.

Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.

1902(e)(8) and 1905(a) of the Act

X b. For qualified Medicare beneficiaries defined in Section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under Section 1905(p)(1). The eligibility determination is valid for:

X 12 months
_____ 6 months
_____ months (no less than 6 months and no more than 12 months)

TN No: 05-004

Approval Date 07/05/05

Effective Date 7/1/05

Supersedes TN 04-003

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation

1920A(b) of the Act

Condition or Requirement

X For presumptive eligibility for children under age 19 only.

Coverage for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period. The presumptive eligibility period begins on the day a qualified entity determines that a child under age 19 meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the child files an application for Medicaid by the last day of the month following the month in which the qualified entity made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the child does not file an application for Medicaid by the last day of the month following the month in which the qualified entity made the determination, the period ends on that last day.

TN No: 07-018

Approval Date

6/30/08

Effective Date 1/1/08

Supersedes TN. No: NEW

Citation	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	<p>12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</p> <p>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</p> <p>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A</u>.</p>
1917(c)	<p>13. Transfer of Assets - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</p> <p>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9(a) to ATTACHMENT 2.6-A</u>, except in instances where the agency determines that the transfer rules would work an undue hardship.</p>
1917(d)	<p>14. Treatment of Trusts - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</p> <p>— The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;</p> <p><u>x</u> The agency meets the requirements in section 1917(d)(4)(B) of the Act, for use of <u>Miller</u> trusts.</p> <p>The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in <u>Supplement 10 to ATTACHMENT 2.6-A</u>.</p>

Revision: HCFA-PM-99-1

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OMB No.:0938-0673

State: Colorado

Citation Condition or Requirement

1924 of the Act

15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

- X the maximum standard permitted by law;
 the minimum standard permitted by law; or
\$ a standard that is an amount between the minimum and the maximum.

TN No. 99-005
Supersedes
TN No. NEW

Approval Date 12/09/99

Effective Date 07/01/99

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

<u>Family Size</u>	<u>Need Standard</u>	<u>Payment Standard</u>	<u>Maximum Payment Amounts</u>
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See Attachment of AFDC charts

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level--

☒ 133 percent ☐ _____ percent (no more than 185 percent)
(specify)

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____

TN No. 92-2
Supersedes
TN No. 87-14

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Effective Date 10/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.
4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

TN No. 92-14
Supersedes 92-02 Approval Date 6/11/92 Effective Date 1/1/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Rateable Reduction
is .8475

STATE: COLORADO

AFDC STANDARDS OF ASSISTANCE CHART
Effective January 1, 1988

NUMBER OF CARETAKER RELATIVES	NUMBER OF CHILDREN											
	0	1	2	3	4	5	6	7	8	9	10	Each Addl
<u>No Caretaker Relative</u>												
185% Standard	-	216	453	680	906	1085	1254	1398	1535	1672	1807	123
Need Standard	-	117	245	368	490	587	678	756	830	904	977	67
Grant Standard	-	99	207	311	415	497	574	640	703	766	828	56
<u>One Caretaker Relative</u>												
185% Standard	468	612	778	943	1119	1289	1424	1561	1702	1835	1970	123
Need Standard	253	331	421	510	605	697	770	844	920	992	1065	67
Grant Standard	214	280	356	432	512	590	652	715	779	840	902	56
<u>Two Caretaker Relative</u>												
185% Standard	660	812	986	1161	1324	1455	1595	1733	1866	2001	2136	123
Need Standard	357	439	533	628	716	787	861	937	1009	1082	1155	67
Grant Standard	302	372	451	532	606	666	729	794	855	916	978	56

TN No. 92-2
Supersedes
TN No. 88-9

Approval Date 6/11/92 Effective Date 10/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Colorado

INCOME ELIGIBILITY LEVELS (Continued)

B. **OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL**

1. **Pregnant Women and Infants**

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(10)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

For pregnant women, based on 185 percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

INCOME ELIGIBILITY LEVELS (Continued) NOT APPLICABLE

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Between Ages 6 and 8

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 8 years of age under the provisions of section 1902(1)(2) of the Act are as follows:

Based on 100 percent (no more than 100 percent) of the official Federal income poverty line.

Family Size

Income Level

<u>1</u>	\$ <u> </u>
<u>2</u>	\$ <u> </u>
<u>3</u>	\$ <u> </u>
<u>4</u>	\$ <u> </u>
<u>5</u>	\$ <u> </u>
<u>6</u>	\$ <u> </u>
<u>7</u>	\$ <u> </u>
<u>8</u>	\$ <u> </u>
<u>9</u>	\$ <u> </u>
<u>10</u>	\$ <u> </u>

TN No. 92-2
Supersedes
TN No. 87-14

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on _____ percent of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

TN No. 92-14
Supersedes _____
TN No. 92-02 Approval Date 6/11/92 Effective Date 1/1/92
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

I. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: ☒ 85 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1990: ☒ 90 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

Income Levels

1
2

\$ _____
\$ _____

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Supersedes
TN No. 87-14

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Effective Date 10/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORDAO

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 198⁷ USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 198⁷: ☐ 80 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1990: ☐ 85 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1991: ☐ 95 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

Income Levels

1
2

\$ _____
\$ _____

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO NONE

INCOME LEVELS (Continued) NOT APPLICABLE

D. MEDICALLY NEEDY

 Applicable to all groups.

 Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007 ^{1/}	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 ^{1/}
<input type="checkbox"/> urban only				
<input type="checkbox"/> urban & rural				
	\$ _____	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____	\$ _____
3	\$ _____	\$ _____	\$ _____	\$ _____
4	\$ _____	\$ _____	\$ _____	\$ _____

For each additional person, add:

\$ _____ \$ _____ \$ _____ \$ _____

^{1/} The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

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Supersedes
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1991

SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 9
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO NONE

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007 ^{1/}	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 ^{1/}
<input type="checkbox"/> urban only				
<input type="checkbox"/> urban & rural				
5	\$	\$	\$	\$
6	\$	\$	\$	\$
7	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$

For each
addi-
tional
person,
add:

\$ \$ \$ \$

^{1/} The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

- ☐ Same as SSI resources levels.
☒ Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No Test</u>
<u>2</u>	<u>No Test</u>

*Also
per phone call
9.8.00*

b. Optional Groups

- ☒ Same as SSI resources levels.
☐ Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>\$2,000</u>
<u>2</u>	<u>\$3,000</u>

TN No. 00-010
Supersedes
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

2. Infants

a. Mandatory Group of Infants

- ☒ Same as resource levels in the State's approved AFDC plan.
☐ Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u> <i>No test</i>
<u>2</u>	<u> </u>
<u>3</u>	<u> </u>
<u>4</u>	<u> </u>
<u>5</u>	<u> </u>
<u>6</u>	<u> </u>
<u>7</u>	<u> </u>
<u>8</u>	<u> </u>
<u>9</u>	<u> </u>
<u>10</u>	<u> </u>

*Do
per phone call
9-8-00*

TN No. 00-010
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

b. Optional Group of Infants

// Same as resource levels in the State's-approved AFDC plan.

/x/ Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>No resource test</u>
<u>2</u>	<u>No resource test</u>
<u>3</u>	<u>No resource test</u>
<u>4</u>	<u>No resource test</u>
<u>5</u>	<u>No resource test</u>
<u>6</u>	<u>No resource test</u>
<u>7</u>	<u>No resource test</u>
<u>8</u>	<u>No resource test</u>
<u>9</u>	<u>No resource test</u>
<u>10</u>	<u>No resource test</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

3. Children

- a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act.
(children who have attained age 1 but have not attained age 6.)

 Same as resource levels in the State's approved AFDC plan.

 x Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u> 1 </u>	<u>No resource test</u>
<u> 2 </u>	<u>No resource test</u>
<u> 3 </u>	<u>No resource test</u>
<u> 4 </u>	<u>No resource test</u>
<u> 5 </u>	<u>No resource test</u>
<u> 6 </u>	<u>No resource test</u>
<u> 7 </u>	<u>No resource test</u>
<u> 8 </u>	<u>No resource test</u>
<u> 9 </u>	<u>No resource test</u>
<u> 10 </u>	<u>No resource test</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

- b. Mandatory Group of Children under section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

 Same as resource levels in the State's approved AFDC plan.

 x Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u> 1 </u>	<u>No resource test</u>
<u> 2 </u>	<u>No resource test</u>
<u> 3 </u>	<u>No resource test</u>
<u> 4 </u>	<u>No resource test</u>
<u> 5 </u>	<u>No resource test</u>
<u> 6 </u>	<u>No resource test</u>
<u> 7 </u>	<u>No resource test</u>
<u> 8 </u>	<u>No resource test</u>
<u> 9 </u>	<u>No resource test</u>
<u> 10 </u>	<u>No resource test</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

4. Aged and Disabled Individuals

☒ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>\$2,000</u>
<u>2</u>	<u>\$3,000</u>
<u>3</u>	<u>\$3,000</u>
<u>4</u>	<u>\$3,000</u>
<u>5</u>	<u>\$3,000</u>

☐ Same as medically needy resource levels (applicable only if State has a medically needy program)

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Supersedes
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Approval Date 09/08/00

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AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 7
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO NONE

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY NOT APPLICABLE

Applicable to all groups -

☐ Except those specified below under the provisions of section 1902(f) of the Act.

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>
<u>3</u>	<u> </u>
<u>4</u>	<u> </u>
<u>5</u>	<u> </u>
<u>6</u>	<u> </u>
<u>7</u>	<u> </u>
<u>8</u>	<u> </u>
<u>9</u>	<u> </u>
<u>10</u>	<u> </u>

For each additional person

TN No. 00-010
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HCFA ID: 7985E1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Post Eligibility Treatment of Income deductions by institutionalized individuals for amounts of incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or other third party insurance.

Reasonable limits imposed are:

- For medical expenses incurred after an individual becomes eligible, prior authorization by the Colorado Department of Health Care Policy and Financing or its designee for all expenses.
- Verification of medical necessity required by attending physician.
- Validation that requested expense is not a benefit of Colorado Medicaid program.
- Determination that the allowable cost for services or supplies does not exceed the basic Medicaid rate.
- Restriction that cost will not be allowed for items that are for cosmetic reasons only.
- Determination if expenses requested are a duplication of expenses previously authorized.
- The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.
- Medical and remedial care expenses incurred up to 3 months prior to Medicaid eligibility.

ion: HCFA-PM-91- (BPD)
1991

SUPPLEMENT 4 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

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ion: HCFA-PM-91- (BPD)
1991

SUPPLEMENT 5 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

TN No. 92-2
Supersedes
TN No. 87-14

Approval Date 6/11/92

Effective Date 10/1/91

HCFA ID: 7985EII

sion: HCFA-PM-91- (BPD)
1991

SUPPLEMENT 5a TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

TN No. 92-2
Supersedes
TN No. 87-14

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Effective Date 10/1/91

HCFA ID: 7985EII

State - COLORADO

Standards for Optional State Supplementary payments

Payment Category Reasonable Classification	Administered by FEDERAL STATE	Income Level 1/				INCOME DISREGARDS EMPLOYED
		GROSS		NET		
		1 PERSON	COUPLE	1 PERSON	COUPLE	
AGED						
(1)	(2)	(3)		(4)		(5)
Living Independently	XX	300% of SSI	300% of SSI	\$567	\$1,134	Same as SSI
Living Independently with Home Care	XX	300% of SSI	300% of SSI	\$990	300% of SSI	Same as SSI
In Foster Care Home Care	XX	300% of SSI	300% of SSI	\$769	\$1,538	
In an institutional setting would receive supp. payment Home Care	XX	300% of SSI	300% of SSI	NA	NA	NA
Aged, Blind or Disabled and receiving home and community based services	XX	300% of SSI	300% of SSI	NA	NA	NA
In nursing home no State supp. payment program	NA	NA	NA	NA	NA	NA
Aged, blind or disabled in an institutional setting would not receive supp. payment if outside facility because income exceeds SSI or State supp. pay levels	XX	300% of SSI	300% of SSI	NA	NA	NA

1/Includes maximum home care allowance for one individual.

TN# 01-001

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Supersedes

TN# 00-019

tion: HCFA-PM-91- (BPD)
1991

SUPPLEMENT 7 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

NOT APPLICABLE

TN No. 92-2
Supersedes
TN No. 85-8

Approval Date 6/11/92

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On: HCFA-PM-91- (BPD)
1991

SUPPLEMENT 8 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN No. 92-2
Supersedes
TN No. 85-8

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

STATE OF COLORADO

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902 (r) (2) OF THE ACT*

X Section 1902 (f) State _____ Non-Section 1902 (f) State

1. All wages paid by the Census Bureau for temporary employees related to the decennial Census are excluded.

Methodologies less restrictive than AFDC

Wages paid by the Census Bureau for temporary employment related to census activities are excluded for the following eligibility groups:

X Qualified children and pregnant women under 1902(a)(10)(A)(i)(III).

X Poverty level pregnant women and infants (133 –185% FPL) under 1902(a)(10)(A)(i)(IV).

X Poverty level children under age 6 (133% FPL) under 1902(a)(10)(A)(i)(VI).

X Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII).

X Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below:

- 1902(a)(10)(A)(ii)(I)
- 1905(a)(i)
- 1902(a)(10)(A)(ii)(II)
- 1902(a)(10)(A)(ii)(IV)

NOTE: The Special Income Level Group under 1902(a)(10)(A)(ii)(V), the Individuals Who Would be Eligible if In an Institution Group under 1902(a)(10)(A)(ii)(VI) and the Hospice Group under 1902(a)(10)(A)(ii)(VII) cannot be included in this disregard.

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

STATE OF COLORADO

- _____ Medically Needy under 1902(a)(10)(C)(i)(III).
- _____ All aged, blind or disabled groups in 209(b) states under 1902(f).
- X QMBs, SLMBs and QIs under 1905(p).

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(a)(10)(A)(ii)(XV) OF THE ACT

The agency uses more liberal income methodologies than the SSI program in determining whether a family meets the income standard of 450% of FPL for the following groups:

 X TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State.

The income exclusions in addition to standard SSI methodology are as follows:

- a. One-third of child support for the applicant/recipient child from an absent parent must be disregarded;
- b. The first \$400 of gross monthly earnings, not to exceed \$1,620 in a calendar year, shall be exempt from consideration as earned income of a disabled or blind child who is a student regularly attending school.
- c. The applicant spouse's income does not count toward the applicant.

*More liberal methods may not result in exceeding gross income limitations under Section 1903 (f).

Supplement 8a to ATTACHMENT 2.6-A
Page 2a

The agency uses more liberal income methodologies than the SSI program in determining whether a family meets the income standard of 300% of FPL for the following groups.

- X Family Opportunity Act - Children who have not attained 19 years of age, who would be considered disabled under Section 1614(a)(3)(C) of the Act, and whose family income meets the 300% of federal poverty level standard described on Page 12p of the Attachment 2.6-A.

Since the eligibility income limit is substantially higher than the SSI limit and the Department disregards 33% of household income, the income methodology described here is no more restrictive than the SSI disregards.

The Income Methodologies are as follows:

The gross amount of earned and unearned income is countable toward eligibility and premium payment, with the following exclusions:

- a. Deduct the employment expense disregard of \$90; and
- b. Deduct dependent care disregard.
- c. The unearned income disregard described in this section shall be applied to the total amount received for each individual
 - i. The first \$50 per household per month of any current monthly obligation shall be disregarded. Monthly support includes child support, and/or maintenance, and/or alimony. The disregard shall be divided among each person that receives the monthly support.
- d. A disregard of 33% shall be taken from the family's net countable income.

*More liberal methods may not result in exceeding gross income limitations under Section 1903 (f).

TN No 12-013
Supersedes TN No.

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

STATE OF COLORADO

2. Parents/caretaker relatives, pregnant women, and children under age 20 who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State Agency under 1902(a)(10)(A)(ii)(II)
Methodologies less restrictive than AFDC

In determining countable income, the agency disregards the income difference by the family size in the amount of the AFDC payment standard and 100% of the Federal Poverty Level (as revised annually in the Federal Register) plus \$1 using all AFDC income counting methodologies except the 185% of the need standard income test, the \$30 plus 1/3 earned income disregard for the first 4 months, and the \$30 disregard for 8 calendar months following the 4 consecutive months of \$30 plus 1/3 disregard.

3. Qualified pregnant women and children under 1902(a)(10)(A)(i)(III)
Methodologies less restrictive than AFDC

In determining countable income, the agency disregards the income difference by the family size in the amount of the AFDC payment standard and 100% of the Federal Poverty Level (as revised annually in the Federal Register) plus \$1 using all AFDC income counting methodologies except the 185% of the need standard income test, the \$30 plus 1/3 earned income disregard for the first 4 months, and the \$30 disregard for 8 calendar months following the 4 consecutive months of \$30 plus 1/3 disregard.

4. Parents/caretaker relatives, pregnant women, and children under age 20 who would be eligible for AFDC if they were not in a medical institution under 1902(a)(10)(A)(ii)(IV)
Methodologies less restrictive than AFDC

In determining countable income, the agency disregards the income difference by the family size in the amount of the AFDC payment standard and 100% of the Federal Poverty Level (as revised annually in the Federal Register) plus \$1 using all AFDC income counting methodologies except the 185% of the need standard income test, the \$30 plus 1/3 earned income disregard for the first 4 months, and the \$30 disregard for 8 calendar months following the 4 consecutive months of \$30 plus 1/3 disregard.

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

STATE OF COLORADO

5. Poverty-level related pregnant women, infants, and children under 1902(a)(10)(A)(i)(IV), (VI) (VII) and (ii)(IX),
Methodologies less restrictive than AFDC

In determining countable income, the agency uses all AFDC income counting methodologies except the 185% of the need standard income test and any more liberal income methodologies specified for these eligibility groups in Supplement 8a to Attachment 2.6-A.

6. Poverty-level related children aged 6 through 18 under 1902(a)(10)(A)(i)(VII)

The agency disregards household income between 100% and 133% of the federal poverty level FPL for the appropriate family size as published in the Federal Register

*More liberal methods may not result in exceeding gross income limitations under Section 1903 (f).

Revision: HCFA-PM-91-
1991

(BPD)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

 / Section 1902(f) State

 X / Non-Section 1902(f) State

DISREGARD: In the following instance, Colorado shall employ a methodology in determining resource eligibility which is less restrictive than the methodology under the federal SSI program (Title XVI of the Social Security Act). For adult financial and Medicaid recipients effective 4/1/88, if the individual cannot sell otherwise countable property for two-thirds of the actual value as defined in the section on equity value, the property shall be exempted provided that the individual continues reasonable efforts to sell the property. This is done by listing the property with an agency or by advertising in the local media as examples. The county must verify on a quarterly basis that a reasonable effort is being made to sell the property. If it is not determined to be a reasonable effort, the property shall not be exempted.

HOW MORE LIBERAL: Resources are not considered in the determination of Medicaid eligibility for individual who would otherwise be ineligible. Medicaid eligibility continues until the property is sold. Then the individual becomes ineligible for Medicaid until the resources are again below the prescribed limit.

GROUPS COVERED: Aged, blind and disabled institutionalized individuals or couple who are institutionalized for at least 30 consecutive days and who are eligible under a special income level as defined in 42 CFR 435.231 and Section 1902 (a) (10) (A) (ii) (V) of the Act. This more liberal methods will not result in exceeding gross income limitations under section 1903(f).

TN No. 93-001

Supersedes

TN No. 92-2

Approval Date MAY 28 1993

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2)
OF THE ACT

For the groups at Sections 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(ii)(I), 1902(a)(10)(A)(ii)(II), 1902(a)(10)(A)(ii)(IV), and 1902(a)(10)(A)(ii)(VIII) of the Act, the agency disregards all resources in determining eligibility.

TN# 05-019

APPROVAL DATE 12/27/05

SUPERCEDES TN# 05-014

EFFECTIVE DATE July 1, 2006

Revision:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION
1902(r)(2) OF THE ACT.

☐ Sections 1902(f) state ☒ Non-Section 1902(f) state

1. The following resource methodology applies to individuals covered in Section
1902(a)(10)(E)(i)-(iii) (QMB, SLMB, and QI-1):

- Disregard an additional \$1,500 for individual and \$3,000 for couples
in resources

TN No. 18-0032

Supersedes

TN No. 11-009

Approval Date 7/31/2018

Effective Date 4-01-2018

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups: Individuals in a medical institution for at least 30 consecutive days with gross income that does not exceed 300 percent of the SSI income standard – 1902(a)(10)(A)(ii)(V).

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a “qualified State long-term care insurance partnership” policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

X The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State’s Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
- The policy was issued no earlier than the effective date

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

of this State plan amendment.

- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

- a. ☒ The agency uses a procedure which provides for a total period of ineligibility greater than 30 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds \$12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

TN No. 92-2
Supersedes
TN No. 87-1

Approval Date 6/11/92 Effective Date 10/1/91

ion: HCFA-PM-91- (BPD)
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State: COLORADO

b. ☒ The period of ineligibility is less than 30 months,
as specified below:

c. ☒ The agency has provisions for waiver of denial of
eligibility in any instance where the State
determines that a denial would work an undue
hardship.

1. The individual is:

- in an ICF, SNF, or other medical institution as
permitted under Section 1917 (c)(2)(B)(i).
- threatened with eviction, and
- the money has irretreivable lost.

TN No. 92-2 Approval Date 6/11/92 Effective Date 10/1/91
Supersedes
TN No. 89-13

HCFA ID: 7985ET1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

2. Transfer of the home of an individual who is an inpatient in a medical institution.

/X/ A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under OBRA 93.

- a. The lookback period for non trust transfers is 36 months. The lookback period for trust transfers is 60 months.
- b. Multiple transfers within the lookback period are added together if the penalty period of the first transfer has not expired.
- c. For property transferred on or after Aug 11, 1994 and not subject to the exceptions on page 2 of this supplement, an individual is ineligible for a period of time after the date on which he disposed of the home equal to the period of the uncompensated value. The period of ineligibility is determined by dividing the uncompensated value of the home by the average amount payable under this plan for care in an SNF.

TN No. 94-020
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TN No. 92-2

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State: COLORADO

b. ☒

Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

NOT APPLICABLE

TN No. 92-2
Supersedes
TN No. 87-1

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State: COLORADO

No individual is ineligible by reason of item A.2 if--

- (i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;
- (ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;
- (iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or
- (iv) The agency determines that denial of eligibility would work an undue hardship.

TN No. 92-2 Approval Date 6/11/92 Effective Date 10/1/91
Supersedes
TN No. 87-1

HCFA ID: 7985EII

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

3. 1902(f) States

☒ Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is \$12,000 or less:

2. If the uncompensated value of the transfer is more than \$12,000:

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Supersedes
TN No. 87-1

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

TN No. 92-2
Supersedes
TN No. 87-1

Approval Date 6/15/92 Effective Date 10/1/91

HCFA ID: 7985EII

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

— The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

— The following other long-term care services for which medical assistance is otherwise under the agency plan:

State: COLORADO

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
- X the first day of the month in which the asset was transferred;
- the first day of the month following the month of transfer.
4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:
- X the average monthly cost to a private patient of nursing facility services in the agency (in the state);
- the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.
5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;
- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

TN No. 95-010
Supersedes NEW Approval Date 09/14/95 Effective Date 1-1-95
TN No. NEW

State: COLORADO

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--
- a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:
- X does not impose a penalty;
- imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.
- b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:
- X does not impose a penalty;
- imposes a series of penalties, each for less than a full month.
7. Transfers made so that penalty periods would overlap--
The agency:
- X totals the value of all assets transferred to produce a single penalty period;
- calculates the individual penalty periods and imposes them sequentially.
8. Transfers made so that penalty periods would not overlap--
The agency:
- X assigns each transfer its own penalty period;
- uses the method outlined below:

State: COLORADO

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

 The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

 For transfers of individual income payments, the agency will impose partial month penalty periods.

 x For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

 The agency uses an alternate method to calculate penalty periods, as described below:

State: COLORADO

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

Individual requires Long-term care
Individual transfer is irretrievably lost
Individual will lose Long-term care

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Individual has no alternative living arrangement
Funds are irretrievably lost or
Funds do not provide services required

TN No. 95-010
Supersedes NEW Approval Date 09/11/95 Effective Date 1-1-95
TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006**, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

- Nursing facility services.
- Nursing facility level of care provided in a medical institution.
- Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

— The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

- The Home health services (section 1905(a)(7));
- Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal agency withholds payment to non-institutionalized individuals for the following services:

- Care services furnished to individuals who are not

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

TRANSFER OF ASSETS

inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

— The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

3. Penalty Date. The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- The first day of a month during or after which assets have been transferred for less than fair market value;

— The State uses the first day of the month in which the assets were transferred

X The State uses the first day of the month after the month in which the assets were transferred, or

- The date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid; AND

Which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period - Institutionalized Individuals. In determining the penalty for an institutionalized individual, the agency uses:

X The average monthly cost to a private patient of nursing facility services in the State at the time of application;

— The average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

TRANSFER OF ASSETS

5. Penalty Period - Non-institutionalized Individuals. The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ Imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care.

X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods. Transfer by a spouse that results in a penalty period for the individual:

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

TRANSFER OF ASSETS

8. Treatment of a transfer of income:

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

 X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

 For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship.

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

- (a) Of medical care such that the individual's health or life would be endangered; or
- (b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers.

The agency has established a process under which hardship waivers may be requested that provides for:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

TRANSFER OF ASSETS

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers For Hardship Applicants.

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

_____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed _____ days (may not be greater than 30).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria are applied.

1. The period of ineligibility resulting from the imposition of the transfer or the trust provisions may be waived if denial of eligibility would create an undue hardship. Undue hardship can be established only if all of the following conditions are met:
 - a. The individual is otherwise eligible;
 - b. The individual is unable to obtain medical care without the receipt of Medicaid benefits;
 - c. The individual is experiencing an emergency, life threatening episode and without medical care is in imminent danger of death, or the individual would be deprived of food, shelter, clothing or other necessities of life; and
 - d. The individual must also produce evidence to prove that the assets have been irretrievably lost, and that all reasonable avenues of legal recourse to regain possession of them have been exhausted.
2. Undue hardship shall not exist when the application of the trust or transfer rules merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.
3. Notice of an undue hardship exception shall be given to the applicant or client, and a determination of whether an undue hardship waiver will be granted shall be given in a timely manner. An adverse determination may be appealed in accordance with the appeal process as set forth in Recipients Appeals Rule. 10 Colorado Code of Regulations 2505-10, Section 8.057.

TN# 05-011

APPROVAL DATE 9/27/05

SUPERCEDES TN# 95-010

EFFECTIVE DATE July 1, 2005

State/Territory: COLORADO

Citation

Condition or Requirement

COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES

1902(u) of the
Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

- ___ The methodology as described in SMM section 3598.
- ___ Another cost-effective methodology as described below.

TN No. 92-9
Supersedes
TN No. New

Approval Date 6/16/92

Effective Date 10/1/91

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

42 CFR 435.725 (c) (1) An additional personal needs allowance may be included in the personal needs allowance in a given accounting period for taxes that are owed and expected to be withheld from income or paid by the individual in the accounting period.

If taxes are not withheld or paid, the State must adjust the personal needs allowance accordingly and recalculate the individual's countable income for the period.

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 5 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

TN No. 99-005
Supersedes
TN No. 94-025

Approval Date 12/09/99

Effective Date 07/01/99

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The state covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State Plan effective July 16, 1996:

- X Pregnant women with no other eligible children.
- X AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training with the expectation that the child will graduate before age 19.
- In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.
- The agency applies lower income standards which are not lower than the AFDC standards in effect on May 12, 1988, as follows:
- The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

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

STATE OF COLORADO

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

_____ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1995, as follows:

 X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

- No resource test
- Disregards the income difference by the family size in the amount of the AFDC payment standard and 100% of the Federal Poverty Level (as revised annually in the Federal Register) plus \$1 using all AFDC income counting methodologies except the 185% of the need standard income test, the \$30 plus 1/3 earned income disregard for the first 4 months, and the \$30 disregard for 8 calendar months following the 4 consecutive months of \$30 plus 1/3 disregard
- All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded

 X The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

- Resource limit of \$2,000.00
- One motor vehicle of any value is allowed
- Requirement of parental deprivation
- \$30 plus 1/3 remaining earned income disregard for the first 4 months
- \$30 disregard for 8 calendar months following the 4 consecutive months of \$30 plus 1/3 disregard
- 185% of the need standard gross income test

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

STATE OF COLORADO

_____ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

_____ The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

ELIGIBILITY UNDER SECTION 1925 OF THE ACT
TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative's employment, or due to the loss of a time-limited earned income disregard. (42 CFR 435.112, 1902(a)(52), 1902(e)(1), and 1925 of the Act)

The amount, duration, and scope of services for this coverage are specified in Section 3.5 of this State plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

☒ During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.

☐ For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

The State extends Medicaid eligibility under TMA for an initial period of:

☐ 6 months. For TMA eligibility to continue into a second 6-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.

☒ 12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

"Section 1924 Provisions"

- A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility the State resource standard is \$74,280 effective July 1, 1995 for individuals institutionalized on or after that date. This figure is adjusted annually.
- C. The definition of undue hardship for the purpose of determining if institutionalized spouse receive Medicaid in spite of having excess countable resources is described below:

"Undue hardship" means that an institutionalized spouse, whose income is below the Medicaid income standard and who meets the level-of-care screen for Medicaid nursing home placement, faces eviction from a medical institution or nursing facility.

TN No. 95-019
Supersedes TN No. 90-1 Approval Date 11/27/95 Eff. date 7-1-95
HCFA ID: 1038P/0015P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB)
INFECTED INDIVIDUALS

For TB infected individuals under §1902(z)(1) of the Act, the income and resource eligibility levels are as follows:

N/A

TN No. 00-010
Supersedes _____ Approval Date 09/08/00 Effective Date 04/01/00
TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____ Colorado _____

ASSET VERIFICATION SYSTEM

- 1940(a)
of the Act
1. The agency will provide for the verification of assets for purposes of determining or re-determining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.
 - A. The request and response system must be electronic:
 - (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
 - (2) The system cannot be based on mailing paper-based requests.
 - (3) The system must have the capability to accept responses electronically.
 - B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
 - C. The system must establish and maintain a database of FIs that participate in the agency's AVS.
 - D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or re-determine the individual's eligibility.
 - E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

TN No. _____ 16-0008 _____

Supersedes

Approval Date: 10/26/2016 Effective Date: 07/01/2016

TN No. _____ New _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____ Colorado _____

ASSET VERIFICATION SYSTEM

2. System Development

_____ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

 X B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

_____ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

_____ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

_____ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

TN No. _____ 16-0008 _____

Supersedes _____ Approval Date: 10/26/2016 Effective Date: 07/01/2016

TN No. _____ New _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____ Colorado _____

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

Colorado is in the process of evaluating the necessary steps to secure a vendor to implement AVS system as of January 2018.

The vendor selected will have a system that meets the requirements of Supplement 16 to Attachment 2.6-A, page 1.

TN No. _____ 16-0008 _____
Supersedes _____ Approval Date: _____ 10/26/2016 _____ Effective Date: _____ 07/01/2016 _____
TN No. _____ New _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADODISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR
INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f)

The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

 X \$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

 An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is _____.

 This higher standard applies statewide.

 This higher standard does not apply statewide. It only applies in the following areas of the State:

 This higher standard applies to all eligibility groups.

 This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

TN No. 06-010

Approval Date 10/19/06

Supersedes TN No. New

Effective Date July 1, 2006

State Plan Under Title XIX of the Social Security Act

State: COLORADO

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 03/06/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
	<p>For each population group, indicate the lower of:</p> <ul style="list-style-type: none"> The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or 133% FPL. <p>If a population group was not covered as of 12/1/09, enter "Not covered".</p>	<p>Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.</p>			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	Yes	No	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	Yes	No	No	No
Children Age 19 or 20	Not covered	N/A	N/A	N/A	N/A
Childless Adults	Not covered	N/A	N/A	N/A	N/A

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

☒ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

☐ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

The state:

☒ Applies existing state data from periods before January 1, 2014.

☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).
3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
☐ Yes. The combined enrollment cap adjustment is described in Attachment C
☐ No.
4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:
☐ Applies a special circumstances adjustment(s).
☒ Does not apply a special circumstances adjustment.
2. The state:
☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
☒ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).
3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

- ☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.
- ☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

- ☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)
- ☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

- ☐ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- ☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

- A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
- B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☒ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

CO 14-035 Attachment A

Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan

COLORADO

03/20/2014

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibility standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	Parents/Caretaker Relatives FPL %	60%	68%	no	new SIPP conversion	SIPP
2	Noninstitutionalized Disabled Persons Dollar standards Single Couple	\$699 \$1,036	\$720 \$1,067	n/a	new SIPP conversion	SIPP
3	Institutionalized Disabled Persons SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	Children Age 19-20	n/a	n/a	n/a	n/a	n/a
5	Childless Adults FPL %	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable.

Note: The numbers in this summary chart will be updated automatically in the case of modifications in the CMS-approved MAGI Conversion Plan.

TN: CO-14-035

Approval Date: 04/23/2015

Effective Date: 04/01/2014

**Colorado Department of Health Care Policy and Financing
Methodology for Identification of Applicable FMAP Rates
TN CO 14-035
Resource Proxy Explanation**

The effective date of this resource proxy for the Colorado Medicaid Expansion is April 1, 2014.

In applying a Resource Proxy to adjust FMAP claiming, Colorado believes the following information important to consider:

No mandatory Medicaid eligibility categories included a resource/asset test as of December 2009. Only the optional Medicaid eligibility categories for Disabled Individuals Institutionalized and Disabled Individuals Non-Institutionalized were subject to a resource/asset test as of December 2009. Colorado notes that said resource/asset test has not been changed and is still current.

Due to Colorado having a hierarchical eligibility determination process wherein clients are screened for eligibility in a disabled category prior to being tested for MAGI adult eligibility, Colorado's non-newly disabled population is theoretically comprised of two types of clients: 1) disabled clients that have been denied eligibility under a non-MAGI disability category due to failing the asset test, and 2) disabled clients that have opted not to provide information regarding their assets and subsequently could not be screened for eligibility under a non-MAGI disabled category. In the second group, there are both applicants that would have been eligible in the disabled category had they submitted asset information and applicants that would not.

Disabled clients that have been denied eligibility under a non-MAGI disability category due to failing the asset test should be eligible for 100% FMAP as these clients would not have been eligible for Medicaid under the 2009 eligibility standard. However, because the State cannot determine what the outcome would have been for the second type of applicant, CMS has indicated all expenditure related to these clients should be considered ineligible for the 100% enhanced FMAP.

Consequently, to develop a resource proxy, the State will utilize a statistically significant historical data set (currently assuming SFY 2009-10, SFY 2010-11, and SFY 2011-12) correlating with the populations identified above. The State intends to calculate the resource proxy as follows:

$$A / (A + B) \text{ or } 461 / (461 + 153) = 75.081433225\%$$

Where

A = SFY 2009 – 2010, SFY 2010 – 2011, SFY 2011 – 2012 *count of denials due to being over the asset limit*; a total of 461

B = SFY 2009 – 2010, SFY 2010 – 2011, SFY 2011 – 2012 *count of denials due to failure to provide asset information*; a total of 153

The percentage generated from the formula above is applied to expenditures for non-newly eligible clients to create a total amount to be reported at 100% FMAP rather than the standard match applicable to non-newly eligible clients. The remaining expenditures would be eligible for the standard federal match rate.

June 30, 2014

Attachment B to TN CO 14-035

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

OMB-No. 0938-0193

COLORADO

State/Territory: _____

Citation

2.7

Medicaid Furnished Out of State

431.52 and
1902(b) of the
Act, P.L. 99-272
(Section 9529)

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

TN NO. 87-5

Supersedes

TN NO. 82-12

Approval Date 3/19/87

Effective Date 10/1/86

HCFA ID:0053C/0061E

Revision: HCFA-PM-94-5
APRIL 1994

(MB)

State/Territory: COLORADO

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

42 CFR
Part 440,
Subpart B
1902(a), 1902(e),
1905(a), 1905(p),
1915, 1920, and
1925 of the Act

1902(a)(10)(A) and
1905(a) of the Act

3.1 Amount, Duration, and Scope of Services

- (a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

- (i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
- (ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

— Not applicable. Nurse-midwives are not authorized to practice in this State.

TN No. 94-023

Supersedes

TN No. 92-1

Approval Date 09/26/94

Effective Date 7-1-94

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Colorado

Citation 3.1(a)(1) Amount, Duration, and Scope of Services:
Categorically Needy (Continued)

1902(e)(5) of
the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/X/ (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10),
clause (VII)
of the matter
following (Z)
of the Act F

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

TN No. 93-011

Supersedes

TN No. 92-1

Approval Date

6/7/93

Effective Date 5/15/93

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State/Territory: Colorado

Citation 3.1(a)(1) Amount, Duration, and Scope of Services:
Categorically Needy (Continued)

- 1901 (a)(1)(D) (vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
- 1902(e)(7) of (vii) Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
- 1902(e)(9) of the ☐ (viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
- 1902(a)(52) and 1925 of the (ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needs, specifics all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that my complicate the pregnancy.

TN No. 93-011

Supersedes

TN No. 93-002

Approval Date 6/7/93

Effective Date 5/15/93

HCFA ID: 7982E

State of COLORADO

PACE State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN No.: 00-024
Supersedes
TN NO.: NEW

Approval Date 05/18/01

Effective Date 10/01/00

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State/Territory: Colorado

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

42 CFR Part 440 (a)(2) Medically needy.
Subpart B

☒ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

42 CFR 440.220
1902(a)(10)(C)(iv)
of the Act

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

☒ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the
Act

(ii) Prenatal care and delivery services for pregnant women.

TN No. <u>92-1</u>	Approval Date <u>4/9/92</u>	Effective Date <u>10/1/91</u>
Supersedes		
TN No. <u>87-13</u>		

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State/Territory: Colorado

Citation 3.1(a)(2) Amount, Duration, and Scope of Services:
Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☐ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

☐ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140,
440.150, ~~440.160~~
Subpart B,
442.441,
1902(a)(20)
and (21) of the
Act

☐ (vii) Services in an institution for mental diseases for individuals over age 65.

☐ (viii) Services in an intermediate care facility for the mentally retarded.

☐ (ix) Inpatient psychiatric services for individuals under age 21.

1902(a)(10)(C)

TN No. 93-011

Supersedes

TN No. 92-1

Approval Date 6/7/93

Effective Date 5/15/93

HCFA ID: 7982E

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: Colorado

Citation

3.1(a)(2) Amount, Duration, and Scope of Services:
Medically Needy (Continued)

1902(e)(9) of
Act

- (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23)
and 1929 of the Act

- (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN No. 00-009
Supersedes
TN No. 93-002 Approval Date 09/13/00 Effective Date 04/01/00

Enclosure 4

Page 200.

State of _____
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1905(a)(26) and 1934

____ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

TN No.: 00-024
Supersedes
TN NO.: NEW

Approval Date 05/18/01 Effective Date 10/01/00

Revision: HCFA-PM-98-1 (CMISO)
APRIL 1998

State: COLORADO

<u>Citation</u>	3.1 <u>Amount, Duration, and Scope of Services</u> (continued)
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act	(a)(3) <u>Other Required Special Groups: Qualified Medicare Beneficiaries</u> Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i) <u>Other Required Special Groups: Qualified Disabled and Working Individuals</u> Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii) <u>Other Required Special Groups: Specified Low-Income Medicare Beneficiaries</u> Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I) 1905(p)(3)(A)(ii), and 1933 of the Act	(iii) <u>Other Required Special Groups: Qualifying Individuals - I</u> Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

TN No. 00-006
Supersedes Approval Date 06/23/04 Effective Date 04/01/00
TN No. 98-005

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: COLORADO

Citation

1902(a)(10)
(E)(iv)(II), 1905(p)(3)
(A)(iv)(II), 1905(p)(3)
the Act

(iv) Other Required Special Groups: Qualifying
Individuals - 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the
Act

(a)(5) Other Required Special Groups: Families
Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

TN No. 00-006

Supersedes

Approval Date 06/23/00 Effective Date 04/01/00

TN No. 98-005

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: COLORADO

Citation

Sec. 245A(h)
of the
Immigration and
Nationality Act

(a)(6) Limited Coverage for Certain Aliens

- (i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they --
 - (A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act.
 - (B) Are children under 18 years of age; or
 - (C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983
- (ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

TN No. 00-006

Supersedes

Approval Date 06/23/00 Effective Date 04/01/00

TN No. 94-007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Colorado

Citation**3.1(a)(6) Amount, Duration and Scope of Services: Limited Coverage for Certain Aliens (Continued)**

1902(a) and 1903(v) of the Act

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act. (Emergency services for undocumented aliens do not include services related to organ transplant procedures.)

1905(a)(9) of the Act

(a)(7) Homeless Individuals.

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

1902 (a)(47) of 1920 of the Act

☒ **(a)(8) Presumptive Eligible Pregnant Women.**

Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

42 CFR 441.55

50 FR 43654

1902 (a)(43), 1905

(a)(4)(B) and 1905(r) of the Act

(a)(9) EPSDT Services.

The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B) and 1905(r) of the Act with respect to early and periodic screening, diagnostic and treatment (EPSDT) services.

TN No: 05-004

Approval Date

7/05/05

Effective Date 7/1/05

Supersedes TN 04-003

Revision: HCFA-PM-91-
1991

(BPD)

OMB No.: 0938-

State: Colorado

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT
Services (continued)

42 CFR 441.60 / / The Medicaid agency has in effect agreements with continuing
care providers. Described below are the methods employed to
assure the providers' compliance with their agreements.**

42 CFR 440.240 (a)(10) Comparability of Services
and 440.250

1902(a) and 1902
(a)(10), 1902(a)(52),
1903(v), 1915(g),
1925(b)(4), and 1932
of the Act

Except for those items or services for which sections
1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the
Act, 42 CFR 440.250, and section 245A of the
Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are
equal in amount, duration, and scope for each categorically
needy person.
- (ii) The amount, duration, and scope of services made available
to the categorically needy are equal to or greater than those
made available to the medically needy.
- (iii) Services made available to the medically needy are equal in
amount, duration, and scope for each person in a
medically needy coverage group.
- / / (iv) Additional coverage for pregnancy-related service and
services for conditions that may complicate the pregnancy
are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits monthly encounter data
reflecting the number of examinations completed, the number of
examinations where a referable condition was identified, and the
number of follow-up treatment encounters. Medicaid staff make
periodic on-site reviews to monitor the provider's record of case
management.

TN # 03-026
Supersedes TN # 92-03

Effective Date 07/01/03
Approval Date 12/16/03

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State of Colorado

Citation

42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

- (1) Home health services are provided to all categorically needy individuals 21 years of age or over.
- (2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

- (3) Home health services are provided to the medically needy:

☐ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☒ Yes, to individuals under age 21; SNF services are provided

☐ No; SNF services are not provided

☒ Not applicable; the medically needy are not included under this plan

TN # 77-4
Supersedes
TN #

Approval Date 1/28/77 Effective Date 1/1/77

Revision: HCFA-PM-93-8 (BPD)
December 1993

State/Territory: COLORADO

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

TN No. 94-004
Supersedes 92-1 Approval Date 1-5-94 Effective Date October 1, 1993
TN No. 92-1

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to Assure
Quality of Services

The standards established and the
methods used to assure high quality
care are described in ATTACHMENT 3.1-C.

TN # 77-4
Supersedes
TN # _____

Approval Date 1/28/77 Effective Date 1/1/77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 441.20
AT-78-90

3.1(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN # 77-4
Supersedes
TN # _____

Approval Date 1/28/77 Effective Date 1/1/77

Revision: HCFA-PM-87-5 (BERC)
APRIL 1987

OMB No.: 0938-0193

State/Territory: COLORADO

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

☐ Yes.

☐ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

☒ Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

☐ No.

☒ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

Under EPSDT, transplants are provided if determined to be medically necessary and to the extent that FFP is available.

TN No. 92-03
Supersedes
TN No. 87-13

Approval Date 6/16/92

Effective Date

10/1/91

HCFA ID: 1008P/0011P

Revision: HCFA-PH-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: COLORADO

Citation:
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of
the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

- (1) Are medically dependent on a ventilator for life support at least six hours per day;
- (2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

☐ 30 consecutive days;

☐ ___ days (the maximum number of inpatient days allowed under the State plan);

- (3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;
- (4) Have adequate social support services to be cared for at home; and
- (5) Wish to be cared for at home.

☐ Yes. The requirements of section 1902(e)(9) of the Act are met.

☒ Not applicable. These services are not included in the plan.

TN No. 89-10
Supersedes
TN No. 87-13

Approval Date 4/18/89

Effective Date 5/1/89

HCFA ID: 1008P/0011P

28(a)

Division: HCFA-PM-91- (MB)
1991

State/Territory: Colorado

Citation

1905(a)(24) and
1930 of the Act
P.L. 101-508
(Section 4712
OBRA 90)

3.1(1)

Community supported living
arrangements services

Community supported living
arrangements services
provided to developmentally disabled
individuals in accordance with section
1930 of the Act.

 Yes.

XX No.

Attachment 3.1-F identifies the
community supported living arrangements
services provided.

AUG 5 1996

No. 96-005
percedes
No. 92-26

Approval Date 05/09/96

Effective Date 4-1-96

State of Colorado

**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

1.a. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations *
☐ Not Provided

b. Inpatient Psychiatric Care provided in a facility licensed as a hospital.

☒ Provided: ☐ No limitations ☒ With limitations *
☐ Not Provided

2.a Outpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations *
☐ Not Provided

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

☒ Provided: ☒ No limitations ☐ With limitations *
☐ Not Provided

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA – Pub. 45 - 4).

☒ Provided: ☒ No limitations ☐ With limitations *
☐ Not Provided

3.a. Other laboratory and x-ray services.

☒ Provided: ☒ No limitations ☐ With limitations *
☐ Not Provided

Description provided on attachment

TN No. 03-022
Supersedes
TN No. 92-3

Approval Date 11/06/03

Effective Date 09/01/03

State of Colorado

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- Provided: ☒ No limitations ☐ With limitations*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
- 4.c. Family planning services and supplies for individuals of child-bearing age.
- Provided: ☐ No limitations ☒ With limitations*
- 4.d. Face-to-Face Tobacco Use Cessation Counseling Services for Pregnant Women
- Provided: ☐ No limitations ☒ With limitations*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
- Provided: ☐ No limitations ☒ With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
- Provided: ☐ No limitations ☒ With limitations*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.
- Provided: ☒ No limitations ☐ With limitations*

* Description provided on attachment.

TN: 14-009

Approval Date: 9/8/15

Supersedes TN: 11-049

Effective Date: July, 1, 2014

State:

**AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY**

b. Optometrists' services.

// Provided: // No limitations / X/ With limitations*

// Not provided.

c. Chiropractors' services.

// Provided // No limitations // With limitations*

/X/ Not provided.

d. Other practitioners' services.

/X/ Provided Identified on Supplement to Attachment 3.1-A,
"Limitations to Care and Services"

// Not provided

7. Home health services.

**a. Intermittent or part-time nursing services provided by a home health agency
or by a registered nurse when no home health agency exists in the area.**

Provided: // No limitations / X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: // No limitations / X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: // No limitations /X/ With limitations*

*Description provided on attachment.

TN No. 10-010

Approval Date: 8/25/10

Supersedes TN No. 96-001 (page 3)

Effective Date: 7/1/2010

HCFA ID: 7986

State/Territory: COLORADO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology services provided by a home health agency.

x Provided: No limitations x With limitations *
 Not provided

8. Private duty nursing services.

x Provided: No limitations x With limitations *
 Not provided

* Description provided on Supplement to ATTACHMENT 3.1-A, "Limitations to Care and Services".

TN # 96-001
SUPERSEDES TN # 92-3 APPROVAL DATE 01/11/96 EFFECTIVE DATE ~~7-1-95~~
10/01/95

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

STATE OF COLORADO

Attachment 3.1-A
Page 4
OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.
☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
10. Dental services.
☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
11. Physical therapy and related services.
- a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
- b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
- c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment.

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

STATE OF COLORADO

Attachment 3.1-A
Page 5
OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs:
☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
- b. Dentures:
☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
- c. Prosthetic devices:

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
- d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
13. Other diagnostic, screening, preventive and rehabilitative services, i.e. other than those provided elsewhere in the plan:
- a. Diagnostic services
☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

*Description provided on attachment

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

b. Screening services.

- ☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Preventive services.

- ☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Rehabilitative services.

- ☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

- ☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Skilled nursing facility services.

- ☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Intermediate care facility services.

- ☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on attachment.

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986
OMB NO.: 0938-0193

ATTACHMENT 3.1-A
Page 7

State/Territory: COLORADO

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
- ☒ Provided ☒ No limitations ☐ With limitations*
- ☐ Not provided.
- b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.
- ☒ Provided ☒ No limitations ☐ With limitations*
- ☐ Not provided.
16. Inpatient psychiatric facility services for individuals under 22 years of age.
- ☒ Provided ☒ No limitations ☐ With limitations*
- ☐ Not provided.
17. Nurse-midwife services.
- ☒ Provided ☒ No limitations ☐ With limitations*
- ☐ Not provided.
18. Hospice care (in accordance with section 1905(o) of the Act.
- ☒ Provided ☐ No limitations ☒ Provided in accordance with Section 2302 of the Affordable Care Act
- ☐ With limitations* ☐ Not provided.

* Description provided on attachment.

TN No. 14-049

Approval Date: 03/12/15

Supersedes TN No. 12-001

Effective Date: 10/1/2014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

 Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

 Provided: With limitations*

X Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 00-016

Supersedes

TN No. 96-004

Approval Date 03/06/01

Effective Date 10/01/00

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

Attachment 3.1-A
Page 8a
OMB No.: 0938-

State of Colorado

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE
CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

/X/ Provided // No limitations /X/ With limitations*
// Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

// Provided // No limitations // With limitations*
/X/ Not provided

23. Certified pediatric or family nurse practitioners' services.

// Provided /X/ No limitations // With limitations*

*Description provided in attachment.

TN No: 05-004

Approval Date 7/05/05

Effective Date 7/1/05

Supersedes TN No. 04-003

State/Territory: _____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

* Description provided on attachment

TN No. 01-009

Supersedes

TN No. 92-3

Approval Date 10/25/01 Effective Date 09/01/01

* CURRENT

Revision: HCFA-Region VIII
AUGUST 1990

ATTACHMENT 3.1-A
Page 9b

STATE Colorado

- g. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA'89):

☒ Provided: ☒ No limitations ☐ With limitations*

*Description provided on attachment.

TN No. 90-15 Approval Date 10/12/90 Effective Date 10/1/90
Supersedes
TN No. NEW

State: COLORADO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

 provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

 Provided: State Approved (Not Physician) Service Plan Allowed
 Services Outside the Home Also Allowed
 Limitations Described on Attachment

 X Not Provided.

Enclosure 5

Attachment 3.1-A

State of Colorado PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the
Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in
Supplement 3 to Attachment 3.1-A.

☒ Election of PACE: By virtue of this submittal, the State elects PACE as an
optional State Plan service.

☐ No election of PACE: By virtue of this submittal, the State elects to not add
PACE as an optional State Plan service.

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

STATE OF COLORADO

Supplement to Attachment 3.1-A

LIMITATIONS TO CARE AND SERVICES

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

X Provided: X No limitations With limitations None licensed or approved

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

X Provided: No limitations X With limitations (please describe below)

Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please check all that apply:

X (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services

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LIMITATIONS TO CARE AND SERVICES

1. Inpatient Hospital Services are benefits with the following limitations:

- (1) Inpatient hospital dialysis treatment is a benefit for inpatient clients only in these cases:
 - (a) hospitalization is required for an acute medical condition for which emergency dialysis treatments are required; or
 - (b) the client is admitted to the hospital for a non-related medical condition, and needs to receive the regular maintenance treatment that is usually received in an outpatient dialysis program; or
 - (c) placement or repair of the dialysis route (shunt or cannula).
- (2) Services that are defined as experimental by the U.S. Food and Drug Administration are not benefits.

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2. Outpatient Hospital Services

Routine and annual physical examinations are not provided unless determined to be medically necessary based upon a medical diagnosis, complaint or symptom.

81-15
7-6-81
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LIMITATIONS TO CARE AND SERVICES

4.b EPSDT Program

A. Medically necessary services not otherwise provided under the State Plan but available to EPSDT participants include:

- Other necessary health care, diagnostic treatment and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the EPSDT screening service will be provided when medically necessary to EPSDT participants.
- Under EPSDT, medically necessary organ transplants are provided when not experimental or investigational, and when alternative, less costly treatments have been trialed or determined ineffective.

B. Medically necessary services not otherwise provided under the State Plan but available to EPSDT participants include:

- Preventive services including fluoride varnish
- Restorative services
- Diagnostic services (radiology/diagnostic imaging/oral pathology) that are medically and dentally necessary
- Periodontics
- Endodontics
- Oral and maxillofacial surgery
- Orthodontics
- Dentures

Dental services are available for individuals age 20 and under that prevent and abate tooth decay, restore dental health and are medically necessary. Some of these services may require prior authorization. The Department authorizes additional service if:

- the proposed services are medically appropriate and
- the proposed services are more cost effective than alternative services.

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LIMITATIONS TO CARE AND SERVICES

C. Services provided by Colorado state licensed dental hygienist.

- Licensed dental hygienists may render services as defined by the scope of practice of their license issued by the Department of Regulatory Agencies (DORA).
- Dental hygienists employed by a dentist, clinic or institution cannot receive direct reimbursement.
- Unsupervised dental hygienists as defined by DORA may bill Medicaid for the following preventive dental services for clients age 20 and under: prophylaxis, fluoride, oral hygiene instructions, sealants and periodic evaluations.

A list of approved procedure codes and policy limitations for dental providers will be updated in conjunction with the American Dental Association's biannual publication of the Current Dental Terminology (CDT) codes on dental procedures and nomenclature and will be posted on the Department's Web site as a provider bulletin.

- D.** Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disability, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan treatment, (B) provided by an individual who is qualified to provide such services and who is not the legally responsible adult, and (C) a client's place of residence or outside a client's place of residence, when Personal Care Activities take place outside of the client's residence.

1. Scope

Personal Care Services (PCS) are a benefit for Colorado Medicaid clients, ages 0 through 20 years of age, which are medically necessary and are sufficient in amount, scope and duration to reasonably achieve their purpose. PCS provide pediatric clients assistance with activities of Daily Living and Instrumental Activities of Daily Living through hands-on assistance (actually performing a task for the person), supervision and/or prompting or cuing the client to complete the task. PC services in Colorado's program includes a range of human assistance provided to children with an assessed need for personal care services which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability or condition that warrants such assistance.

These services are provided to a client who does not require medically skilled staff. Services must be medically necessary, and must be consistent with the unique nature and severity of the client's illness, injury or disability, his or her particular medical needs, and accepted standards of practice, without regard to whether the illness, injury or disability is acute, chronic, or terminal.

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The scope of the benefit is defined by tasks which are comprised of ADLs and IADLs, as outlined in the State Medicaid manual, Section 4480 (C). These tasks include but are not limited to: Ambulation/Locomotion, Bathing/Showering, Dressing, Meal Preparation, Feeding, Hygiene-Hair Care/Grooming, Hygiene-Mouth Care, Hygiene-Nail Care, Hygiene-Shaving, Hygiene-Skin Care, Mobility-Positioning, Mobility-Transfer, Protective Oversight, Toileting-Bladder Care, Toileting-Bowel Care, Toileting-Bowel Program, Toileting-Catheter Care, and Medication Reminders.

2. Qualified providers Providing Personal Care Services include:

a. Class A and Class B Home Care Agencies and qualified staff who are:

i. licensed by the State of Colorado;

ii. in compliance with Colorado Department of Public Health and Environment Home Care Regulations, 6 C.C.R. 1011-1

3. Place of Service

PCS are provided in a client's place of residence or outside a client's place of residence, when Personal Care Activities take place outside of the client's residence.

4. State Approved Service Plan

The state uses both a State-approved and a Physician-approved Plan – a State-approved 485 service plan is used for clients receiving Personal Care and Home Health care. For Clients receiving only Personal Care, a Physician-approved Care Plan is used which is a written list of specific Personal Care tasks provided to a client by the Personal Care Worker. The Care Plan shall be updated at least annually or as required by the client's needs and/or condition.

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4.c. Family Planning Services and Supplies

- A. The Department of Health Care Policy and Financing (the Department) covers family planning services and supplies, with the exception of infertility services and supplies.

The Colorado Department of Health Care Policy and Financing (the Department) covers family planning services and supplies, as noted under Section 1905(a)(4)(c) of the Social Security Act and 42 CFR 441.20.

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4 d Tobacco Cessation Counseling Services for Pregnant Women

1. Allowable Providers

Face-to-face tobacco cessation counseling services for pregnant women are provided

- ☒ (i) By or under supervision of a physician,
- ☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; * or
- ☐ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations

*describe any limits on who can provide these counseling services:

All providers are required to complete a tobacco cessation counseling training course in order to deliver tobacco cessation counseling to pregnant women. This training course requirement applies to both the practitioner who is furnishing the service directly, and the provider who is supervising others who are furnishing the service

2. Service Limitations

- **Intermediate Counseling:** A maximum of five units per year of tobacco use cessation counseling in an individual setting. Each unit is greater than three minutes and up to ten minutes long.
- **Intensive Counseling:** A maximum of three units per year of tobacco use cessation counseling in an individual or group setting. Each unit is greater than ten minutes long.

T N # 11-049

Approval Date

3/6/12

Supersedes T N # NEW

Effective Date 1/1/2012

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SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

4b.(I) School Health Services Program Benefits

Medicaid 1905(a) benefits can be furnished to Medicaid eligible student beneficiaries that require medical or mental/behavioral health services identified as medically necessary in an Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established. Furthermore, any 1905(a) benefit/service covered in the community can be performed in a school-based setting. Services in a school-based setting must be performed by qualified practitioners as set forth in the State Plan for the services they are providing and shall meet applicable qualifications under 42 CFR Part 440 and/or Colorado state law. All eligible recipients must be allowed the freedom of choice to receive services from any willing and qualified practitioner. Beneficiaries shall receive services delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client. Participation by Medicaid-eligible recipients is optional.

A. Personal Care Services

Definition:

Personal care services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP, other medical plans of care, or other service plan approved by the state.

Services:

Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands on assistance or cueing so that the person performs the task by him/herself

Providers:

Personal care services must be provided by a qualified provider in accordance with 42 CFR § 440.167, who is 18 years or older and has been trained to provide the personal care services required by the client.

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SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

B. Specialized Transportation

Definition:

Specialized transportation services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the transportation services are medically necessary and documented in an IEP/IFSP.

Services:

Services must be provided on the same date of service that a Medicaid covered service, required by the student's IEP/IFSP, is received. Transportation must be on a specially adapted school bus to and/or from the location where the Medicaid service is received. Transportation services are not covered on a regular school bus unless an Aide for the transported student(s) is present and is required by the student's IEP/IFSP.

All specialized transportation services provided must be documented in a transportation log.

Providers:

Transportation services include direct services personnel, e.g. bus drivers, aides etc. employed or contracted by the school district.

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- 5.a. Physician's services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Adult clients are limited to one routine annual physical examination per state fiscal year.

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Supersedes TN No. 04-016

Approval Date 8/17/11
Effective Date 7/1/2011

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- 5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Medical services are a benefit when determined to be medically necessary as based upon a medical diagnosis.

Surgical services including dental splints or other devices are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones.

Emergency treatment can be provided to an adult client who:

- Presents with an acute condition of the oral cavity that requires hospitalization and or immediate surgical care.
- Presents with a condition of the oral cavity that would result in acute hospital medical care and or subsequent hospitalization if no immediate treatment is rendered.

Emergency treatment provided to an adult client includes, but is not limited to:

- Immediate treatment or surgery to repair trauma to the jaw.
- Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose.
- Extraction of tooth or tooth structures associated with the emergency treatment of a condition of the oral cavity.
- Repair of traumatic oral cavity wounds.
- Anesthesia services ancillary to the provision of emergency treatment.

Additional non-emergent procedures are available for adult clients with a documented concurrent medical condition. Allowable concurrent medical conditions include:

- neoplastic disease requiring chemotherapy and/or radiation
- pre organ transplant
- post organ transplant
- pregnancy
- chronic medical condition in which there is documentation that the medical condition is exacerbated by a condition of the oral cavity.

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Dental procedures for adults with a concurrent medical condition may include:

- clinical oral evaluations
- radiographs
- test and laboratory examinations
- periodontal and non-periodontal surgical procedures
- extractions
- biopsy
- removal of lesions, tumors, cysts and neoplasms
- treatment of fractures
- management of temporomandibular joint dysfunction
- repair procedures
- anesthesia and professional consultation

Both the dental and medical provider must provide documentation that the concurrent medical condition is exacerbated by the condition of the oral cavity.

The following services/treatments are not a benefit for adult clients under any circumstances:

- preventive services to include prophylaxis
- fluoride treatment and oral hygiene instruction
- treatment for dental caries, gingivitis and tooth fractures
- restorative and cosmetic procedures including but not limited to inlay and onlay restorations, crowns, treatment of the oral cavity in preparation for partial or full mouth dentures and assessment for the delivery of dentures or subsequent adjustments to dentures and bridges.

Telemedicine Services

Telemedicine means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a client.

Telemedicine includes:

- Synchronous services provided “live” where the client and the distant provider interact with one another in real time through an audio (including

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telephone and relay calls), audio-video, or data communications. Peripherals may be included, such as transmission of a live ultrasound exam.

- Asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to and retrieved by a health care practitioner at another site for medical evaluation and consultation.

Telemedicine does not include consultations provided by facsimile machines, text messaging, or electronic mail.

To provide telemedicine services, health care practitioners must act within their scope of practice and be licensed practitioners as defined by State law.

All state plan prior authorization requirements apply to services provided through telemedicine. Prior authorization requests must state the intent to provide the service as a telemedicine service. A telemedicine service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental.

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6.b. Ophthalmologist or Optometrist Services

- A. These are services for clients ages 21 and over. These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider.
- 1) One routine non-pediatric eye exam per calendar year, when medically necessary to diagnose, manage, or treat a client with signs or symptoms of injury or disease of the eye.
 - 2) Determination of the refractive state (an exam to test for visual acuity and the need for corrective lenses), only in these situations:
 - a.) As part of the diagnostic eye exam described in (1).
 - b.) After eye surgery.
- B. These are the services for clients ages 20 and younger (EPSDT program). These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider.
- 1) Routine vision screening and diagnostic eye exams.
 - 2) Orthoptic vision treatment services.

TN No. 17-0043
Supersedes TN No. 10-010

Approval Date March 2, 2018
Effective Date December 1, 2017

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6.d. Other practitioners' services.

The following services are provided:

1. Services provided by State licensed Psychologists .
2. Services provided by Certified Registered Nurse Anesthetists.
3. Services provided by Clinical Nurse Specialists.
4. Services provided by Physician Assistants.
5. Services provided by licensed Pharmacists.
 - a. Licensed Pharmacists administering vaccines in the state of Colorado must be certified in pharmacy based immunization delivery in compliance with the Colorado Board of Pharmacy Rules at 3 CCR 719 § 19.00.00 (2017).
 - b. Licensed Pharmacists that have entered into a Collaborative Pharmacy Practice Agreement for the purposes of administering antagonist injections must be certified in compliance with the Colorado Board of Pharmacy Rules at 3 CCR 719-1 § 17.00.00 (2017).

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6.d. Other practitioners' services

The following services are provided:

1. Services provided by State licensed Psychologists.
2. Services provided by Certified Registered Nurse Anesthetists.
3. Services provided by Clinical Nurse Specialists.
4. Services provided by Physician Assistants.
5. Services provided by licensed Pharmacists.
 - a. Licensed Pharmacists administering vaccines in the state of Colorado must be certified in pharmacy based immunization delivery in compliance with the Colorado Board of Pharmacy Rules at 3 CCR 719 § 19.00.00 (2017).
 - b. Licensed Pharmacists that have entered into a Collaborative Pharmacy Practice Agreement for the purposes of administering antagonist injections must be certified in compliance with the Colorado Board of Pharmacy Rules at 3 CCR 719-1 § 17.00.00 (2017).
 - c. Licensed Pharmacists, or licensed pharmacy interns under the supervision of licensed Pharmacists, may provide medication therapy counseling services to fee-for-service Medical Assistance Program clients. Medication therapy counseling services may be conducted face-to-face, over the telephone, or through a virtual meeting.

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Telemedicine Services

Telemedicine means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a client.

Telemedicine includes:

- Synchronous services provided "live" where the client and the distant provider interact with one another in real time through an audio-video communications circuit. Peripherals may be included, such as transmission of a live ultrasound exam.
- Asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to and retrieved by a health care practitioner at another site for medical evaluation and consultation.

Telemedicine does not include consultations provided by telephone (interactive audio) or facsimile machines.

To provide telemedicine services, health care practitioners must act within their scope of practice and be licensed practitioners as defined by State law.

All state plan prior authorization requirements apply to services provided through telemedicine. Prior authorization requests must state the intent to provide the service as a telemedicine service. A telemedicine service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental.

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7 Home Health Services

A Service Limitations

- 1 Acute Home Health shall be assessed for medical necessity and is provided during a 60 calendar day episode
- 2 Long Term Home Health is provided for 61 calendar days or longer for chronic conditions Medicaid clients receiving Long Term Home Health shall be assessed for medical necessity and services shall be prior authorized by the State designated agency
- 3 All services provided by a home care agency must be medically necessary and under a physician's order as part of a written plan of care, reviewed every 60 days, indicating the amount, duration and scope of the home care services the client can receive
- 4 Sample post-pay review applies to all Home Health services
- 5 Effective January 1, 2000, maximum daily reimbursement limits are set for long term home health and for acute home health These maximum reimbursement limits are based upon type and cost of long term home health services (primarily aide visits) and acute home health services (primarily nursing visits) These maximums will be adjusted in accordance with rate changes

B Services

a Skilled nursing services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
b Home health aide services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
c Physical therapy services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home Health
d Occupational therapy services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home

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APPROVAL DATE _____

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EFFECTIVE DATE October 1, 2011

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7 Home Health Services

e	Speech/language pathology services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home
f	Home health telehealth services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
g	Medical supplies, equipment and appliances suitable for use in the home	Provided to Medicaid clients for use in the home

C Provider Qualifications

- 1 Physical therapists and Speech therapists are licensed by the State of Colorado
 - i Physical therapists must meet the provider qualifications for Medicaid found at 42 CFR 440.110
 - ii Speech therapists must meet the provider qualifications for Medicaid found at 42 CFR 440.110
- 2 Occupational therapists are not licensed in Colorado but must be registered at the Colorado Department of Regulatory Agencies (DORA)
 - i Occupational therapists must meet the provider qualifications for Medicaid found at 42 CFR 440.110

D All Home Care agencies are required to meet the conditions of participation in Medicare found at 42 CFR 484

E Provider Choice

- I Clients are free to choose from any qualified Colorado Medicaid provider

TN# 11-012

APPROVAL DATE 12/16/11

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42 CFR 440.80

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8. Private Duty Nursing Services

Private Duty Nursing is face-to-face skilled nursing that is more individualized and continuous than the nursing care that is available under the Home Health benefit or routinely provided in a hospital or nursing facility. Private Duty Nursing is provided in the home, or outside of the home when normal life activities take the client away from the home. Private Duty Nursing shall not be reimbursed in a hospital or nursing facility. Private Duty Nursing services provided to eligible clients shall be provided through Medicaid licensed Home Health agencies.

To be eligible for Private Duty Nursing, a Medicaid client must meet medical necessity criteria.

Private Duty Nursing services are provided by a registered nurse or a licensed practical nurse; under the direction of the recipient's physician.

Private Duty Nursing services may be provided by one nurse to more than one client at the same time, in the same setting, at a reduced rate.

The amount of Medicaid-reimbursed Private Duty Nursing per day may not exceed the hours that are determined necessary under the medical criteria up to sixteen hours per day.

For EPSDT clients, Private Duty Nursing will be provided up to the amount of medical need.

All Private Duty Nursing services must be prior authorized.

TN# 09-038

APPROVAL DATE 12/7/09

SUPERCEDES TN# 04-006

EFFECTIVE DATE: July 1, 2009

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9. CLINIC SERVICES

Provided in an ambulatory surgery center that has an agreement with the Centers for Medicare and Medicaid Services under Medicare to participate as an ambulatory surgery center and meets the conditions set forth in the Act. Covered surgical procedures are those groupings of surgical procedures approved by the Centers for Medicare and Medicaid Services. Additional surgical procedures may be included as approved by the Department of Health Care Policy and Financing.

Provided in a dialysis center certified by the Colorado Department of Public Health and Environment. Routine dialysis center services are all items and services necessary for delivering dialysis including routinely provided drugs, laboratory tests, and supplies for dialysis-related services.

Drug and alcohol treatment provided to a pregnant woman with a substance use disorder who is at risk of poor birth outcome. Approved services must be provided in a facility which is not part of a hospital but is organized and operated as a free-standing alcohol or drug treatment program approved and certified by the Division of Behavioral Health of the Colorado Department of Human Services or in a facility which is not part of a hospital but is organized and operated as a school-based clinic. Allowable services include risk assessment, case management, drug/alcohol individual and group therapy, and health maintenance group.

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LIMITATIONS TO CARE AND SERVICES

10 Dental Services

Dental services for adults age 21 and over are limited to the following categories of service and may require prior authorization:

- a. Routine diagnostic and preventive services:
 - 1. Prophylaxis
 - i. Adult cleaning, two per twelve months
 - 2. Examinations
 - 3. Radiographs
 - i. Bitewings, one set (2-4 films) per twelve months.
 - ii. Intra-oral; complete series, one per sixty months.
 - iii. Panoramic image; with or without bitewings, one per sixty months.
- b. Restorative services
- c. Endodontic services
- d. Periodontal services

For clients under 21 years of age, dental services are provided in accordance with the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) service category. See Supplement to Attachment 3.1-A, section 4b.

Dental services for adults 21 years of age and older, except for services for the immediate relief of severe pain, alleviation of acute infection, or necessary because of trauma, are limited to a total of \$1,500 per adult Medicaid recipient per state fiscal year. Medically necessary services reimbursed under the Medical and Surgical Services Furnished by a Dentist benefit at Attachment 4.19-B, Methods and Standards for Establishing Payment Rates – Other Types of Care, Item 5.b. Medical and Surgical Services Furnished by a Dentist, are not subject to the \$1,500 limitation.

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LIMITATIONS TO CARE AND SERVICES

11. PHYSICAL THERAPY AND RELATED SERVICES

11a. Physical therapy

- Services shall be provided by a licensed physical therapist who is an approved Medicaid provider, or a licensed physical therapist assistant under the general supervision of a licensed physical therapist who is an approved Medicaid provider.
- A medical prescription for services is required and the service/procedure must be a covered benefit of the Medicaid program.
- Prior authorization is required for services to exceed 48 units of any combination of physical and occupational therapy per 12-month period. A prior authorization request shall be effective for a length of time that is determined medically necessary, not to exceed a maximum of 12 months.
- Physical therapy services are limited to a maximum of five units of service per day. A unit is defined by the current procedural terminology (CPT) code.
- Services shall be provided in accordance with 42 CFR 440.110.

11b. Occupational therapy

- Services shall be provided by a licensed occupational therapist who is an approved Medicaid provider or a licensed occupational therapy assistant under the general supervision of a licensed occupational therapist who is an approved Medicaid provider.
- A medical prescription for services is required and the service/procedure must be covered benefit of the Medicaid program.
- Prior authorization is required for services to exceed 48 units of any combination of physical and occupational therapy per 12-month period. A prior authorization request shall be effective for a length of time that is determined medically necessary, not to exceed a maximum of 12 months.
- Occupational therapy services are limited to a maximum of five units of service per day. A unit is defined by the current procedural terminology (CPT) code.
- Services shall be provided in accordance with 42 CFR 440.110.

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11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech-language pathologist or audiologist)

- Audiology services shall be provided by a licensed audiologist or an audiologist's aide. An audiologist's aide is a person who, after appropriate training and demonstrated competency, performs tests that are prescribed, directed, and supervised by a licensed audiologist as recommended by the American Academy of Audiology.
- Speech-language pathology services may be provided by any of the following:
 - o A certified speech-language pathologist;
 - o A clinical fellow under the general supervision of a certified speech-language pathologist;
 - o A speech-language pathology assistant under the general supervision of a certified speech-language pathologist. A speech-language pathology assistant is a person who has an associate's degree from a technical training program in speech-language pathology assistants' scope of work as recommended in ASHA guidelines.
- A medical prescription for services is required and the service/procedure must be a covered benefit of the Medicaid program.
- Speech-language pathology services are limited to five units per date of service. A unit is defined by the current procedural terminology (CPT) code.
- Diagnostic procedures provided by an audiologist for the purpose of determining general hearing levels or for the distribution of a hearing device are not a covered benefit, except for the EPSDT population.
- Speech-language pathology services provided for simple articulation or academic difficulties that are not medical in origin are not a covered benefit.

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LIMITATIONS TO CARE AND SERVICES

12.a. Prescribed Drugs

1. Only those drugs designated by companies participating in the federally approved Medicaid drug rebate program and not otherwise excluded according to the Department's rules are regular drug benefits, with the following exceptions:
 - a. Brand name drugs not covered by rebate agreements are a covered benefit if the Department has made a determination that the availability of the drug is essential, such drug has been given a "1-A" rating by the Food and Drug Administration (FDA), and a prior authorization has been approved. Reimbursement of any drugs that are a regular drug benefit may be restricted as set forth in the Department's rules.
 - b. Only those investigational drugs that are specifically named in the state plan are a covered benefit.
2. Restrictions, including prior authorizations, may be placed on drugs for which it has been deemed necessary to address instances of fraud or abuse, potential for, and history of, drug diversion and other illegal utilization, over-utilization, other inappropriate utilization or the availability of more cost-effective alternatives. The prior authorization process provides for a turn-around response by telephone or other telecommunications device within 24 hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a 72-hour supply of medication.
3. Erectile dysfunction drugs will only be covered for FDA approved indications other than erectile or sexual dysfunction.
4. Generic drugs shall be prescribed to clients in the fee-for-service program unless
 - a. Only a brand name drug is manufactured.
 - b. A generic drug is not therapeutically equivalent to the brand name drug.
 - c. The final cost of the brand name drug is less expensive to the Department.
 - d. The drug is used for the treatment of
 - 1) Biologically based mental illness as defined in C.R.S. 10-16-104 (5.5);
 - 2) Treatment of cancer;
 - 3) Treatment of epilepsy; or
 - 4) Treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
 - e. The client has been stabilized on a brand name medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand name drug would be unacceptably disruptive.

TN No. 18-0016

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- f. The client has taken a generic drug but is unable to continue treatment on the generic drug.
 - g. Any exceptions to the generic drug requirement shall be granted in accordance with procedures established by the Department.
5. The following are not pharmacy benefits of the Medical Assistance Program
- a. Spirituous liquors of any kind;
 - b. Dietary needs or food supplements unless prior authorized within the Department guidelines;
 - c. Personal care items such as mouthwash, deodorants, talcum powder, bath powder, soap of any kind, dentifrices, etc.;
 - d. Medical supplies; and
 - e. Drugs classified by the FDA as “investigational” or “experimental.”

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Services**Limitations**

12.a Prescribed Drugs

6. Pursuant to 42 U.S.C. Section 1396r-8, the Department is establishing a Preferred Drug List which indicates the Preferred and Non-preferred Drugs in selected therapeutic drug classes. Those products within a selected therapeutic drug class that are designated Non-preferred will require prior authorization. All drugs covered by the National Drug Rebate Agreements remain available to Medical Assistance Program clients, though some drugs may require prior authorization. The prior authorization process for covered outpatient drugs will conform to the provisions of section 1927(d)(5) of the Social Security Act. The Department will appoint a Pharmacy and Therapeutics Committee and utilize the Drug Utilization Review Board in accordance with Federal Law.
7. CMS has authorized the state of Colorado to enter into the Colorado Medicaid Supplemental Drug Rebate Agreement for drugs provided to the Medical Assistance Program. This supplemental drug rebate agreement was submitted to CMS on November 2, 2007 and has been authorized by CMS. Any additional versions of the rebate agreements negotiated between the state and manufacturer(s) after November 2, 2007 will be submitted to CMS for authorization. The Department may collect supplemental rebates from drug manufacturers for Preferred Drugs. Supplemental rebates received by the Department in excess of those required under the National Drug Rebate Program will be shared with the Federal government on the same percentage basis as applied under the National Drug Rebate Agreement. All drugs covered by the Medical Assistance Program, irrespective of a supplemental rebate agreement, will comply with the provisions of the National Drug Rebate Agreement. The unit rebate amount is confidential and cannot be disclosed except in accordance with Section 1927(b)(3)(D) of the Social Security Act.

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Limitations

12.a Prescribed Drugs

8. CMS has authorized the State of Colorado to also enter into Medicaid Value-Based Supplemental Drug Agreements with Manufacturers on a voluntary basis. These contracts will be executed on a model agreement entitled "Value-Based Supplemental Agreement" submitted to CMS on December 4, 2018 with an effective date of October 1, 2018.

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Citation	Provision
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit- Part D.

☒ **The following excluded drugs are covered**

("All" drugs categories covered under the drug class) ☐

("Some" drugs categories covered under the drug class) ☒
-List the covered common drug categories not individual drug products directly under the drug class

("None" of the drugs under this class are covered) ☐

☐ (a) agents when used for anorexia or weight loss

☒ (b) agents when used for weight gain

☐ (c) agents when used to promote fertility

☒ (d) agents when used for the symptomatic relief of cough and colds.

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- ☒ (e) prescription vitamin and mineral products, except prenatal vitamins and fluoride, for documented deficiency.
- ☒ (f) nonprescription drugs.
Nonprescription drugs prescribed for a medically accepted indication in the following classes:
aspirin; cough and cold or allergy preparations consisting of antihistamines, analgesics/antipyretics, cough suppressants, decongestants, and expectorants or combinations thereof; doxylamine; emergency contraceptives; fluoride preparations; intranasal corticosteroids; iron supplements; laxatives; l-methylfolate; pain relievers; proton pump inhibitors; pyridoxine; smoking cessation preparations.
- ☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

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12.b. Dentures

1. Complete and Partial Removable Prosthetics are a benefit for recipients age 21 and older based on medical necessity. Services consist of fabrication of complete or partial dentures and are subject to Prior Authorization Requests.
 - a. Complete Dentures are limited to one set every 7 years, includes initial 6 months of relines
 - b. Partial Dentures are limited to one set every 7 years

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12.c. Prosthetic Devices

May be prior authorized as
medically necessary for adult
clients and for clients of the
EPSDT Program.

TN 98-010

Approval Date 12/9/98 Effective Date 07/01/98

Supersedes
TN 96-003

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12.d. Eyeglasses and Contact Lenses

- A. These are services for clients ages 21 and over. These services must be provided by a certified ophthalmologist, licensed optometrist, or physician who is an approved Medicaid provider:
- 1) Eyeglasses (up to two single or multi-focal clear glass or plastic lenses with one frame, without filters or coatings) following eye surgery and where medically necessary.
 - 2) Contact lenses following eye surgery and where medically necessary, if eyeglasses are not sufficient to treat the client's refractive error.
 - 3) Ocular prosthetics where medically necessary.
- B. These are the services for clients ages 20 and younger (EPSDT program). These services must be provided by a certified ophthalmologist, licensed optometrist, or physician who is an approved Medicaid provider.
- 1) Eyeglasses (up to two single or multifocal clear glass, plastic, or polycarbonate lenses with one frame) where medically necessary.
 - 2) Replacement or repair of eyeglass frames or lenses. Repairs are not to exceed the cost of replacement.
 - 3) Contact lenses where medically necessary, if eyeglasses are not sufficient to treat the client's refractive error.
 - 4) Ocular prosthetics where medically necessary.

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Item 13.b Screening Services

Supplement to Attachment 3.1-A, 13.b. was superseded by TN 17-0050.

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Item 13.c Preventive Services

Services provided are according to the United States Preventive Services Task Force (USPSTF) A and B recommendations along with approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP). Documentation is available to support claiming of FMAP for such services. As changes are made to the USPSTF and/or ACIP, coverage and billing codes will be updated to comply with the changes. Cost sharing is not applied to any of these services.

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

The purpose of SBIRT services is to screen clients for potential risky substance use behaviors. These services are not designed for treatment of clients already diagnosed with a substance abuse disorder or those already receiving substance abuse treatment services.

a. Covered Services

- i. Full Screening, using an evidence-based screening tool approved by the Department. The full screening is indicated for clients with positive pre-screens and for clients with signs, symptoms, and medical conditions that suggest risky substance use. There is a limit of 2 full screens per client per state fiscal year. Providers are required to use an evidence-based screening tool for the full screen.
- ii. Brief Intervention and Referral to Treatment. A brief intervention may be a single session or multiple sessions of motivational discussion focused on raising a client's awareness of a problem and motivating a client to change a health behavior. Brief intervention services are covered for clients who are identified as at-risk for a substance abuse disorder through the use of an evidence-based screening tool. Brief intervention services may occur on the same date of service as the screening or on a later date. A brief intervention may only be done after a positive full screen has been obtained. There is a limit of 4 sessions per client per state fiscal year. Each session is limited to 2 units per session, at 15 minutes per unit.
- iii. All goods and services described in Section 1905(a) of the Social Security Act are a covered benefit under Early and Periodic Screening, Diagnostic and Treatment for those 20 and under when medically necessary as defined at 10 C.C.R. 2505-10, Section 8.076.1.8, regardless of whether such goods and services are covered under the Colorado Medicaid State Plan.

b. Eligible Providers

- i. The following professionals are eligible to provide services or supervise staff who provide services:

1. Licensed health practitioners include:

TN No. 17-0050

Approval Date March 9, 2018

Supersedes TN No. 13-058

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- a. Advanced Practice Nurse (APN) pursuant to CRS 12-38-111.5.
 - b. Physician/Psychiatrist pursuant to CRS 12-36-101.
 - c. Physician assistant pursuant to CRS 12-36-106.
2. Licensed clinicians include:
 - a. Licensed Clinical Social Worker (LCSW) pursuant to CRS 12-43-404.
 - b. Licensed Professional Counselor (LPC) pursuant to CRS 12-43-603.
 - c. Licensed Marriage and Family Therapist (LMFT) pursuant to CRS 12-43-504.
 - d. Licensed Addiction Counselor (LAC) pursuant to CRS 12-43-804.
 - e. Psychologist, Psy.D/Ph.D pursuant to CRS 12-43-304.
- ii. Non-licensed providers may deliver the SBIRT services under the supervision of licensed providers if such supervision is within the legal scope of practice for that licensed provider. The licensed provider assumes professional responsibility for the services provided by the unlicensed provider. All non-licensed providers who deliver SBIRT services under the supervision of licensed providers must meet the following requirements:
 1. Complete a minimum of 60 hours professional experience such as coursework, internship, practicum, education or professional work within their respective field. This experience should include a minimum of 4 hours of training that is directly related to SBIRT services.
 2. Complete a minimum of 30 hours of face-to-face client contact within their field. This may include internships, on-the-job training, or professional experience.

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13.d. Rehabilitative Services

Outpatient Behavioral Health Services

Outpatient Behavioral Health Services are a group of services designed to provide medically necessary behavioral health services to eligible Medicaid clients in order to restore these individuals to their highest possible functioning level. These services are provided to, or directed exclusively toward the treatment of the Medicaid client. Services are provided in accordance with Section 1902(a)(23) of the Social Security Act with regard to free choice of providers, and services may be provided by any willing, qualified provider as described below.

- a. Covered Services, Definitions, and Qualified Providers.
Outpatient Behavioral Health Services are comprised of the following individual services and may be provided by the following qualified providers:

Service	Definition	Provider Types
Individual Psychotherapy	Therapeutic contact with one client.	<ul style="list-style-type: none">• Physician/Psychiatrist• Psychologist, Psy.D./Ph.D.• Licensed Clinician• CMHC* See definitions below
Individual Brief Psychotherapy	Therapeutic contact with one (1) client.	<ul style="list-style-type: none">• Physician/Psychiatrist• Psychologist, Psy.D/Ph.D• Licensed Clinician• CMHC
Family Psychotherapy	Therapeutic contact with one client, typically a child/youth, with one or more of the client's family members and/or caregivers present and included in the therapeutic process and communications.	<ul style="list-style-type: none">• Physician/Psychiatrist• Psychologist, Psy.D/Ph.D• Licensed Clinician• CMHC

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Service	Definition	Provider Types
Group Psychotherapy	Therapeutic contact with more than one client.	<ul style="list-style-type: none">• Physician/Psychiatrist• Psychologist, Psy.D/Ph.D• Licensed Clinician• CMHC
Behavioral Health Assessment	An initial or ongoing diagnostic evaluation of a client to determine the presence or absence of a behavioral health diagnosis, to identify behavioral health issues that impact health and functioning, and to develop an individual service/care plan.	<ul style="list-style-type: none">• Physician/Psychiatrist• Psychologist, Psy.D/Ph.D• Licensed Clinician• CMHC
Pharmacological Management	Monitoring of medications prescribed and consultation provided to clients by a physician or other medical practitioner authorized to prescribe medications as defined by State law, including associated laboratory services as indicated.	<ul style="list-style-type: none">• Physician/Psychiatrist• A PN or PA with prescriptive authority• CMHC
Outpatient Day Treatment	Therapeutic contact with a client in a structured program of therapeutic activities lasting more than four (4) hours but less than 24 hours per day. Services include assessment and monitoring; individual/group/family therapy; psychological testing; medical/nursing support; psychosocial education; skill development and socialization training focused on improving functional and behavioral deficits; medication management; and expressive and activity therapies. When provided in an outpatient hospital program or other approved facility, may be called "partial hospitalization."	<ul style="list-style-type: none">• CMHC• Physician/Psychiatrist
Emergency/Crisis Services	Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to a crisis situation with a client, including associated laboratory services, as indicated.	<ul style="list-style-type: none">• Physician/Psychiatrist• Psychologist, Psy.D/Ph.D• Licensed Clinician• CMHC

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Provider Type	Definition
Licensed Health Practitioners	Physician/Psychiatrist pursuant to CRS 12-36-101. Advanced Practice Nurse (APN) pursuant to CRS 12-38-111.5. Physician assistant pursuant to CRS 12-36-106.
Licensed Clinician	Licensed Addiction Counselor (LAC) pursuant to CRS 12-43-804. Licensed Clinical Social Worker (LCSW) pursuant to CRS 12-43-404. Licensed Marriage and Family Therapist (LMFT) pursuant to CRS 12-43-504. Licensed Professional Counselor (LPC) pursuant to CRS 12-43-603. Psychologist, Psy.D/Ph.D pursuant to CRS 12-43-304.
Community Mental Health Center (CMHC)	A facility that meets the definition of a CMHC as set forth in CRS 27-66-101 and is licensed in accordance with CRS 25-3-101.

b. Non-Covered Services

Outpatient Behavioral Health Services do not include, and federal financial participation is not available for, any of the following:

- Room and board services
- Educational, vocational and job training services
- Habilitation services
- Services to inmates in public institutions as defined in 42 CFR § 435.1010
- Services to individuals residing in institutions for mental diseases as described in 42 CFR § 435.1010
- Recreational and social activities
- Services that must be covered elsewhere in the Medicaid State Plan

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Item 13.d. Rehabilitative Services (continued)

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Substance Use Disorder Treatment and Withdrawal Management Services

Substance use disorder (SUD) services include services along the continuum of care defined by the American Society of Addiction Medicine (ASAM). The Department covers the full continuum of SUD services. Services are provided to Medicaid beneficiaries with one or more diagnosed SUD(s). Services are determined according to medical necessity which include an assessment of level of clinical severity and function.

SUD treatment services, unless otherwise specified, must be performed by a licensed health practitioner with a certification in addiction counseling or a licensed clinician. Services may also be performed under the supervision of a licensed health practitioner with a certification in addiction counseling or a licensed clinician in facilities that are licensed by the State.

1. Licensed health practitioners include:
 - a. Licensed Physician
 - b. Licensed Psychiatrist
 - c. Licensed Advanced Practice Nurse (APN)
 - d. Licensed Physician Assistant (PA)
2. Licensed clinicians include:
 - a. Licensed Clinical Social Worker (LCSW)
 - b. Licensed Professional Counselor (LPC)
 - c. Licensed Marriage and Family Therapist (LMFT)
 - d. Licensed Addiction Counselor (LAC)
 - e. Licensed Psychologist, PhD/PsyD

Services shall be provided in an out-of-state setting if medically necessary and no suitable treatment option is found in Colorado. Out-of-state providers must enroll as a Colorado Medicaid Provider pursuant to 10 C.C.R. 2505-10, Section 8.013.1.

The following Practitioners and Qualifications chart is applicable to each of the substance use disorder services and service components that follow in this section. All services must be provided within the scope of the provider's licensure.

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Licensed Professionals	
Provider Type/Qualifications	Services Provided
<ul style="list-style-type: none">• Licensed Marriage and Family Therapist (LMFT) 42 CFR 440.60• Licensed Clinical Social Worker (LCSW) 42 CFR 440.60• Licensed Professional Counselor 42 CFR 440.60• Licensed Clinical Alcohol and Drug Counselor (LAC) 42 CFR 440.60• Licensed Addiction Counselor 42 CFR 440.60• Licensed Psychologist 42 CFR 440.60	<ul style="list-style-type: none">• Substance use disorder assessment• Individual and family therapy• Group therapy• Alcohol/drug screening counseling• Treatment coordination
<ul style="list-style-type: none">• Licensed Psychiatrist/Physician 42 CFR 440.50	<ul style="list-style-type: none">• Medical/nursing care and evaluation• Medication administration or supervision• Medication Assisted Treatment• Individual and family therapy• Group therapy• Treatment coordination
<ul style="list-style-type: none">• Licensed Advanced Practice Nurse CRS 12-255-111	<ul style="list-style-type: none">• Medical/nursing care and evaluation• Medication administration or supervision• Medication Assisted Treatment• Treatment coordination
<ul style="list-style-type: none">• Licensed Physician Assistant CRS 12-240-113	<ul style="list-style-type: none">• Medical/nursing care and evaluation• Medication administration or supervision• Medication Assisted Treatment• Treatment coordination
<ul style="list-style-type: none">• Licensed Registered Nurse CRS 12-255-104	<ul style="list-style-type: none">• Medical/nursing care and evaluation• Medication administration or supervision• Treatment coordination

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Outpatient Substance Use Disorder Treatment Services

Outpatient substance use disorder treatment services are designed to help patients achieve changes in their alcohol and/or other drug use. They are tailored to each patient's level of clinical severity and functioning.

Allowable services include:

1. Substance use disorder assessment. An evaluation designed to determine the level of drug or alcohol abuse or dependence, and the comprehensive treatment needs of a client.
2. Individual and family therapy. Therapeutic substance abuse counseling and treatment services with one client per session. Family therapy will be directly related to the client's treatment for substance use or dependence.
3. Group therapy. Therapeutic substance abuse counseling and treatment services with more than one client.
4. Alcohol/drug screening counseling. Counseling services provide in conjunction with the collection of urine to test for the presence of alcohol or drugs.
5. Medication Assisted Treatment (MAT). MAT consists of administration, management, and oversight of methadone or another approved controlled substance to an opiate dependent person for the purpose of decreasing or eliminating dependence on opiate substances. Administration, management and oversight of methadone or another approved controlled substance shall only be provided by:
 - a. Licensed Physicians;
 - b. Licensed Physician Assistants; and
 - c. Licensed Advance Practice Nurse.

Intensive Outpatient Substance Use Disorder Services

Intensive outpatient treatment services are delivered with greater frequency than standard outpatient services. This level of care is appropriate for patients who have more complex needs.

Allowable services include:

1. Substance use disorder assessment. An evaluation designed to determine the level of drug or alcohol abuse or dependence, and the comprehensive treatment needs of a client.

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2. Individual and family therapy. Therapeutic substance abuse counseling and treatment services with one client per session. Family therapy will be directly related to the client's treatment for substance use or dependence.
3. Group therapy. Therapeutic substance abuse counseling and treatment services with more than one client.
4. Alcohol/drug screening counseling. Counseling services provided in conjunction with the collection of urine to test for the presence of alcohol or drugs.

Residential Substance Use Disorder Treatment Services

Residential treatment services are delivered in settings that provide 24-hour structure, support and clinical interventions for patients. These services are appropriate for patients who require time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment. Higher levels of residential treatment provide safe, stable living environments for patients who need them to establish or maintain their recovery apart from environments that promote continued use in the community.

Allowable service components include:

1. Substance use disorder assessment. An evaluation designed to determine the level of drug or alcohol abuse or dependence, and the comprehensive treatment needs of a client.
2. Individual and family therapy. Therapeutic substance abuse counseling and treatment services with one client per session. Family therapy will be directly related to the client's treatment for substance use or dependence.
3. Group therapy. Therapeutic substance abuse counseling and treatment services with more than one client.
4. Alcohol/drug screening counseling. Counseling services provided in conjunction with the collection of urine to test for the presence of alcohol or drugs.

Withdrawal Management Services

Clinically managed or medically monitored services aimed at the reduction of physiological and psychological features of withdrawal through short-term services delivered on a 24-hour basis for the purpose of stabilizing intoxicated patients, managing withdrawal and facilitating access to substance use disorder treatment.

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Allowable service components include:

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1. Individual therapy. Therapeutic substance abuse counseling and treatment services with one client per session.
2. Group therapy. Therapeutic substance abuse counseling and treatment services with more than one client.
3. Alcohol/drug screening counseling. Counseling services provided in conjunction with the collection of urine to test for the presence of alcohol or drugs.
4. Medication administration or supervision of self-administration of medication as clinically indicated.
5. Medical/nursing care and evaluation. Assessment of patient progress through withdrawal and provision of medical interventions as indicated by evaluation.
6. Treatment coordination.

Service Limitations

Services are subject to prior authorization, must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license and applicable state law.

Rehabilitative services do not include and FFP is not available for any of the following, in accordance with section 1905(a)(13) of the Act:

1. Room and board
2. Educational, vocational and job training services
3. Habilitation services
4. Services to inmates in public institutions as defined in 42 CFR 435.1010
5. Services to individuals residing in institutions for mental diseases as described in 42 CFR 435.1010
6. Recreational and social activities
7. Services that must be covered elsewhere in the state Medicaid plan.

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13.d. Rehabilitative Services: Mental Health and Substance Abuse Rehabilitation Services for Children

Mental health rehabilitative services treatment, including substance abuse treatment, are ordered by a licensed physician or licensed mental health provider in accordance with Colorado state laws governing their practice, and are for the maximum reduction of mental disability and restoration of function to the best possible level. All limitations on services may be exceeded based on medical necessity. Recipients of these services may reside in a congregate setting, however, these clients are not residents of an Institution for Mental Disease (IMD). The determination of individual recipient disability, treatment goals, care plan to achieve treatment goals, progress benchmarks and assessment of progress will be made by a licensed practitioner in keeping with accepted standards and/or best practices of mental health treatment and documented in the recipient's record. Licensed mental health providers include licensed psychologist, licensed psychiatrist, licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor, and licensed social worker supervised by a licensed clinical social worker.

Services Include:

- Psychiatric diagnostic interview examination upon out-of-home placement including history, mental status, or disposition, provided by a licensed health practitioner or a licensed clinician.
- Individual psychotherapy (brief), insight oriented behavior modifying and/or supportive, including, when indicated, therapy for substance abuse, provided face-to-face in an office or outpatient clinic by a licensed health practitioner, a licensed clinician, or a CMHC.
- Individual psychotherapy (long), insight oriented behavior modifying and/or supportive, including, when indicated, therapy for substance abuse, provided face-to-face in an office or outpatient clinic by a licensed health practitioner, a licensed clinician, or a CMHC.
- Psychotherapy for Crisis, including psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize trauma, provided face-to-face by a licensed health practitioner, a licensed clinician, or a CMHC.

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- Family psychotherapy (conjoint therapy) for the exclusive benefit of the child recipient and with the recipient present, unless recipient and family contact is contraindicated, including, when indicated, therapy for substance abuse, provided by a licensed health practitioner, a licensed clinician, or a CMHC.
- Group psychotherapy, excluding a multifamily group, including, when indicated, therapy for substance abuse, provided by a licensed health practitioner, a licensed clinician, or a CMHC.
- Psychological testing (professional) includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report, provided by a licensed health practitioner, a licensed clinician, or a CMHC. Face-to-face with the patient time only.
- Psychological testing (technician) includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI and WAIS), with licensed mental health provider interpretation and report, administered by technician, per hour of technician time, under the supervision of a licensed health practitioner or a licensed clinician. Face-to-face with the patient time only.
- Interactive group psychotherapy provided by a licensed health practitioner, a licensed clinician, or a CMHC, including when indicated, therapy for substance abuse.
- Pharmacologic management, including prescription, use, and review of medication, when performed with psychotherapy services, provided by a licensed health practitioner.

Exclusions

Mental Health and Substance Abuse Rehabilitative Services for Children do not include the following:

- Room and board services;
- Educational, vocational and job training services;
- Recreational or social activities
- Services provided to inmates of public institutions or residents of institutions for mental diseases; and
- Services that are covered elsewhere in the state Medicaid plan.

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Provider Qualifications

1. Licensed health practitioners include:
 - a. Advanced Practice Nurse (APN) pursuant to CRS 12-38-111.5.
 - b. Physician/Psychiatrist pursuant to CRS 12-36-101.
 - c. Physician assistant pursuant to CRS 12-36-106.
2. Licensed clinicians include:
 - a. Licensed Clinical Social Worker (LCSW) pursuant to CRS 12-43-404.
 - b. Licensed Professional Counselor (LPC) pursuant to CRS 12-43-603.
 - c. Licensed Marriage and Family Therapist (LMFT) pursuant to CRS 12-43-504.
 - d. Licensed Addiction Counselor (LAC) pursuant to CRS 12-43-804.
 - e. Psychologist, Psy.D/Ph.D pursuant to CRS 12-43-304.
3. Community Mental Health Center (CMHC)
 - a. A facility that meets the definition of a CMHC as set forth in CRS 27-66-101 and is licensed in accordance with CRS 25-3-101.

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13.d. Rehabilitative Services (continued) Enhanced Behavioral Health Therapy has been removed. This page intentionally left blank.

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LIMITATIONS TO CARE AND SERVICES

Item 16. Inpatient psychiatric facility services for individuals under 21 years of age

Inpatient psychiatric services are provided under the direction of a physician and in accordance with 42 CFR §441.151 Subpart D (a) (1). Services are furnished in either a freestanding psychiatric hospital or a Psychiatric Residential Treatment Facility to Medicaid clients under the age of 21. If the client was receiving services immediately before he or she turned 21, services shall be furnished until the date the client no longer requires the services or the date the client reaches the age of 22. The need for services must be certified prior to admission, as required in 42 CFR §441 Subpart D, except in an emergency.

1. Freestanding Psychiatric Hospital

- a. Eligible Providers: Psychiatric hospitals that meet all hospital enrollment requirements as defined in 42 CFR §441.151 Subpart D (2) (i).
- b. The reimbursement methodology for Freestanding Psychiatric Hospitals is described in Attachment 4.19-A.

2. Psychiatric Residential Treatment Facility (PRTF)

- a. Eligible Providers. A PRTF must meet the following criteria to be eligible to provide PRTF services:
 - i. Is a separate, stand-alone facility other than a hospital
 - ii. Provides a range of services to treat the psychiatric condition of clients under the age of 21 on an inpatient basis under the direction of a physician
 - iii. Meets the Conditions of Participation found at 42 C.F.R. Part 441, Subpart D, including the accreditation requirements
 - iv. Meets the Condition of Participation for Use of Restraint or Seclusion in Psychiatric Facilities or Programs, found at 42 C.F.R. Part 483, Subpart G
- b. The reimbursement methodology for Psychiatric Residential Treatment Facilities is described in Attachment 4.19-D.

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LIMITATIONS TO CARE AND SERVICES

18. Hospice Care

1. Hospice care is available to any Medicaid client if:
 - a. The client elects to receive the hospice benefit, and
 - b. The client's attending physician has certified a prognosis of nine months or fewer to live, if the individual has an attending physician. Otherwise, Medical Director of the hospice or the physician member of the Interdisciplinary Team will certify the prognosis.
2. Hospice care includes the following services:
 - a. Nursing care provided by or under the supervision of a registered nurse;
 - b. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.;
 - c. Counseling services, including dietary and spiritual counseling, provided to the client and his or her family members or other persons caring for the client;
 - d. Bereavement counseling delivered through an organized program under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient);
 - e. Short-term general inpatient care necessary for pain control and/or symptom management up to 20 percent of total hospice days;
 - f. Short-term inpatient care of up to five consecutive days per benefit period to provide respite for the client's family or other home caregiver, that conforms to the written plan of care;
 - g. Medical appliances and supplies, including drugs and biologicals which are used primarily for symptom control and relief of pain related to the terminal illness;
 - h. Intermittent hospice home health aide services available and adequate in frequency to meet the needs of the client. Hospice home health aide services may include unskilled personal care and homemaker services that are incidental to a visit;
 - i. Occupational therapy, physical therapy, and speech-language pathology appropriate to the terminal condition, provided for the purposes of symptom

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control or to enable the terminal client to maintain activities of daily living and basic functional skills;

- j. Physician services provided by a physician as defined in 42 CFR 410.20, except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy; and
 - k. Any other service that is specified in the client's plan of care as reasonable and necessary for the palliation and management of the client's terminal illness and related conditions and for which payment may otherwise be made under Medicaid.
3. A client aged 21 and over who has elected hospice is not eligible to receive services that are related to the treatment of the client's condition for which a diagnosis of terminal illness has been made. A client under the age of 21 is eligible to receive hospice services concurrently with services related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

TN No. 12-001
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Approval Date 4/13/12
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19. TARGETED CASE MANAGEMENT SERVICES: Persons with a Developmental Disability

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Medicaid recipients who have been determined by a Community Centered Board to have a developmental disability and are actively enrolled in the Home and Community Based Services waiver for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services waiver (HCBS-SLS), HCBS-Children's Extensive Support waiver (HCBS-CES), HCBS- Children's Habilitation Residential Program (HCBS-CHRP) waiver, and Early Intervention Services. Excluded are children with developmental disabilities or delays enrolled in the Children's HCBS waiver, adults with developmental disabilities who are enrolled in other Medicaid waiver programs, and persons residing in Class I nursing facilities or Intermediate Care Facilities- for Individuals with Intellectual and Developmental Disabilities (ICF-IID) .

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

Targeted Case Management (TCM) services to this population will consist of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources.

Targeted Case Management services will involve at least one activity regarding the individual each month in which Targeted Case Management services are billed for one or more of the following purposes:

- a. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;

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19. TARGETED CASE MANAGEMENT SERVICES: Persons with a Developmental Disability

- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Comprehensive assessment shall be completed at the time of enrollment. Assessment information shall be reviewed at least annually. Reassessment shall occur when the client experiences significant change in need or in level of support.

- b. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual.
 - c. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
 - d. Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- Monitoring shall be completed as necessary to ensure implementation of the care plan and to evaluate health and welfare. Follow up actions shall be performed when necessary to address health and safety concerns or services in the care plan. Monitoring shall include direct contact and observation with the client in a place where services are delivered and at a frequency as follows:
- HCBS-DD at least once per quarter;
 - HCBS-SLS at least once per quarter;

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19. TARGETED CASE MANAGEMENT SERVICES: Persons with a Developmental Disability

- HCBS-CES at least once per quarter;
- HCBS-CHRP at least once per quarter; or
- Early Intervention at least every six months

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Targeted Case Management services for HCBS waivers will be provided by Case Management Agencies (CMA). CMA means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management services for Home and Community Based Services waivers pursuant to section CRS 25.5-10-209.5. Providers must meet established program requirements and attend all required trainings.

Targeted Case Management services for Early Intervention will be provided by Community Centered Boards (CCB) which are a private corporation, for-profit or not-for-profit, that is designated pursuant to section 25.5-10-209. CCB Case Managers who provide Targeted Case Management services will have, at a minimum, a bachelor's level degree of education, five (5) years of experience in the field of developmental disabilities, or some combination of education and experience appropriate to the requirements of the position.

All Home and Community Based Services (HCBS) case managers must be employed by an approved CMA.

The minimum required for Targeted Case Management case managers for HCBS waivers is a bachelor's degree in a human behavioral science or related field of study. If an individual does not meet the minimum requirement, the case management agency shall request a waiver from the Department and demonstrate that the individual meets one of the following:

- Experience working with long-term services and supports (LTSS) population, in a private or public agency, which can substitute for the required education on a year for year basis; or
- A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.

A copy of this waiver request with Department approval shall be kept in the case manager's personnel file.

HCBS Case manager supervisor educational experience: The case management agency's supervisor(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

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19. TARGETED CASE MANAGEMENT SERVICES: Persons with a Developmental DisabilityFreedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Effective April 1, 2012, the total number of units per client is limited to 60 units through June 30, 2012. Effective July 1, 2012, the total number of units per client is limited to 240 units per fiscal year per person for each state fiscal year (July 1 through June 30). One unit is equal to 15 minutes.

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Service #19

A. Targeted Group:

Title XIX eligible individuals ages 0 - 21 who are referred for, or are receiving, services pursuant to an Individualized Education Program (IEP), an Individualized Health Services Plan (IHSP), an Individualized Family Services Plan (IFSP), a Section 504 Accommodation Plan, and who have a disability or who are medically at risk. These individuals may be enrolled in a managed care program or receiving Title XIX services in a fee-for-service environment. In either case, they remain eligible to receive case management services under this section.

A disability is defined as a physical or mental impairment that substantially limits one or more major life activities. Medically at risk refers to individuals who have a diagnosable physical or mental condition that has a high probability of impairing cognitive, emotional, neurological, social or physical development.

B. Areas of the State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are activities that assist the target population in gaining access to needed medical, social, educational and other services. These services include services covered under the Colorado Medicaid State Plan as well as those services not covered under the State Plan. Case management services include the following activities:

TN No. 95-003

Supersedes

TN No. New

Approved 02/13/98

Effective 07/01/97

1. Needs Assessment

Reviewing the individual's current and potential strengths, resources, deficits and need for medical, social, educational and other services. Results of assessments and evaluations are reviewed and a meeting is held with the individual, his or her parent(s) and/or guardian, and the case manager to determine whether services are needed and, if so, to develop a service plan.

2. Service Planning

Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parent(s) or legal guardian, and the case manager. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs. The Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), the Section 504 Accommodation Plan or Individualized Health Service Plan (IHSP) may act as the service plan.

Service planning may include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

3. Service Coordination, Monitoring, and Advocacy

Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, consultation, and monitoring. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the individual, his or her parent(s) or legal guardian and the case manager, and the individual, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes advocating for the individual in matters regarding access, appropriateness and proper utilization of services.

4. Service Plan Review

Periodic review of the progress the individual has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of

the plan, or termination of case management services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the individual and other involved parties.

5. Crisis Assistance Planning

Evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual.

Case record documentation of the above service components is included as a case management activity.

Case management services do not include:

Program activities of the agency itself that do not meet the definition of targeted case management.

Administrative activities necessary for the operation of the agency providing case management services other than the overhead costs directly attributable to targeted case management.

Diagnostic, treatment, or instructional services, including academic testing.

Services that are an integral part of another service already reimbursed by Medicaid.

Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.

E. Non-Duplication of Services:

To the extent any eligible recipients in the identified target population are receiving Targeted Case Management services from another provider agency as a result of being members of other covered target groups, the provider agency will ensure that case management activities are coordinated to avoid unnecessary duplication of service. The State assures that it will not seek Federal matching for case management services that are duplicative.

To the extent that any of the services required by the client are a Title XIX benefit of a managed care organization of which the client is a member, the provider will ensure that timely referrals are made and that coordination of care occurs.

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TN No. NEW

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Effective 07/01/97

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this service.

F. Free Choice of Providers:

The State assures that the provision of case management services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. Participation by eligible targeted recipients is optional. Medicaid TCM services will be made available to all eligible targeted recipients and must be delivered by qualified providers on a statewide basis with procedures to ensure continuity of service without duplication and in compliance with federal and state mandates and regulations related to serving the targeted population in a uniform and consistent manner.

G. Provider Qualifications:

Targeted case management providers must meet the qualifications established by the State to develop and implement IEPs or services required under the most current provisions of the Individuals with Disabilities Education Act (IDEA). The development of an IEP is dependant upon the needs of the individual student as determined by consultation that may include any or all of the following professions: special education, school psychologist, occupational therapist, physical therapist, speech language specialist, social worker, school counselor, and other specialists as identified. Those providing input must meet state or national licensure, registration, or certification requirements of the profession in which they practice. The targeted case management provider must be one of the above identified professionals.

H. Service Provision Documentation:

The provision of TCM will be recorded on a Service Record form that meets the federal Targeted Case Management documentation requirements identified in Section 4302.2 of the State Medicaid Manual (December 1991).

A unit of service is defined as each completed 15-minute increment that meets the description of a case management activity with or on behalf of the individual, his or her parent(s) or legal guardian.

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LIMITATIONS TO CARE AND SERVICES

19a. Targeted Case Management Services for Behavioral Health

Target Group:

Medicaid clients enrolled in the Colorado Medicaid Community Mental Health Services Program (a Section 1915(b) waiver program) who have or are being assessed for a mental health diagnosis(es) covered under the Colorado Medicaid Community Mental Health Services Program.

Areas of State in which Services will be Provided:

- ☒ Entire state
- ☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide)

Comparability of Services:

- ☒ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- ☐ Services are not comparable in amount, duration and scope.

Definition of Services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:
 - a. Taking client history;
 - b. Identifying the individual's needs and completing related documentation; and
 - c. Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the individual.
2. Development of a specific care plan that:
 - a. Is based on the information collected through the assessment;
 - b. Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

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19a. Targeted Case Management Services for Behavioral Health (Continued)

- c. Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - d. Identifies a course of action to respond to the assessed needs of the eligible individual.
- 3. Referral and related activities:
 - a. To help an eligible individual obtain needed services including activities that help link an individual with:
 - i. Medical, social, educational providers; or
 - ii. Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- 4. Monitoring and follow-up activities:
 - a. Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
 - i. Services are being furnished in accordance with the individual's care plan;
 - ii. Services in the care plan are adequate; and
 - iii. If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Monitoring shall be completed as necessary to ensure implementation of the care plan and to evaluate health and welfare. Follow up actions shall be performed when necessary to address health and safety concerns or services in the care plan. Case management may include contacts with non-eligible individuals that are directly related to identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs

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LIMITATIONS TO CARE AND SERVICES

19a. Targeted Case Management Services for Behavioral Health (Continued)

Qualifications of Providers:

Targeted Case Management may be provided by the following qualified providers:

- a. Advanced Practice Nurse (APN) pursuant to CRS 12-38-111.5.
- b. Licensed Clinical Social Worker (LCSW) pursuant to CRS 12-43-404.
- c. Licensed Professional Counselor (LPC) pursuant to CRS 12-43-603.
- d. Licensed Marriage and Family Therapist (LMFT) pursuant to CRS 12-43-504.
- e. Licensed Addiction Counselor (LAC) pursuant to CRS 12-43-804.
- f. Psychologist, Psy.D/Ph.D pursuant to CRS 12-43-301
- g. Physician/Psychiatrist pursuant to CRS 12-36-101.
- h. Physician assistant pursuant to CRS 12-36-106.

Targeted Case Management may be provided in a licensed Community Mental Health Center by practitioners working under the supervision of a qualified provider.

Freedom of Choice:

The State assures that:

1. The provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act;
2. Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this State Plan Amendment; and
3. Eligible individuals will have free choice of the providers of other medical care under the State Plan.

Freedom of Choice Exception:

- ☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

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LIMITATIONS TO CARE AND SERVICES

19a. Targeted Case Management Services for Behavioral Health (Continued)

Access to Services:

The State assures that:

1. Case management services will be provided in a manner consistent with the best interest of the eligible individual and will not be used to restrict an individual's access to other services under the State Plan;
2. Individuals will not be compelled to receive case management services;
3. The receipt of other Medicaid services will not be conditioned on the receipt of case management services;
4. The receipt of case management services will not be conditioned on the receipt of other Medicaid services; and
5. Providers of case management services do not exercise the Department's authority to authorize or deny the provision of other services under the State Plan.
6. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations:

Case management does not include the following:

1. Activities not consistent with the definition of case management services under Section 6052 of the Deficit Reduction Act;
2. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
3. Activities integral to the administration of foster care programs; or
4. Activities for which third parties are liable to pay.

Additional Limitations:

An individual who has been assessed and determined not to have a mental health

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LIMITATIONS TO CARE AND SERVICES

- 19a. Targeted Case Management Services for Behavioral Health (Continued)
diagnosis(es) covered under the Colorado Medicaid Community Mental Health Services Program is eligible for case management services under this State Plan Amendment for only ten business days after the date the determination was made.

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19.b. TARGETED CASE MANAGEMENT SERVICES: Transition Services

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Medicaid recipients age 18 and older, who are:

1. Eligible for services through a Home and Community Based Services (HCBS) Waiver, reside in a nursing home, Intermediate Care Facility for Individuals with Intellectual and developmental Disabilities (ICF-IDD), or Regional Center, and have expressed interest in moving to a home and community-based setting; or
2. Medicaid recipients receiving HCBS waiver services provided by State operated Regional Centers who want to transition to a private HCBS provider.

[X] Target group includes individuals who are transitioning or have recently transitioned to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutes for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Director's Letter (SMDL) July 25, 2000).

Areas of the State in which services will be provided (§1915(g)(1) of the Act):

[X] Entire State

[] Only in the following geographic areas:

Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1)):

[] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope (1915(g)(1)).

Definition of Services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Assessments are completed upon referral, when there is a change in the risk assessment plan, or when the client requests a revision.

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- Development (and periodic revision) of a service plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
 - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
- Monitoring and follow-up activities:
 - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - o Services are being furnished in accordance with the individual's care plan;
 - o Services in the care plan are adequate; and
 - o Changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring shall occur no less than weekly in the first three months post-transition and at least twice monthly the remainder of the transition period unless otherwise documented in the risk mitigation plan, including the reason why the frequency was changed.

Transition period means the period of time in which the member receives TCM-TS for the purpose of successful integration into community living. A transition period is completed when the member has successfully established community residence and is no longer in need of TCM-TS based on the risk mitigation plan

[X] Case management includes contacts with non-eligible individuals that are directly related to identifying the individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining

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services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Targeted Case Management: Transition Services may be provided by: a Transition Coordinator employed by a Transition Coordination Agency or Case Management Agency.

Providers must meet established program requirements and attend all required trainings. Transition Coordinators must have a Bachelor's degree in a human behavioral science or related field of study. An individual who does not meet the minimum educational requirement may qualify as a coordinator under the following conditions:

- Experience working with LTSS population, in a private or public social services agency may substitute for the required education on a year for year basis.
- When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.
- The Agency shall request a waiver/memo from the Department in the event that the Coordinator does not meet minimum educational requirements. A copy of this waiver/ memo stating Department approval will be kept in the Coordinator's personnel file that justifies the hiring of a Coordinator who does not meet the minimum educational requirements.

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specific geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§ 1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group includes eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services for those individuals.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt

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of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records in a data system provided by the Department that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included

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in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§ 1902(a)(25) and 1905(c))

Case management services do not include:

- Program activities of the agency itself that do not meet the definition of targeted case management.
- Administrative activities necessary for the operation of the agency providing case management services.
- Diagnostic, treatment, or instructional services, including academic testing.
- Services that are an integral part of another service already reimbursed by Medicaid.

Non-Duplication of Services:

To the extent any eligible recipients in the identified target population are receiving Targeted Case Management services from another provider agency as a result of being members of other covered target groups, the provider agency will ensure that case management activities are coordinated to avoid unnecessary duplication of service. The State assures that it will not seek Federal Financial Participation (FFP) for case management services that are duplicative.

To the extent that any of the services required by the client are a Title XIX benefit of a managed care organization of which the client is a member, the provider will ensure that timely referrals are made and that coordination of care occurs.

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this service.

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Unit Limitations:

Effective January 1, 2019, the total number of Targeted Case Management: Transition Services units per client is limited to 240 units per service year. A unit of service is defined as each completed 15-minute increment that meets the description of a Targeted Case Management: Transition Services activity. The service unit per client limit may be exceeded based on a determination of medical necessity by the State or exceeded with prior authorization.

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LIMITATIONS TO CARE AND SERVICES

20. Extended Services for Pregnant Women

Drug and alcohol abuse treatment services for pregnant women with substance use disorders who are assessed to be at risk of a poor birth outcome shall be covered when provided in accordance with 42 CFR 440.60 by a practitioner who is, at minimum, a licensed addiction counselor or certified addiction counselor, level II or higher.

Enhanced prenatal care services include care coordination, counseling, nutrition counseling, and home visits and may be provided to pregnant women who are assessed to be at risk of a poor birth outcome due to lifestyle behaviors and psychosocial circumstances such as tobacco use, unstable living environment, or young age.

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LIMITATIONS TO CARE AND SERVICES

Services

Limitations

21. Ambulatory Prenatal Care

Outpatient services only. Labor and delivery are not covered.

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LIMITATIONS TO CARE AND SERVICES

24a. TRANSPORTATION

- Non-emergent medical transportation shall be provided, with limitations, as an administrative service. See Attachment 3.1-D: Methods of Assuring Transportation.
- Emergency medical transportation shall be provided as a medical service.
 - Emergency medical transportation shall include land and air ambulance as certified by the health care provider to be appropriate for the particular circumstances.
 - Coverage of emergency medical transportation shall require a physician's statement of medical necessity or a trip report.
 - Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized without risk to the client's health.

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Targeted Case Management Services for the Nurse Home Visitor Program

Target Group: First-time pregnant women and their first baby up to the child's second birthday.

Areas of state in which services will be provided:

X Entire State

___ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope.

Definition of services: Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

- taking client history;
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

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Targeted Case Management Services for the Nurse Home Visitor Program

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with:
 - medical, social, educational providers; or
 - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:

Providers must meet established program training requirements, program protocols, program management information systems and program evaluation requirements on research-based model programs that have demonstrated significant reductions in: infant behavioral impairments, the number of reported incidents of child abuse and neglect, the number of subsequent pregnancies, receipt of public assistance, and criminal activity. The nurse home visitors must be licensed as professional nurses pursuant to Article 38 of Title 12, C.R.S., or accredited by another state or voluntary agency that the state board of nursing has identified by rule pursuant to Section 12-38-108(1)(a), C.R.S., as one whose accreditation may be accepted in lieu of board approval. The nurse supervisors are required to be nurses with Master's degrees in nursing or public health, unless the implementing entity can demonstrate that such a person is either unavailable within the community or an appropriately qualified nurse without a Master's degree is available.

Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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Targeted Case Management Services for the Nurse Home Visitor Program

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Access to Services:

The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Limitations:

Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
- Activities integral to the administration of foster care programs;
- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

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TARGETED CASE MANAGEMENT SERVICES FOR SUBSTANCE ABUSE TREATMENT

Target Group:

Targeted case management services will be provided to alcohol or other drug-dependent Medicaid clients who need assistance in obtaining necessary social, educational, vocational and other services.

Areas of state in which services will be provided:

- ☒ Entire State
- ☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

- ☒ Services are provided in accordance with section 1902(a) (10) (B) of the Act.
- ☐ Services are not comparable in amount duration and scope.

Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history;
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;

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TARGETED CASE MANAGEMENT SERVICES FOR SUBSTANCE ABUSE TREATMENT

- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
 - medical, social, educational providers or
 - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:

Targeted case management services for substance abuse treatment must be performed by qualified provider that is a licensed health practitioner with a certification in addiction counseling or a licensed clinician.

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TARGETED CASE MANAGEMENT SERVICES FOR SUBSTANCE ABUSE TREATMENT

1. Licensed health practitioners include:
 - a. Advanced Practice Nurse (APN) pursuant to CRS 12-38-111.5.
 - b. Physician/Psychiatrist pursuant to CRS 12-36-101.
 - c. Physician assistant pursuant to CRS 12-36-106.
2. Licensed clinicians include:
 - a. Licensed Clinical Social Worker (LCSW) pursuant to CRS 12-43-404.
 - b. Licensed Professional Counselor (LPC) pursuant to CRS 12-43-603.
 - c. Licensed Marriage and Family Therapist (LMFT) pursuant to CRS 12-43-504.
 - d. Licensed Addiction Counselor (LAC) pursuant to CRS 12-43-804.
 - e. Licensed Psychologist, Psy.D/Ph.D pursuant to CRS 12-43-301.

Services may be offered by practitioners working under the supervision of a qualified provider in facilities that have been licensed to provide substance use disorder treatment by the Office of Behavioral Health of the Department of Human Services.

Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Access to Services:

The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other

Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

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TARGETED CASE MANAGEMENT SERVICES FOR SUBSTANCE ABUSE TREATMENT

The State assures that individuals will receive comprehensive, case management services, on a one-to-one basis, through one case manager.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

The State assures that case management is only provided by and reimbursed to community case management providers.

The State assures that Federal Financial Participation is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

Case Records:

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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TARGETED CASE MANAGEMENT SERVICES FOR SUBSTANCE ABUSE TREATMENT

Limitations:

Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
- Activities integral to the administration of foster care programs;
- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

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PACE State Plan Amendment (Page 1 of 8)

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations.

B. X The State will include eligibility groups specified in 42 CFR 435.236.

The State is using spousal impoverishment eligibility rules for PACE participants found eligible under the 435.217 group.

C. The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

D. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)

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PACE State Plan Amendment (Page 2 of 8)

1. ☐ The following standard included under the State plan (check one):
- (a) ☐ SSI
 - (b) ☐ Medically Needy
 - (c) ☐ The special income level for the institutionalized
 - (d) ☐ Percent of the Federal Poverty Level: _____%
 - (e) ☐ Other (specify): _____

2. ☐ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

3. ☒ The following formula is used to determine the needs allowance:

For recipients who reside in assisted living, the Old Age Pension Standard should be used. For recipients not in assisted living, the allowance shall be 300% of the SSI/FBR.

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

- 1. ☐ SSI Standard
- 2. ☐ Optional State Supplement Standard
- 3. ☐ Medically Needy Income Standard
- 4. ☐ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
- 5. ☐ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- 6. ☐ The amount is determined using the following formula:
- 7. ☒ Not applicable (N/A)

(C.) Family (check one):

- 1. ☒ AFDC need standard
- 2. ☐ Medically needy income standard

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PACE State Plan Amendment (Page 3 of 8)

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard
that is not greater than the standards above: _____ %
of _____ standard.
5. _____ The amount is determined using the following formula:

6. _____ Other
7. _____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

STATE OF COLORADO

PACE State Plan Amendment (Page 4 of 8)

Regular Post Eligibility

2. N/A 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

- (a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1. ___ The following standard included under the State plan (check one):
 - (a) ___ SSI
 - (b) ___ Medically Needy
 - (c) ___ The special income level for the institutionalized
 - (d) ___ Percent of the Federal Poverty Level: _____%
 - (e) ___ Other (specify): _____
2. ___ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
3. The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

- (B.) Spouse only (check one):
1. _____ The following standard under 42 CFR 435.121:

2. _____ The Medically needy income standard

3. _____ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not
greater than the standards above: _____ % of _____
standard.

TN: 13-043

Approval Date 1/21/14

Supersedes TN: 07-013

Effective Date 10-1-2013

STATE OF COLORADO

PACE State Plan Amendment (Page 5 of 8)

5. _____ The amount is determined using the following formula:

6. _____ Not applicable (N/A)

(C.) Family (check one):

1. _____ AFDC need standard

2. _____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. _____ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

5. _____ The amount is determined using the following formula:

6. _____ Other

7. _____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

TN: _____ 13-043

Approval Date 1/21/14

Supersedes TN: 07-013

Effective Date 10-1-2013

STATE OF COLORADO

PACE State Plan Amendment (Page 6 of 8)

1. Individual (check one)

(A). ___ The following standard included under the State plan (check one):

1. ___ SSI
2. ___ Medically Needy
3. ___ The special income level for the institutionalized
4. ___ Percent of the Federal Poverty Level: ___%
5. ___ Other (specify): _____

(B). ___ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.

(C) X The following formula is used to determine the needs allowance:

For recipients who reside in assisted living, the Old Age Pension Standard should be used. For recipients not in assisted living, the allowance shall be 300% of the SSI/FBR.

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

II. Rates and Payments

A. X The State assures that the capitated rates will be less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. ___ Rates are set at a percent of fee-for-service costs

TN: ___ 13-043

Approval Date 1/21/14

Supersedes TN: 07-013

Effective Date 10-1-2013

STATE OF COLORADO

PACE State Plan Amendment (Page 7 of 8)

- 2. ____ Experience-based (contractors/State's cost experience or encounter data)
(please describe)
- 3. ____ Adjusted Community Rate (please describe)
- 4. X Other (please describe)

The State uses three steps to determine PACE rates: (1) calculate the maximum per-member-per-month amount based on what it would cost to serve PACE clients through fee-for-service, (2) negotiate below the upper payment limit (UPL); and (3) adjust rates to allow for patient payment. The steps are described below.

Calculating the Maximum Allowable Per-Member-Per-Month Rate

The State calculates capitation rates annually for PACE based on historical fee-for-service expenses for an actuarially equivalent population of Medicaid clients who are 55 years of age and older, who require a nursing facility level of care. The State includes in this analysis only those clients who are eligible for full Medicaid benefits.

The State compiles the base data by selecting fee-for-service claims for these clients who meet the above criteria during the two most recent fiscal years of data available. The State uses all claims for all state plan service categories, because PACE rates are designed to cover all state plan services.

Only Fee-for-Service claims that were actually paid are included in the analysis to create a historical per-member-per-month rate. The State also removes from the analysis any payments made by pharmacy rebates or third party insurance, and takes into account any other payment adjustments that were made during the two fiscal years under consideration.

Using this historical rate, the State forecasts costs to create a prospective rate. The State takes into consideration both trends (consistent increases or decreases in certain service categories) and any upcoming policy changes that might change utilization and costs. The result of this analysis is a proposed maximum per-member-per-month rate. This amount is also considered the UPL.

Negotiating Below the UPL

To ensure that the State pays under the UPL per the CMS checklist, the State negotiates a rate below the UPL with the PACE providers. This is the rate used to pay PACE organizations.

STATE OF COLORADO

PACE State Plan Amendment (Page 8 of 8)

Adjusting for Patient Payment

The total PACE rate is the combination of fee-for-service claims experience paid by the State plus fee-for-service patient contributions as calculated through the Post Eligibility Treatment of Income (PETI) process. Actual final payment to the PACE provider is that rate less each PACE enrollee's payment contribution. The State makes interim estimated payments based upon expected average patient contribution but reconciles these estimated amounts based upon actual reported contributions on an annual basis, as data becomes available.

- B. X The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. At the Department's request, the most recent PACE rates were certified. The Department will furnish contact information for its actuaries upon request.
- C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between Colorado Benefits Management System (CBMS) and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system.

State/Territory: COLORADO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

The following ambulatory services are provided.

*Description provided on attachment.

TN No. 87-5

Supersedes

TN No. 81-34

Approval Date 3/19/87

Effective Date 10/1/86

HCFA ID: 0140P/0102A

ion: HCFA-PM-91- (BPD)
1991

ATTACHMENT 3.1-B
Page 2
OMB No. 0938-

State/Territory: COLORADO NONE

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☐ Provided: ☐ No limitations ☐ With limitations*

2a. Outpatient hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

☐ Provided: ☐ No limitations ☐ With limitations*

Other laboratory and X-ray services.

☐ Provided: ☐ No limitations ☐ With limitations*

4a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

c. Family planning services and supplies for individuals of childbearing age.

☐ Provided: ☐ No limitations ☐ With limitations*

* Description provided on attachment.

TN No. 92-3

Approval Date 6/16/92

Effective Date 10/1/91

Supersedes

TN No. 90-08

HCFA ID: 7986E

Revision: HCFA-PM-93-5 (MB)
MAY 1993

ATTACHMENT 3.1-B
Page 2a
OMB NO:

State/Territory: Colorado

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY
GROUP(s): _____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ☐ No limitations ☐ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ☐ No limitations ☐ With limitations:

*Description provided on attachment.

TN No. 00-009
Supersedes 93-002 Approval Date 09/13/00 Effective Date 04/01/00
TN No. 93-002

State/Territory: COLORADO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

☐ Provided: ☐ No limitations ☐ With limitations*

b. Optometrists' Services

☐ Provided: ☐ No limitations ☐ With limitations*

c. Chiropractors' Services

☐ Provided: ☐ No limitations ☐ With limitations*

d. Other Practitioners' Services

☐ Provided: ☐ No limitations ☐ With limitations*

7. Home Health Services

- a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☐ Provided: ☐ No limitations ☐ With limitations*

- b. Home health aide services provided by a home health agency.

☐ Provided: ☐ No limitations ☐ With limitations*

- c. Medical supplies, equipment, and appliances suitable for use in the home.

☐ Provided: ☐ No limitations ☐ With limitations*

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☐ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.

TN No. 87-5
Supersedes
TN No. 81-34

Approval Date 3/19/87

Effective Date 10/1/86

HCFA ID: 0140P/0102A

State/Territory: COLORADO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

8. Private duty nursing services.

☒ Provided: ☒ No limitations ☒ With limitations*

9. Clinic services.

☒ Provided: ☒ No limitations ☒ With limitations*

10. Dental services.

☒ Provided: ☒ No limitations ☒ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☒ No limitations ☒ With limitations*

b. Occupational therapy.

☒ Provided: ☒ No limitations ☒ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

☒ Provided: ☒ No limitations ☒ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☒ No limitations ☒ With limitations*

b. Dentures.

☒ Provided: ☒ No limitations ☒ With limitations*

*Description provided on attachment.

TE No. 87-5

Supersedes

TE No. 81-34

Approval Date 3/19/87

Effective Date 10/1/86

HCFA ID: G14OP/0102A

State/Territory: COLORADO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

c. Prosthetic devices.

☒ Provided: ☒ No limitations ☒ With limitations*

d. Eyeglasses.

☒ Provided: ☒ No limitations ☒ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☒ Provided: ☒ No limitations ☒ With limitations*

b. Screening services.

☒ Provided: ☒ No limitations ☒ With limitations*

c. Preventive services.

☒ Provided: ☒ No limitations ☒ With limitations*

d. Rehabilitative services.

☒ Provided: ☒ No limitations ☒ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☒ With limitations*

b. Skilled nursing facility services.

☒ Provided: ☒ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 87-5

Supersedes

TN No. 81-34

Approval Date 3/19/87

Effective Date 10/1/86

HCFA ID: 014GP/0102A

State/Territory: COLORADO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

c. Intermediate care facility services.

☐ Provided: ☐ No limitations ☐ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

☐ Provided: ☐ No limitations ☐ With limitations*

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☐ Provided: ☐ No limitations ☐ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☐ Provided: ☐ No limitations ☐ With limitations*

17. Nurse-midwife services.

☐ Provided: ☐ No limitations ☐ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.

TN No. 875
Supersedes
TN No. 81-34

Approval Date 3/19/87

Effective Date 10/1/86

HCFA ID: 0140P/0102A

State/Territory: COLORADO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

☐ Provided: ☐ With limitations*

☐ Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

☐ Provided: ☐ With limitations*

☐ Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

☐ Provided: ☐ Additional coverage**

- b. Services for any other medical conditions that may complicate pregnancy.

☐ Provided: ☐ Additional coverage** ☐ Not provided.

21. Certified pediatric or family nurse practitioners' services.

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

* Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

** Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 00-016

Supersedes

TN No. 94-022

Approval Date 03/06/01

Effective Date 10/01/00

State/Territory: _____

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.)

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

- b. Transportation.

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

- b. Services provided in Religious Nonmedical Health Care Institutions.

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

- c. Reserved

- d. Nursing facility services for patients under 21 years of age.

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

- e. Emergency hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

* Description provided on attachment

TN No. 01-009

Supersedes

TN No. 87-13

Approval Date 10/25/01 Effective Date 09/01/01

State/Territory: COLORADO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NONE

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☐ Provided ☐ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☐ Provided: ☐ State Approved (Not Physician) Service Plan Allowed
☐ Services Outside the Home Also Allowed
☐ Limitations Described on Attachment
☐ Not provided.

TN No. 00-013
Supersedes 93-002 Approval Date 08/11/00 Effective Date 04/01/00
TN No. 93-002

Enclosure 6

Attachment 3.1-B

**State of Colorado
PACE State Plan Amendment Pre-Print**

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically
Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in
Supplement 3 to Attachment 3.1-A.

☒ Election of PACE: By virtue of this submittal, the State elects PACE as an
optional State Plan service.

☐ No election of PACE: By virtue of this submittal, the State elects to not add
PACE as an optional State Plan service.

7-20
OFFICIAL

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Attachment 3.1-C

State of Colorado

METHODS AND STANDARDS OF ASSURING HIGH QUALITY CARE

1. The following is a description of the methods that will be used to assure that the medical and remedial care and services are of high quality, and a description of the standards established by the State to assure high quality care:
 - a. Practitioners will be licensed or otherwise authorized to practice under State law. This means persons who are authorized to practice medicine as licensed physicians, or physicians in approved training programs supervised by licensed physicians;
 - b. Medical institutions will be licensed by the State;
 - c. Independent clinical laboratories will be certified according to Medicare Standards;
 - d. Patients can obtain needed medical services from the facility or practitioner which in the judgment of competent medical authority is best able to meet their medical needs whether the facility or practitioner is in or outside the state;
 - e. The scope of care and services offered includes the use of specialist and consultative services;
 - f. The medical unit will continuously review and evaluate the utilization of the quality of medical care and services;
 - g. The Medical Care Advisory Committee at frequent intervals will review reports of care and services provided and make indicated suggestions to the Department and to the disciplines involved concerning the quality and utilization of the care and services offered or needed.
 - h. X-ray units will be certified according to Medicare standards.

91-20
1/15/82
eff. 10/1/81

RECEIVED
DEC 18 1 40 PM '81
ADJ. CLERK

1915(i) HCBS State Plan Services

Administration and Operation

This Section has been deleted effective February 12, 2019.

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

STATE OF COLORADO

Attachment 3.1-D

Page 1

METHODS OF ASSURING TRANSPORTATION

The Colorado Medical Assistance Program provides non-emergent medical transportation (NEMT) as an administrative service and administrative expense.

The state-designated entity shall assure that necessary NEMT services covered by the Colorado Medical Assistance Program for eligible clients who do not have access to other means of transportation including free transportation, and, require transportation to obtain a non-emergency Medicaid service. The state-designated entity can be either county departments of human/social services or a designated broker. Payment will be made for the least expensive transportation suitable to the client's condition. The distance to be traveled, transportation methods available, treatment facilities available, and the physical condition and welfare of the client shall all determine the type of NEMT authorized. The type of transportation available may vary by region because of rural and urban conditions.

Reimbursable NEMT methods shall include personal vehicle, ambulance, taxi, mobility vehicle, wheelchair van, bus, train, air, and other forms of public and private conveyance. Reimbursement for non-brokered NEMT shall be the lower of submitted charges or fee schedule rate as determined by the Department of Health Care Policy and Financing. Brokered NEMT, which is used only in non-emergency circumstances, shall be reimbursed through negotiated contracts based on fee-for-service rates and expenditures.

Covered places of service may include transportation of clients to or from Medicaid-enrolled providers to receive Colorado Medicaid covered services. When necessary, transportation may include urgent care facilities, hospital to hospital transportation, and out-of-state transportation. Covered ancillary services may include escorts, meals, and lodging.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates can be found on the official Web site of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf.

Clients are made aware of NEMT services through the following methods:

- Informational packet mailed to all newly enrolled Medicaid clients
- EPSDT outreach coordinators (for children and families)
- Official Web site of the Department of Health Care Policy and Financing
- Enrollment broker
- Customer Service Contact Center
- County departments of human/social services
- Transportation broker via outreach to Medicaid providers in the service area

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

STATE OF COLORADO

Attachment 3.1-D

Page 2

Non-covered services include: services provided solely for convenience of the client; charges incurred while client is not in the vehicle; , transportation to or from non-covered medical services, waiting time, cancellations, transportation which is covered by another entity, charges for additional passengers except when acting as an escort for a child or at-risk adult, or, the siblings or children of the client receiving medical services; charges for the cost of transporting siblings who are not receiving a medical service; and transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program unless the facility does not have an available vehicle.

Clients residing in counties covered by the NEMT broker may contact the broker by calling a toll-free telephone number.

The Department of Health Care Policy and Financing contracts with a competitively procured transportation broker for the provision of non-emergent medical transportation services for eligible clients residing in select Colorado counties. Compensation for the brokered services is negotiated based on an analysis of non-brokered fee-for-service transportation reimbursement rates and expenditures.

Some NEMT services require prior authorization. Transportation to out-of-state locations shall require prior authorization and shall be covered when it has been determined, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are not able to be provided by a provider/facility within the state, or when it is the general practice for clients in a particular locality to use medical resources in another state.

Services ancillary to NEMT shall include meals and lodging and are only covered if the trip cannot be completed in one calendar day. The maximum per diem reimbursement rates for meals and lodging and NEMT prior authorization requirements can be found on the official Web site of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf. NEMT, meals, and lodging for one escort attending an at-risk adult or child may be provided.

Transportation to a service that is not a Medicaid benefit is not covered.

Revision: HCFA-PM-87-4
MARCH 1987

ATTACHMENT 3.1-E
Page 1
OMB No. 0938-0193

State/Territory COLORADO

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The following standards and limitations apply to organ transplant services:

I. Prior Authorization

- A. All cases presented for organ transplantation (with the exception of corneal or kidney) require prior authorization.
- B. Each case receives individualized review and is evaluated for medical suitability.
 - 1. The medical necessity for the treatment.
 - (a) Diagnostic confirmation by clinical laboratory studies of the underlying pathological process.
 - (b) Clinical and physiological verification of endstage failure that is unresponsive to applied treatment regimens.
 - (c) Organ transplantation is the best available definitive treatment for the underlying pathological process and endstage functional failure.
 - 2. Consideration will be given to long range prognosis.
 - (a) No coexisting conditions that could contraindicate undertaking organ transplantation.
 - (b) Conduct of the procedures at a medical center of expertise providing high quality care through all necessary support systems and trained, experienced manpower.
 - 3. Medicaid patients may receive treatment only in approved Medicare facilities. If this is not medically feasible the State will consider approval of treatment in non-Medicare approved facilities, if such treatment is recommended by the Department's Peer Review Organization, or medical consultant.

II. Evaluation and treatment at a Transplant Center

All cases undergo evaluation, study, and staging at a medical center specializing in transplantation.

TN No. 92-19
Supersedes
TN No. 74-09

Approval Date 8/18/94 Effective Date 3/1/92

CMS-PM-10120
Date: XXX, 2014

ATTACHMENT 3.1-F
Section 1 (ACC) Page 1
OMB No.:0938-0933

State: COLORADO

Citation	Condition or Requirement
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This section has been deleted effective July 1, 2018.

TN No. 18-0031

Approval Date October 4, 2018

Supersedes TN No. 16-0015

Effective Date July 1, 2018

CMS-PM-XX-X

Date:

ATTACHMENT 3.1-F
Section 2 (PCPP), Page 1
OMB No.:0938-0933

State: COLORADO

Citation

Condition or Requirement

SECTION 2: PRIMARY CARE PHYSICIAN PROGRAM (PCPP)

This Section has been deleted effective August 1, 2014.

TN No. 14-032

Approval Date 9/16/14

Supersedes TN No. 13-003

Effective Date August 1, 2014

CMS-PM-XX-X

Date:

ATTACHMENT 3.1-F ACC Payment Reform Program

Page 1

OMB No.:0938-0933

State: COLORADO

Citation

Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

This Section has been deleted effective July 1, 2018.

TN No. 18-0031

Approval Date October 4, 2018

Supersedes TN No. 14-002

Effective Date July 1, 2018

CMS-PM-10120
Date: January, 2017
OMB No.:0938-0933
State: COLORADO

ATTACHMENT 3.1-F
Section 4, Page 1

Citation

Condition or Requirement

SECTION 4: THE MEDICARE-MEDICAID PROGRAM (MMP)

This Section has been deleted effective December 31, 2017.

TN No. 17-0047
Supersedes TN No. 17-0001

Approval Date: February 1, 2018
Effective Date: December 31, 2017

CMS-PM-10120
Date: _____
OMB No.:0938-0933
State: Colorado

ATTACHMENT 3.1-F ACC: Access Kaiser
Section 5 ACC: Access Kaiser Program, Page **1** of **1**

Citation	Condition or Requirement
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SECTION 5: ACC: ACCESS KAISER PROGRAM

This Section has been deleted effective December 31, 2017.

TN No. 17-0046
Supersedes
TN No. 15-0038

Approval Date January 30, 2018

Effective Date December 31, 2017

Revision: HCFA-PM-93-5 (MB)
May 1993
State: Colorado

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

1902(a)(10)(E)(i) and
1905(p)(i) of the Act

- (1) Medicare Part A and Part B
(i) Qualified Medicare Beneficiaries
(QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.2.5 of Attachment 2.2 -A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for
___ Part A ___ X Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

TN. No. 02-006

Supersedes

TN. No. 00-009

Approval Date

04/04/02

Effective Date

01/01/02

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: COLORADO

Citation

1902(a)(10)(E)(ii)
and 1905(a) of the Act

- (ii) Qualified Disabled and Working
Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii)
and 1905(p)(3)(A)(ii)
of the Act

- (iii) Specified Low-Income Medicare
Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I),
1905(p)(3)(A)(ii), and
1933 of the Act

- (iv) Qualifying Individual-1
(QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II),
1905(p)(3)(A)(ii), and
1933 of the Act

- (v) Qualifying Individual-2
(QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

TN No. 98-005

Supersedes

TN No. 93-008

Approval Date 04/29/98

Effective Date 1/1/98

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: COLORADO

Citation

1843(b) and 1905(a)
of the Act and
42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) withing a group listed at 42 CFR 431.625(d)(2).

— Individuals receiving title II or Railroad Retirement benefits.

— Medically needy individuals (FFP is not available for this group).

1902(a)(30) and
1905(a) of the Act

(2) Other Health Insurance

X The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

TN No. 98-005

Supersedes

TN No. 93-008

Approval Date

04/29/98

Effective Date

1/1/98

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: COLORADO

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n),
1905(a), and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B
describes the methods and standards for
establishing payment rates for services
covered under Medicare, and/or the
methodology for payment of Medicare,
deductible and coinsurance amounts, to the
extent available for each of the following
groups.

Sections 1902
(a)(10)(E)(i) and
1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries
(QMBs)

The Medicaid agency pays Medicare
Part A and Part B deductible and
coinsurance amounts for QMBs
(subject to any nominal Medicaid
copayment) for all services
available under Medicare.

1902(a)(10), 1902(a)(30),
and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for
Medicaid services also covered under
Medicare and furnished to recipients
entitled to Medicare (subject to any
nominal Medicaid copayment). For
services furnished to individuals
who are described in section
3.2(a)(1)(iv), payment is made as
follows:

42 CFR 431.625

___ For the entire range of
services available under
Medicare Part B.

X Only for the amount, duration,
and scope of services otherwise
available under this plan.

1902(a)(10), 1902(a)(30),
1905(a), and 1905(p)
of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare
Part A and Part B deductible and
coinsurance amounts for all services
available under Medicare and pays
for all Medicaid services furnished
to individuals eligible both as QMBs
and categorically or medically needy
(subject to any nominal Medicaid
copayment).

TN No. 00-012

Supersedes

TN No. 93-011

Approval Date

06/23/00

Effective Date

04/01/00

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

STATE OF COLORADO

29d

Citation		Condition or Requirement
1906 of the Act	(c)	<p><u>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></p> <p>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.</p> <p>When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).</p>
1906A of the Act	(c)-1	<p>(X) <u>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></p> <p>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan, as specified in the qualified employer-sponsored coverage, without regard to limitations specified in section 1916 or section 1916A of the Act, for eligible individuals under age 19 who have access to and elect to enroll in such coverage. The eligible individual is entitled to services covered by the State plan which are not included in the employer-sponsored coverage. For qualified employer-sponsored coverage, the employer must contribute at least 40 percent of the premium cost.</p> <p>When coverage for eligible family members under age 19 is not possible unless an ineligible parent enrolls, the Medicaid agency pays premiums for enrollment of the ineligible parent, and, at the parent's option, other ineligible family members. The agency also pays deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan for the ineligible parent.</p>
1902(a)(10)(i) of the Act	(d)	<p>(X) The Medicaid agency pays premiums for individuals described in item 19 of page 23a of Attachment 2.2-A</p>

Revision: HCFA-AT-80-38 (RPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in
Institutions for Mental Diseases

Medicaid is provided for individuals 65 years
of age or older who are patients in
institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441,
Subpart C, and 42 CFR 431.620(c) and (d)
are met.

☐ Not applicable. Medicaid is not provided
to aged individuals in such institutions
under this plan.

TN # 77-4
Supersedes
TN # _____

Approval Date 1/28/77 Effective Date 4/1/77

Revision: ECFA-AT-80-38 (BPP)
May 22, 1980

State of Colorado

Citation
42 CFR 441.252
AT-78-99

3.4 Special Requirements Applicable to
Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F
are met.

TN # 79-17
Supersedes
TN # _____

Approval Date 6/29/79 Effective Date 7/1/79

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State: Colorado

Citation
1902(a)(52)
and 1925 of
the Act

3.5 Families Receiving Extended Medicaid Benefits

- (a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).
- (b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

- ☒ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).
- ☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:
- ☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- ☐ Medical or remedial care provided by licensed practitioners.
- ☐ Home health services.

TN No. 92-1

Supersedes

Approval Date

4/9/92

Effective Date

10/1/91

90-11

HCFA ID: 7982EII

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State: ColoradoCitation

3.5

Families Receiving Extended Medicaid Benefits
(Continued)

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services.
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- ☐ Intermediate care facility services for the mentally retarded.
- ☐ Inpatient psychiatric services for individuals under age 21.
- ☐ Hospice services.
- ☐ Respiratory care services.
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

TN No. 92-1~~Supersedes~~

Approval Date

4/9/92

Effective Date

10/1/91J. 90-11

HCFA ID: 7982EII

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State: Colorado

Citation

3.5 Families Receiving Extended Medicaid Benefits
(Continued)

- (c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--
- ☐ 1st 6 months ☐ 2nd 6 months
- ☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.
- ☐ 1st 6 mos. ☐ 2nd 6 mos.
- (d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:
- ☐ Enrollment in the family option of an employer's health plan.
- ☐ Enrollment in the family option of a State employee health plan.
- ☐ Enrollment in the State health plan for the uninsured.
- ☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

TN No. 92-1

Supersedes

Approval Date

4/9/92

Effective Date

10/1/91

90-11

HCFA ID: 7982EII

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State: Colorado

Citation

3.5 Families Receiving Extended Medicaid Benefits
(Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

☐ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

TN No. 92-1

~~sedes~~

90-11

Approval Date

4/9/92

Effective Date 10/1/91

HCFA ID: 7982E11

3.6 Unemployed Parent

For purposes of determining whether a child is deprived on the basis of the unemployment of a parent, the agency--

— uses the standard for measuring unemployment which was in the AFDC State plan in effect on July 16, 1996.

X uses the following more liberal standard to measure unemployment:

- A person is ¹⁹³¹considered unemployed if the income after deductions is less than the eligibility standard. Two parent families are treated the same as one parent families.

TRANSMITTAL NO. 97-010
Date Approved 04/12/99
Effective Date 08/07/98
Supersedes Transmittal NEW

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: COLORADO

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation

42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

No. 87-12

Armedes

No. _____

Approval Date 8/21/87

Effective Date 4/1/87

HCFA ID: 1010P/0012P

Revision: HCPA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation

42 CFR 431.202

AT-79-29

AT-80-34

4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

TN # 74-20

Supersedes

TN # _____

Approval Date 4/7/75 Effective Date 8/1/74

Revision: HCFA-AT-87-9 (BERC)
AUGUST 1987

OMB No.: 0938-0193

State/Territory:

Colorado

Citation
42 CFR 431.301
AT-79-29

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

TN No. 88-01
Supersedes
TN No. 74-20

Approval Date 3/1/89

Effective Date 10/1/87

HCFA ID: 1000P/0012P

DEC 31 1987

Revision:

State/Territory: ColoradoCitation

42 CFR 431 Subparts P & Q
 50 FR 21839
 75 FR 48847
 1903(u) of
 the Act,
 P.L. 99-509
 (Section 9407)
 P.L. 107-300
 P.L. 111-3

4.4 Medicaid Eligibility Quality Control (MEQC)

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

☐ Yes

☒ Not Applicable. The State operates an Approved MEQC Pilot

(b) In accordance with 431.806(c), the State operates a Medicaid quality control claims processing assessment system that meets the requirements of 431.830 – 431.836.

☐ Yes.

☒ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

(c) In accordance with 431.806(b), Payment Error Rate Measurement (PERM) is implemented in accordance with 42 CFR Part 431, Subpart Q, in substitution to meet the statutory and regulatory ("traditional") Medicaid Eligibility Quality Control (MEQC) review during the State's PERM cycle year.

☐ Yes.

☐ Effective for FFY ____

☐ Effective for FFY ____

☐ Effective for FFY ____

☒ Not applicable.

TN No. 13-008

Supersedes
 TN No. 87-12

Approval Date 9/27/13

Effective Date July 1, 2013

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Colorado

Citation
42 CFR 455.12
AT-78-90
48 FR 3742
52 FR 48817

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

TN No. 89-06
Supersedes
TN No. 83-18

Approval Date 3/1/89

Effective Date 10/1/88

HCFA ID: 1010P/0012P

Revision:

State Colorado

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

<p><u>Citation</u></p> <p>Section 1902(a)(42)(B)(i) of the Social Security Act</p> <p>Section 1902(a)(42)(B)(ii)(I) of the Act</p>	<p><u> X </u> The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.</p> <p><u> </u> The State is seeking an exception to establishing such program for the following reasons:</p> <p><u> X </u> The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.</p> <p>Place a check mark to provide assurance of the following:</p> <p><u> X </u> The State will make payments to the RAC(s) only from amounts recovered.</p> <p>As approved under TN CO-15-0008, the State includes the following exceptions:</p> <ul style="list-style-type: none">• an exception to the requirement that the RAC must hire a minimum of 1.0 FTE medical director in good standing with the State licensing authorities. The State shall require the RAC to hire a .10 FTE medical director who is a physician licensed in good standing in any state in the U.S.• an exception to the current three year claims look back period. The State shall direct the RAC to examine claims for up to seven years from the paid date of the claim.• an exception to the underpayment identification requirement. State law does not authorize a contingency payment for recovery of underpayments nor does it authorize a non-contingent payment methodology. The State shall allow the RAC to identify underpayments but will not pay the RAC for doing so. Providers will need to submit a claim for previously underpaid services directly to the Department within the applicable limits for timely submission of claims in order to recoup identified underpayments.
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No. 16-0003

Supersedes No. 15-0008

Approval Date: 9/1/2016

Effective Date: 6/28/2016

<p>Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act</p>	<ul style="list-style-type: none"> an exception to the requirement that the contingency fee for overpayments may not exceed that of the highest Medicare RAC, as specified by CMS in the Federal Register. The State shall increase the maximum rate to 18 percent (18%), which is the current maximum percentage allowable under State law. <p><u> X </u> The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.</p> <p>The following payment methodology shall be used to determine State payments to Medicaid RACs for recovered overpayments (e.g., the percentage of the contingency fee):</p> <p>The State shall pay the RAC a contingency fee of up to a maximum of 18 percent (18%) for overpayments to conform with the maximum allowable under State law, and as approved under TN CO 15-0008, which formed the basis for Colorado’s competitive procurement process for the contract.</p> <p><u> </u> The State attests that if the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register, the State will only submit for FFP up to the amount equivalent to that published rate.</p>
<p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p>	<p><u> X </u> The following payment methodology shall be used to determine State payments to Medicaid RACs for underpayments:</p> <p>The State shall allow the RAC to identify underpayments but will not pay the RAC for doing so. State law does not authorize a contingency payment for recovery of underpayments nor does it authorize a non-contingent payment methodology. Providers will need to submit a claim for previously underpaid services directly to the Department within the applicable limits for timely submission of claims in order to recoup identified underpayments.</p> <p><u> </u> The State will submit a justification seeking to pay the Medicaid RAC(s) a contingency fee higher than the highest contingency fee rate paid to Medicare RACs as published in the Federal Register.</p>
<p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p>	<p><u> X </u> The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p>

No. 16-0003
Supersedes No. 15-0008

Approval Date: 9/1/2016
Effective Date: 6/28/2016

Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	<u> X </u> The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act	<u> X </u> The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act	<u> X </u> Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

No. 16-0003
Supersedes No. 15-0008

Approval Date: 9/1/2016
Effective Date: 6/28/2016

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: Colorado

Citation
Section 1902(a)(64) of
the Social Security Act
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation
Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN No. 00-015
Supersedes Approval Date 9/29/00 Effective Date 07/01/00
TN No. ~~89-6~~ NEW

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

TN # 78-15
Supersedes
TN # _____

Approval Date 7/17/78

Effective Date 7/1/78

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TN # 78-15
Supersedes
TN # _____

Approval Date 7/17/78 Effective Date 7/1/78

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State of Colorado

Citation
42 CFR 431.18 (b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN # 74-20
Supersedes
TN # _____

Approval Date 1/7/75

Effective Date 8/1/74

Revision: HCFA-AT-80-38 (RFP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal
Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN # 74-20
Supersedes _____
TN # _____

Approval Date 1/7/75

Effective Date 8/1/74

New: HCFA-PM-99-3
JUNE 1999

State: Colorado

Citation

42 CFR 431.51
AT 78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23)
Of the Social
Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

Section 1932(a)(1)
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or a managed care organization, prepaid inpatient health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

TN # 03-031
Supersedes TN # 00-015

Effective Date 07/01/03
Approval Date 12/14/03

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

- (a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the Colorado State Department of Health Care Policy and Financing
- (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): the Colorado State Department of Health Care Policy and Financing
- (c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Centers for Medicare and Medicaid Services on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State <u>Citation</u> 42 CFR 431.610 AT-78-90 AT-80-34	of Colorado 4.11(d) <u>The Colorado State Department of Public Health and Environment</u> (agency) which is the State agency responsible for licensing health institutions through contract with the Medicaid agency that provides the requirements necessary for participation. If institutions and agencies meet the requirements and are approved by the Medicaid agency, the provider may participate in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Attachment 4.11-A

State of Colorado

STANDARDS FOR INSTITUTIONS

<u>TN#</u>	<u>20-0002</u>
<u>Effective Date</u>	<u>1-1-20</u>
<u>Superseded TN#</u>	<u>74-92</u>
<u>Approval Date</u>	<u>4/2/2020</u>

The Following Items are placed in State Plan Book No. II

1. Standards for Hospitals and Health Facilities
2. Chapter I - Definitions
3. Chapter II - Licensure
4. Chapter III - General Building and Fire Safety
5. Chapter IV - General Hospitals
6. Chapter V - Nursing Care Facility
7. Chapter VI - Intermediate Health Care Facility
8. Chapter VII - Residential Care Facility
9. Chapter VIII - Intermediate Care Facility for Individuals with Intellectual Disabilities
10. Chapter IX - Community Clinic and Emergency Center
11. Chapter XI - Convalescent Centers
12. Chapter XIV - Maternity Hospitals

TN#	20-0002
Effective Date	1-1-20
Superseded TN#	74-92
Approval Date	4/2/2020

Revision: HFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado _____

Citation

42 CFR 431.105 (b)
AT-78-90

4.12 Consultation to Medical Facilities

- (a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105 (b).
- (b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

☒ Yes, as listed below:

Rocky Mountain Health Maintenance
Organization
Rocky Mountain Planned Parenthood

☐ Not applicable. Similar services are not provided to other types of medical facilities.

TN # 75-14
Supersedes
TN # _____

Approval Date 2/12/76 Effective Date 7/1/75

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- 42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
- 42 CFR Part 483 (b) For providers of NF services, the requirements of 42 CFR Part 483, 1919 of the Act Subpart B, and section 1919 of the Act are also met.
- 42 CFR Part 483, (c) For providers of ICF/IID services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
- 1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b) (2) and (c) are met.



Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

State/Territory: Colorado

Citation

1902 (a)(58)

1902(w)

4.13 (e)

For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, and prepaid inpatient health plans, are required to do the following:
 - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
 - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
 - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
 - (e) Ensure compliance with requirements of State Law (whether

TN # 03-025
Supersedes TN # 92-5

Effective Date 07/01/03
Approval Date 12/16/03

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

State/Territory: Colorado

statutory or recognized by the
courts) concerning advance
directives; and

- (f) Provide (individually or with
others) for education for staff
and the community on issues
concerning advance directives.

- (2) Providers will furnish the written
information described in paragraph
(1)(a) to all adult individuals at
the time specified below:

- (a) Hospitals at the time an
individual is admitted as an
inpatient.
- (b) Nursing facilities when the
individual is admitted as a
resident.
- (c) Providers of home health care or
personal care services before the
individual comes under the care of
the provider;
- (d) Hospice program at the time of
initial receipt of hospice care by
the individual from the program;
and
- (e) Managed care organizations and prepaid
inpatient health plans at the time of enrollment
of the individual with the organization.

- (3) Attachment 4.34A describes law of the
State (whether statutory or as
Recognized by the courts of the
State) concerning advance directives.

Not applicable. No State law
Or court decision exist regarding
advance directives.

TN # 03-025
Supersedes TN # 92-5

Effective Date 07/01/03
Approval Date 12/16/03

State/Territory: ColoradoCitation 4.14 Utilization/Quality Control

42 CFR 431.630
42 CFR 456.2
50 FR 15312
1902(a)(30) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

 Directly X By undertaking medical and utilization review requirements through a contract with a utilization and Quality Improvement Organization (QIO) or QIO-Like Entity designated under 42 CFR Part 475 and 1903(a)(3)(C) of the Act. The contract with the QIO-

- (1) Meets the requirements of §434.6(a);
- (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
- (3) Identifies the services and providers subject to QIO review;
- (4) Ensures that QIO review activities are not inconsistent with the QIO review of Medicare services; and
- (5) Includes a description of the extent to which QIO determinations are considered conclusive for payment purposes.

 X Quality review requirements described in section 1902(a)(30) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the QIO designated under 42 CFR Part 475.

1902(a)(30)
and 1902(d) of the
Act, P.L. 99-509
(section 9431)

 By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

Revision: HCFA-PH-85-3 (BERC)
MAY 1985

State: _____

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

- 4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

☒ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

☐ All hospitals (other than mental hospitals).

☐ Those specified in the waiver.

☐ No waivers have been granted.

TN No. 86-14
Supersedes
TN No. 76-1

Approval Date 11/13/86 Effective Date 7/1/86

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-7 (BERC)
JULY 1985

OMB NO.: 0938-0193

State/Territory: COLORADO

Citation
42 CFR 456.2
30 FR 13312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

☒ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

☐ All mental hospitals.

☐ Those specified in the waiver.

☐ No waivers have been granted.

☐ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

TH No. 86-7
Supersedes
TH No. 76-1

Approval Date 5/16/86 Effective Date 1/1/86

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: _____

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

☒ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

☐ All skilled nursing facilities.

☐ Those specified in the waiver.

☐ No waivers have been granted.

36-14
TN No. ~~76-1~~
Supersedes
TN No. 76-1

Approval Date 11/13/86

Effective Date 7/1/86

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Colorado

OMB NO. 0938-0193

Citation

42 CFR 456.2
50 FR 15312

- 4.14 ☒ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:
- ☐ Facility-based review.
 - ☐ Direct review by personnel of the medical assistance unit of the State agency.
 - ☐ Personnel under contract to the medical assistance unit of the State agency.
 - ☒ Utilization and Quality Control Peer Review Organizations.
 - ☐ Another method as described in ATTACHMENT 4.14-A.
 - ☐ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.
 - ☐ Not applicable. Intermediate care facility services are not provided under this plan.

TN No. 86-14
Supersedes
TN No. 86-6

Approval Date 11/13/86 Effective Date 7/1/86

HCFA ID: 0048P/0002P

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Colorado

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)

- (f) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354

42 CFR 438.356(b) and (d)

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

___ Not applicable.

TN # 04-002

Supersedes TN # 92-15

Effective Date 3-25-04

Approval Date 5/25/04

**TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM**

ATTACHMENT 4.14-B

State of Colorado

**MULTIPLE UTILIZATION REVIEW METHODS FOR INTERMEDIATE CARE
FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES
(ICF/IID)**

The State Agency has contracted with the a Federally certified Quality Improvement Organization (QIO) in accordance with 42 CFR 431.630 to assume direct responsibility for assuring that all the Utilization Control requirements at 42 CFR 456.350 - 438 are met for intermediate care facilities for individuals with intellectual disabilities (ICF/IID). As part of these functions, the QIO shall have binding authority in the admission certification and recertification of recipients under Medicaid; and, in addition, shall review plans of care. In order to assure the satisfactory performance of the QIO in these activities, the Director of the Office of Community Living of the Department of Health Care Policy and Financing or their appointee will be responsible for direct monitoring and evaluation of the QIO. This is accomplished through personal visits with the QIO, direct consultation and reviews of specific case records, submission by the QIO of monthly review activity reports, and the examination and approval of the review criteria developed and used by the QIO. Furthermore, the Office of Community Living or their appointee will be a participating member of the Coordinating Committee whose function it is to oversee the entire Utilization Control process.

Inspections of Care requirements for ICF/IID, at 42 CFR 456.600 will be conducted by the Colorado Department of Public Health and Environment under a separate contract with the State Agency. Inspections of Care requirements for institutions for mental diseases at 42 CFR 456.600 will be conducted by the Colorado Foundation for Medical Care, under a separate contract with the State Agency. These contracts specify that the U.S. Department of Health and Human Services (HHS) and the State Agency may monitor and evaluate the performance of these contracts and shall have access to all records maintained by the contractors pursuant to their agreements. Both contracts contain provisions for the termination of the contracts within 90 days of notification by the Colorado Department of Human Services. Furthermore, both contracts specify that all records are to be maintained in accordance with 42 CFR Part 74 and that the QIO and the Department of Public Health and Environment will safeguard recipient information as required by Subpart F, Part 431, of 42 CFR.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: Colorado

Citation 4.15 Inspection of Care in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part
456 Subpart
I, and
1902(a) (31)
and 1903(g)
of the Act

_____ The State has contracted with a
Peer Review Organization (PRO) to
perform inspection of care for:

_____ ICFs/IID;

_____ Inpatient psychiatric facilities for
recipients under age 21; and

_____ Mental Hospitals.

42 CFR Part
456 Subpart
A and
1902(a) (30)
of the Act

X All applicable requirements of 42 CFR
Part 456, Subpart I, are met with
respect to periodic inspections of care
and services.

_____ Not applicable with respect to intermediate care
facilities for individuals with intellectual
disabilities services; such services are not
provided under this plan.

_____ Not applicable with respect to services for
individuals age 65 or over in institutions for mental
disease; such services are not provided under this
plan.

_____ Not applicable with respect to inpatient psychiatric
services for individuals under age 21; such
services are not provided under this plan.

DEC 10 1993

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational
Rehabilitation Agencies and Title V
Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

IN # 74-24
Supersedes
IN # _____

Approval Date 11/22/74 Effective Date 7/1/74

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

STATE OF COLORADO

**MEDICAL ASSISTANCE PROGRAM
RELATIONS WITH THE DEPARTMENT OF PUBLIC HEALTH AND
ENVIRONMENT**

The Colorado Department of Health Care Policy and Financing has an interagency agreement with the Colorado Department of Public Health and Environment (Title V Grantees) for state health service programs. The interagency agreement with the Department of Public Health and Environment includes responsibilities for the following state health service programs and/or providers: Breast and Cervical Cancer Program, family planning clinics, Health Care Program for Children and Youth with Special Health Care Needs, Nurse Home Visitor Program, Prenatal Plus Program, Vaccines for Children Program and Oral Health Program.

The interagency agreement specifies the mutual objectives and responsibilities of each party to the arrangement; the cooperative and collaborative relationships at the State level; payment or reimbursement, exchange of reports of services furnished to recipients; periodic review and joint planning for changes in the agreements, and continuous liaison between the parties, including designation of State and local liaison staff.

The Colorado Department of Public Health and Environment, as the Title V grantee organization, will be reimbursed based upon cost with appropriate differentiation between administrative costs matchable at the Federal Medicaid Assistance Percentage (FMAP) for the applicable agreements.

TN No. 07-011

Effective Date: July 1, 2007

Supersedes TN No. 93-007

Approval Date 10/19/07

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

Citation

42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

— The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

— The State imposes liens on real property on account of benefits incorrectly paid.

X

The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

— The State imposes liens on both real and personal property of an individual after the individual's death.

TN No. 95-012

Supersedes
TN No. 92-24

Approval Date

9/08/95

Effective Date

04/01/95

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADOCitation(s)

42 CFR 433.36 (c)
1902(a) (18) and
1917(a) and (b) of
The Act

4.17 Liens and Adjustments or Recoveries

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.
- ☒ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.
- (2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).
- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

— In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

TN No.: 14-001
Supersedes TN No.: 10-019

Approval Date: 5/20/14
Effective Date: January 1, 2014

Revision: HCFA-PM-95-3 (MB)
May 1995

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

STATE OF COLORADO

4.17(b)(3) (continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

- (i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, Q I, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.
- (ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.
- (iii) Medical assistance provided for benefits not related to Medicare cost sharing for the above categories of dual eligibles is still subject to estate recovery by the State Medicaid Agency.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

(4)

The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

TN No. 95-012
Supersedes 94-028 Approval Date 09/08/95 Effective Date 04/01/95
TN No. 94-028

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

- 1917(b)1(C) (4) X If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

Revision: HCFA-PM-95-3
MAY 1995

(MB)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
 - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
 - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

TN No. 95-012

Supersedes

TN No. 94-028Approval Date 09/08/95Effective Date 04/01/95

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

(d) ATTACHMENT 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
 - o estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
 - o individual's home,
 - o equity interest in the home,
 - o residing in the home for at least 1 or 2 years,
 - o on a continuous basis,
 - o discharge from the medical institution and return home, and
 - o lawfully residing.

TN No. 95-012

Supersedes

TN No. New

Approval Date

09/08/95

Effective Date

04/01/95

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

TN No. 95-012
Supersedes New Approval Date 09/08/95 Effective Date 09/01/95
TN No. New

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

The State hires a contractor to do medical reviews of institutionalized recipients as requested. Once determination is made that a recipient is not likely to return home, notice is sent to the recipient, the personal representative or guardian, and the Estate Recovery Program contractor. The notice is in letter form and contains the following information; a) reason for the medical determination, b) resulting potential of lien placement, lien definition, explanation that lien placement does not require sale of home, explanation that eligibility is not lost due to lien placement, c) list of exemptions from lien, d) instructions on who to contact if one of the exemptions applies, e) instructions for appealing medical determination (appeal form & envelope are included).

If no appeal is filed within 30 days, the Estate Recovery contractor will place a lien on the property. If an appeal is filed, a Statewide reconsideration panel hearing date is set. A letter is sent to the recipient and/or representative or guardian notifying them of the hearing date and the option to appear or send representation and/or additional information for consideration by the panel. Following the panel hearing, a letter is sent to the recipient and/or representative or guardian explaining the panel's decision and their reason for the decision. Letter notice is also sent to the Estate Recovery contractor regarding the panel decision.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):
Written statements from physicians and/or other health care providers or signed statements by another family member or neighbor describing the type and amount of care provided by the son/daughter and the effect such care may have had on the parent's ability to reside at home; written correspondence between the son/daughter and health care providers regarding the medical condition of the parent, and/or the care provided by the son/daughter; copies of cancelled checks, bank statements, credit card statements, income tax forms or other documents or correspondence showing that the son/daughter provided care and/or financial support to the parent.
3. The State defines the terms below as follows:

- o estate As defined in Colorado probate code CRS 15-10-201(17),
estate includes the property of the decedent, trust, or other person whose affairs are subject to this code as originally constituted and as it exists from time to time during administration.
- o individual's home Real property owned by the recipient and used as their principal place of residence; for institutionalized individuals, used as a principal place of residence immediately preceding admission to the medical institution.
- o equity interest in the home The individual client's interest in a property that is held in joint tenancy or tenancy in common.
- o residing in the home for at least one or two years on a continuous basis,
and Using the home as a principal place of residence.
- o lawfully residing. Residing in the home with the permission of the owner or, if under guardianship, the owner's legal guardian.

TN No. 95-012

Supersedes

TN No. 92-24

Approval Date 09/08/95

Effective Date 04/01/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

4. The State defines undue hardship as follows:

1. The heir/heirs would become eligible for assistance payments without receipt of the proceeds from the estate.
2. By allowing heir/heirs to receive proceeds from an estate, the heir/heirs would discontinue eligibility for assistance payments.
3. If a home is part of a family business and recovery would result in the heir/heirs losing their means of livelihood.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

1. State staff review requests for hardship and if one of the above conditions exist, hardship is acknowledged accordingly. In some cases, the home property may not be recovered on, but other assets in an estate may be recoverable.
2. Cases for recovery under \$500 are not pursued, but if public administrator, personal representative, or executor identifies the State as a creditor and makes notification of probate filing, a claim may be placed even if under \$500.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

A \$500 threshold for liens and estate claims was established in the original operating procedures due to costs in maintaining low dollar cases on active systems and the costs associated with recovery activities due to lack of automation in Colorado's probate and tax assessment systems.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

ESTATES CLAIMS

1. File claim with probate court and determine personal representative for the estate.
2. Send notice to personal representative with explanation of hardship, potential exemptions from recovery, and the address to send request for hardship or exemption review.
3. Any requests for hardship or exemption are forwarded to the State for final determination within 30 days.
4. If a disallowance of claim is filed by representative of the estate, an allowance of claim is filed by the contractor. Legal proceedings follow to determine the viability of the State's claim on the estate.

TEFRA LIENS

1. Once property ownership has been identified, a medical determination is requested from the peer review organization (PRO) contractor.
2. Once recipient has been determined unable to return home, a letter is sent to the recipient and/or their personal representative or guardian giving information on appeal procedures and the time frame for appeal of the medical determination (30 days). Notice is also sent to the Estate Recovery contractor.
3. If no appeal is requested within 33 days, a lien is filed by the Estate Recovery program contractor with letters to the same individuals listed above.
4. If no request for exclusion is received and approved, the lien is updated annually. Liens remain in place until property is sold or death occurs and estate

TN No. 95-012 Approval Date 09/08/95 Effective Date 04/01/95 claim is settled.
Supersedes
TN No. 92-24

Revision: HCFA-AT-91-4(BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Colorado

Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51
through 447.58

1916(a) and (b)
of the Act

(a) Unless a waiver under 42 CFR 431.55⁵⁷(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☒ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

TN # 03-028
Supersedes TN # 92-1

Effective Date 07/01/03
Approval Date 01/28/04

Revision: HCFA-PM-91-4(BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Colorado

Citation 4.18(b)(2) (Continued)

42 CFR 447.51
through
447.58

- (iii) All services furnished to pregnant women.
women.

[] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished by a managed care organization, health insuring organization or prepaid inpatient health plan, in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

[√] Some managed care enrollees in some plan types are charged deductibles, coinsurance rates and copayments in an amount equal to the State Plan service cost-sharing.

[] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.
- (viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

42 CFR 438.108
42 CFR 447.60

1916 of the Act,
P.L. 99-272,
(Section 9505)

TN # 03-028
Supersedes TN # 92-1

Effective Date 07/01/03
Approval Date 01/28/04

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

Citation

4.18(b) (Continued)

42 CFR 447.51
through
447.48

- (3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

☒ 19 or older

☐ 20 or older

☐ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

TN No. 92-1

Supersedes

87-5

Approval Date

4/9/92

Effective Date 10/1/91

HCFA ID: 7982EII

Revision:

OMB No.:

State/Territory: Colorado

Citation
42 CFR 447.51
through 447.58

4.18 (b) (3) (Continued)

- (iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:
- (A) Services(s) for which a charge(s) is applied;
 - (B) Nature of the charge imposed on each service;
 - (C) Amount(s) of and basis for determining the charge(s);
 - (D) Method used to collect the charge(s);
 - (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
 - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
 - (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.
- ☒ Not applicable. There is no maximum.

TN No. 03-012Approval Date 09/25/03Effective Date 7/1/2003Supersedes TN No. 92-1

HCFA ID:

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

Citation

1916(c) of
the Act

4.18(b)(4) ☒

A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.

1902(a)(52)
and 1925(b)
of the Act

4.18(b)(5) ☒

For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.

(d) of
the Act

4.18(b)(6) ☒

A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

TN No. 92-1

Supersedes

Approval Date

4/9/92

Effective Date

10/1/91

2. NEW

HCFA ID: 7982EII

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

Citation
42 CFR 447.51
through 447.58

4.18(c) ☐ Individuals are covered as medically needy under the plan.

(1) ☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through
4 47.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

TN No. 92-1

Supersedes

J. 87-5

Approval Date

4/9/92

Effective Date 10/1/91

HCFA ID: 7982EII

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

Citation

4.18 (c)(2) (Continued)

42 CFR 447.51
through
447.58

- (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.
- (iii) All services furnished to pregnant women.
☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.
- (viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.
☐ Not applicable. No such charges are imposed.

1916 of the Act,
P.L. 99-272
(Section 9505)

447.51 through
447.58

TN No. 92-1

~~Supersedes~~

o. 87-5

Approval Date

4/9/92

Effective Date

10/1/91

HCFA ID: 7982E11

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

Citation

4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☐ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

TN No. 92-1
Supersedes Approval Date 4/9/92 Effective Date 10/1/91
87-5

HCFA ID: 7982E11

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

Citation

4.18(c)(3) (Continued)

447.51 through
447.58

(iii) For the medically needy, and other optional groups,
ATTACHMENT 4.18-C specifies the:

- (A) Service(s) for which charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☐ Not applicable. There is no maximum.

TN No. 92-1

Revised

Approval Date

4/9/92

Effective Date

10/1/91

87-5

HCFA ID: 7982EII

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

- A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
a. Hospital outpatient visit			x	\$3.00 per visit
b. Physician home or office visit (M.D. or D.O.)			x	\$2.00 per visit
c. Clinic visit (Rural Health, FQHC, and Public Health)			x	\$2.00 per visit
d. Brief, individual, group, and partial care community mental health center visits (except services which fall under Home and Community Based Service programs)			x	\$2.00 per visit
e. Pharmacy			x	\$1.00 per prescription or refill for generic or multi-source drugs
			x	\$3.00 per prescription or refill for single-source or brand name drugs
f. Optometrist visit			x	\$2.00 per visit
g. Podiatrist visit			x	\$2.00 per visit
h. Inpatient hospital visit			x	\$10.00 per day
i. Psychiatric services			x	\$.50 per unit of service (defined as 15 minute segments)
j. Durable medical equipment / supplies			x	\$1.00 per date of service
k. Laboratory services			x	\$1.00 per date of service
l. Radiology services			x	\$1.00 per date of service

When the average or typical State payments for the above services are taken into consideration, all copayments were computed at a level to maximize the effectiveness without causing undue hardship on the recipients, assuring that they do not exceed the maximum permitted under 42 CFR 447.54.

Revision:

ATTACHMENT 4.18-A

Page 1 a

OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

A (h.) Inpatient hospital visit (cont.)

An inpatient hospital copayment charge cannot exceed 50 percent of the payment the agency makes for the first day of care in the institution. The system has been coded to calculate the copayment at the lesser of \$10 per covered day or 50% of the average allowable daily rate.

TN No. 03-012

Approval Date 09/25/03

Effective Date 7/1/2003

Supersedes TN No. new

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

- B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

- C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The copayment is collected at the time of service, according to state statute. The recipient may indicate his/her inability to pay at that time. Inability to make a copayment at the time of service characterizes the recipient's immediate financial situation. The provider may not deny services to a recipient who may be unable to pay although this does not extinguish the liability of the recipient.

TN No. 92-10
Supersedes
TN No. 86-3

Approval Date 2/18/92

Effective Date 1-1-92

HCFA ID: 0053C/0061E

Revision:

ATTACHMENT 4.18-A

Page 3

OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers are notified of copayment requirements for services covered and exempt groups and services through Medicaid bulletins issued by the fiscal agent. Providers are required to assess copayment at the time of service delivery. Amendments to section 1916(c) of the Social Security Act include a provision that no provider participating in Medicaid may deny care or services to an individual because of his/her inability to pay the required cost sharing charges. An individual who is unable to pay the copayment will self-declare the inability to pay, and the provider will be required to provide the services. The recipient is still responsible for the copayment and the provider may collect at a later date.

- E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

TN No. 03-012

Approval Date 09/25/03

Effective Date 7/1/2003

Supersedes TN No. 00-028

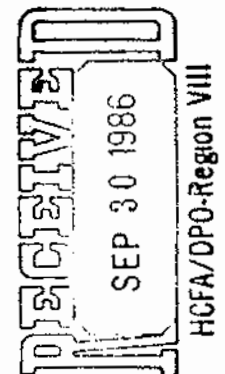
HCFA ID:

State: COLORADO

Service	Type of Charge Deduct. Coins. Copay.			Amount and Basis for Determination

Effective Date 7/1/86

HCFA ID: 0053C/0061E



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: COLORADO

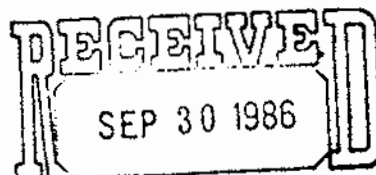
- B. The method used to collect cost sharing charges for medically needy individuals:
- ☒ Providers are responsible for collecting the cost sharing charges from individuals.
 - ☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.
- C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

TN No. 86-3
Supersedes
TN No. 83-11

Approval Date 11/3/86

Effective Date 7/1/86

HCFA ID: 0053C/0061E



HCFA/DPO-Region VIII

Revision:

ATTACHMENT 4.18-C

Page 3

OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

NOT APPLICABLE

- E. Cumulative maximums on charges:

- ☐ State policy does not provide for cumulative maximums.
- ☐ Cumulative maximums have been established as described below:

NOT APPLICABLE

TN No. 03-012

Approval Date 09/25/03

Effective Date 7/1/2003

Supersedes TN No. 92-10

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO
NOT APPLICABLE

Premiums Imposed on Low Income Pregnant Women and Infants

- A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

NOT APPLICABLE

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

* Description provided on attachment.

TN No. 92-4 Approval Date 4/14/92 Effective Date 10/1/91
Supersedes
TN No. New

Position: HCFA-PM-91- (BPD)
1991

ATTACHMENT 4.18-D
Page 2
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

NOT APPLICABLE

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☒ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

TN No. 92-4 Approval Date 4/14/92 Effective Date 10/1/91
Supersedes
TN No. New

HCFA ID: 7986E

Revision: HCFA-PM-91- (BPD)
1991

ATTACHMENT 4.18-E
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

NOT APPLICABLE
Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

NOT APPLICABLE

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

* Description provided on attachment.

TN No. 92-4 Approval Date 4/14/92 Effective Date 10/1/91
Supersedes
TN No. NEW

HCFA ID: 7986E

ion: HCFA-PM-91- (BPD)
1991

ATTACHMENT 4.18-E
Page 2
OMB No.:0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

NOT APPLICABLE

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☒ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

TN No. 92-4 Approval Date 4/14/92 Effective Date 10/1/91
Supersedes
TN No. New

HCFA ID: 7986E

Revision: HCFA-PM-91-
1991 (BPD)

OMB No.: 0938-

State/Territory: Colorado

Citation

4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

- (a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

☐ 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.

☒ Inappropriate level of care days are not covered.

TN No. 92-1

sedes

Approval Date

4/9/92

Effective Date 10/1/91

87-12

HCFA ID: 7982EII

Revision: HCFA-PM-93- 6 (MB)
August 1993

OMB No.: 0938-

COLORADO

State/Territory: _____

Citation
42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902(a)(13)(E)
1903(a)(1) and
(n), 1920, and
1926 of the Act

4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902(a)(10) and
1902(a)(30) of
the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

No. 94-002

Supersedes

TN No. 92-1

Approval Date

12/9/93

Effective Date

10-1-93

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during
a recipient's temporary absence from an
inpatient facility.

☒ Yes. The State's policy is
described in ATTACHMENT 4.19-C.

☐ No.

TN # 79-13
Supersedes
TN # _____

Approval Date 12/19/79 Effective Date 4/1/79

State/Territory: Colorado

Citation

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 (d)

- ☒ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

☒ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

☒ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

- (3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

☒ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

☒ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

- ☐ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

TM No. 23-11
Supersedes
TM No. 33-1

Approval Date 7/6/89

Effective Date 5/1/89

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 447.45 (c)
AT-79-50

4.19 (e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN # 79-29
Supersedes
TN # _____

Approval Date 12/28/79 Effective Date 10/1/79

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: COLORADO

Citation
42 CFR 447.15
AT-78-90
AT-80-34
48 FR 5730

4.19 (f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing charge.

TN No. 89-12
Supersedes
TN No. 83-11

Approval Date 8/21/87

Effective Date 11/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation

42 CFR 447.201

42 CFR 447.202

AT-78-90

4.19(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

TN # 79-33

Supersedes

TN # _____

Approval Date 3/13/80

Effective Date 1/1/80

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 447.201
42 CFR 447.203
AT-78-90

4.19(h) The Medicaid agency meets the requirements
of 42 CFR 446.203 for documentation and
availability of payment rates.

TN # 79-33
Supersedes _____
TN # _____

Approval Date 3/13/80

Effective Date 1/1/80

Revision: HCFA-AT-80-38 (SPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 447.201
42 CFR 447.204
AT-78-90

4.19(i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

TN # 79-33
Supersedes
TN # _____

Approval Date 3/13/80 Effective Date 1/1/80

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State: Colorado

Citation

42 CFR
447.201
and 447.205

4.19(j) The Medicaid agency meets the requirements
of 42 CFR 447.205 for public notice of any changes in
Statewide method or standards for setting payment rates.

1903(v) of the
Act

(k) The Medicaid agency meets the requirements
of section 1903(v) of the Act with respect to payment for medical
assistance furnished to an alien who is not lawfully admitted for
permanent residence or otherwise permanently residing in the United
States under color of law. Payment is made only for care and
services that are necessary for the treatment of an emergency
medical condition, as defined in section 1903(v) of the Act.

TN No. 92-1

Supersedes

90-06

Approval Date

4/9/92

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10/1/91

HCFA ID: 7982E11

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Colorado

Citation

1903(i)(14)
of the Act

4.19(1) The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

TN No. 93-002

Supersedes

TN No. New

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

STATE OF COLORADO

66(b)

4.19 (m) Medicaid Reimbursement for the Administration of Vaccines under the Pediatric
Immunization Program

1928(c)(2)(C)(ii) of the Act

- (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers shall be administered as follows:
- (ii) The State:
 - ☐ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.
 - ☐ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with state law.
 - ☒ sets a payment rate below the level of the regional maximum established by the DHHS Secretary with the exception of those services and providers subject to the minimum payments described at 42 CFR 447.405. State-developed reimbursement rates for vaccine administration are the same for both governmental and private providers.
 - ☐ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

With the exception of those services and providers subject to the minimum payments described at 42 CFR 447.405, the State pays the following rate for the administration of a vaccine:

\$18.93 per immunization vaccine administration, plus or minus any approved physician rate adjustments. State-developed reimbursement rates are the same for both government and private providers using a fee schedule. The current fee schedule can be found at www.colorado.gov/hcpf.

- (iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

Vaccines for Children (VFC) vaccines are provided to both private and governmental providers in the state. The Colorado Department of Public Health and Environment (CDPHE) shall ensure that providers remain compliant with federal, state, and CDPHE VFC program requirements.

Any qualified Medicaid provider including but not limited to private practitioners, public health agencies, outpatient hospital clinics, Rural Health Centers, and Federally Qualified Health Centers may provide immunization services.

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I. Methods and Standards for Establishing Prospective Payment Rates -- Inpatient Hospital Services

A. Payment Methods for Hospitals

Effective December 15, 1989 (unless otherwise specified in this plan) the following prospective payment method shall apply to all Colorado participating hospitals except those specialty hospitals and units within general acute care hospitals designated by the State agency as exempt.

B. Definitions

1. **Diagnosis Related Group (DRG):** A patient classification system that reflects clinically cohesive groupings of inpatient hospitalizations utilizing similar hospital resources. Colorado will adopt the Medicare classification system as a base for the DRG payment system. The State Agency has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.
2. **Principal Diagnosis:** The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.
3. **Relative Weight:** A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases.

Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The State Agency shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

TN No. 04-007
Supersedes
TN No. 03-009

AUG 24 2004
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4. Hospital Peer Groups: A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:
- a. Pediatric Specialty Hospitals: all hospitals providing care exclusively to pediatric populations.
 - b. Rehabilitation Hospitals: hospitals providing rehabilitation (excluding distinct part units and satellite locations).
 - c. Specialty-Acute Hospitals: hospitals providing specialty-acute care (excluding distinct part units and satellite locations).
 - d. Spine/Brain Injury Treatment Specialty Hospital: hospitals providing specialty-acute care and/or rehabilitation care specializing in treatment of a current spine and/or brain injury
 - e. Rural Hospitals: Colorado Hospitals not located within a federally designated Metropolitan Statistical Area (MSA).
 - f. Urban Hospitals: all Colorado hospitals in MSA's including those in the Denver MSA. Also included would be the Rural Referral Centers in Colorado, as defined by HCFA. (SSAS, 1886 (d) (5) (c) (1); Reg. 412.90 (c) and 412.96).

Facilities which do not fall into the peer groups described in a. through d. will default to the peer groups described in e. and f. based on geographic location.

5. Medicare Base Rate: The hospital specific Medicare base rate, which will be obtained directly from the Medicare Intermediaries represents the payment a hospital would receive from Medicare for a DRG with a weight equal to one. The Medicare base rate used for rate setting each State Fiscal Year (July 1 through June 30) will be those effective on each October 1 prior to the beginning of the State Fiscal Year..
6. Disproportionate Share Hospital (DSH) factors: These factors are specific payments made by Medicare to Disproportionate Share Hospitals within the Medicare base rate. The operating and capital Disproportionate Share Hospital factors will be obtained from the Medicare Intermediaries. The operating Disproportionate Share Hospital factor is multiplied by the federal portion of the operating subtotal to get the operating Disproportionate Share Hospital amount. The capital Disproportionate Share Hospital factor is multiplied by the capital portion of the federal payment to get the capital Disproportionate Share Hospital amount.

TN No. 18-

0038

Supersedes

TN No. 04-007

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7. Budget Neutrality: Budget Neutrality for PPS Hospitals is defined as no change in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated. The estimated hospital specific payment is calculated by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the Medicaid base rate. Effective July 1, 2020 Budget Neutrality is defined as a 1.1308% increase in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated.
8. Medicaid Base Rate or Base Rate: An estimated cost per Medicaid discharge.

For PPS Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by modifying the Medicare base rate by a set percentage equally to all PPS Hospitals. This percentage will be determined to maintain Budget Neutrality for all PPS Hospitals.

For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the Medicaid base rate used will be the average Medicaid base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty-one Medicaid discharges in the previous fiscal year.

Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge amount for Nursery, Neo-Natal, Intensive Care Units, and Graduate Medical Education obtained directly from the most recently audited Medicare/Medicaid cost report. Ten percent of each of these cost per discharge amounts will be added on to the base rate.

Effective May 23, 2008, the Graduate Medical Education add-on will not be applied directly to the Medicaid inpatient base rate for Denver Health Medical Center and University of Colorado Hospital. These hospitals will receive reimbursement for Graduate Medical Education costs through a direct payment as they qualify to receive

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a State University Teaching Hospital payment as specified under this Attachment 4.19A.

Starting July 1, 2020, Pediatric Specialty Hospitals will receive a hospital specific Medicaid base rate reduced by 1% to each hospital's July 1, 2019 Medicaid base rate.

Effective July 1, 2008 Urban Center Safety Net Specialty Hospitals will receive their hospital specific Medicare base rate adjusted by the percentage applied to all other hospitals plus 10 percent to account for the specialty care provided. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent. Add-ons are included in the final rate. To qualify as an Urban Center Safety Net Specialty Hospital, the urban hospital's Medicaid days plus Colorado Indigent Care Program (CICP) days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty-seven percent. Medicaid and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by the Department prior to March 1 of each year for July 1 rates. If the provider fails to report the requested days, the days used shall be collected from data published by the Colorado Hospital Association in its most recent annual report available on March 1 of each year. The CICP days shall be those reported in the most recently available CICP Annual Report as of March 1 of each year.

Hospital specific Medicaid base rates are adjusted annually (rebased) and are effective each July 1. Medicaid base rates will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. For instances where the General Assembly appropriates a change in funding during the State Fiscal Year, the hospital specific Medicaid base rates will be adjusted to allow for the change in funding.

Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year.

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Rate letters will document the Medicaid base rate and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

9. Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, Serious Reportable Events will not be used for Colorado Medicaid DRG assignment when the condition was not present on admission. When applicable, reimbursement to a hospital will be adjusted automatically or via retrospective reviews.

TN No. 12-016

Supersedes TN No. 11-031

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Payment Adjustment for Provider Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care Acquired Conditions for non-payment under Section 4.19-A of this State plan, which apply to all inpatient care except for inpatient psychiatric hospitals.

 X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider Preventable Conditions for non-payment under Section 4.19-A of this State plan.

 X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

 Additional Other Provider-Preventable Conditions identified below: None. The State is adopting the baseline approach.

Adjustment Methodology

The State uses the following methodology to adjust payments for the occurrence of provider-preventable conditions:

1. For Health Care Acquired Conditions (HCAC): The State reviews claims to ensure that there was no reimbursement for a secondary diagnosis that is on the list of HCACs, and that was not present on admission. If the State finds any HCAC that was not present on admission, reimbursement will be adjusted automatically at the time of claim adjudication, or after a retrospective review is complete.

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Payment Adjustment for Provider Preventable Conditions (cont'd)

2. No payment is made for inpatient services billed for Other Provider Preventable Conditions, as described in the "Other Provider Preventable Conditions" section. If, during retrospective review, the State finds any Other Provider Preventable Condition that was billed and reimbursed, the State will recover the reimbursement through a claim adjustment.

In the event that individual cases are identified before the provider-preventable conditions policy is fully implemented on July 1, 2012, the State will adjust reimbursements according to the methodology above.

In compliance with 42 CFR 447.26(c), the State assures the following:

1. There is no reduction in payment for a Provider Preventable Condition that existed before treatment had begun for that patient by that provider.
2. The State reduces provider payment for Provider Preventable Conditions only when:
 - a. The identified Provider Preventable Condition would otherwise result in an increase in payment.
 - b. The State can reasonably isolate for nonpayment the portion of the payment directly related to the Provider Preventable Condition and its treatment.
3. Non-payment for Provider Preventable Conditions does not prevent access to services for Medicaid beneficiaries.

TN: 12-008

Supersedes TN: 09-016

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10. Outlier Days: The days in a hospital stay which occur after the trim point. The trim point is that day which would occur at 1.94 standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations may be adjusted when changes are made to the DRG grouper methodology. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.
11. Infant Cost Outlier. To address the need for adequate payment for pediatric hospitalization involving exceptionally high costs or long lengths of stay, the State established day outlier payment at 80% of the hospital DRG per diem (rather than 60%, the Medicare rate) rather than to establish a separate cost outlier mechanism.

C. DRG Method of Payment

1. The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the patient was treated, surgical procedures involved, and complication of the illness. Every DRG has been assigned a relative weight and trim point, based primarily on Colorado-specific cost data. The State Agency shall periodically rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG.
2. The DRG relative weight will be multiplied by the base rate for the hospital to generate the payment amount.
3. When approved outlier days occur, 80% of the DRG per diem will be paid for each additional outlier day. The DRG per diem is the total DRG payment divided by the average length of stay. The percentage will be determined by the State Agency.
4. All State-operated facilities will be exempt from the DRG-based prospective payment system.
5. Abbreviated patient stays will be paid as follows:
 - a. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.

TN No. 04-007

Supersedes

Approval Date AUG 24 2004

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TN No. 03-009, 99-007

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- b. In cases involving transfers, each hospital involved will be paid a DRG per diem for each case based upon the full DRG payment divided by the average length of stay for the DRG (up to a maximum of one full DRG payment.) These discharges may also qualify for outlier payment.
- c. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility. Documented emergency cases are exempt from prior authorization.

D. Adjustments To The Payment Formula

- 1. Adjustments to the DRG classification system, weights, and trim points will be made when appropriate.
- 2. In order to continue to meet the Federal Boren Amendment requirements, the information used to calculate each prospective payment system (PPS) facility's cost per discharge will be updated. The following rebasing and payment protocol for payments is established:
 - a. Effective September 19, 1990, the base rate for each facility shall be calculated based upon the most recently audited cost report available for each facility (as of 12/31/87). Changes made to audited cost reports after the rebasing calculations will not constitute the basis for a provider appeal. For the time period between July 1, 1990 and September 18, 1990, those hospital whose base rate increased by 7% or less, as a result of the implementation of State Plan Amendment 90-02, should be assured a rate increase of at least 7% (not to exceed their FY 91 payment rate) during this 80 day period (July 1, 1990 to September 18, 1990).
 - b. Beginning July, 1991, an annual inflator shall be applied to each facility's cost per discharge. This annual inflator shall be derived as follows:
 - i. The HCFA Hospital Market Basket Index for the most recent year (in this case FY 1990-91) shall be used as the basis for the inflator.

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- b. In cases involving transfers, each hospital involved, excluding rehabilitation and specialty-acute hospitals, will be paid a DRG per diem for each case based upon the full DRG payment divided by the average length of stay for the DRG (up to a maximum of one full DRG payment.) These discharges may also qualify for outlier payment.
- c. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility. Documented emergency cases are exempt from prior authorization.

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 - b. Beginning July, 1991, an annual inflator shall be applied to each facility's cost per discharge. This annual inflator shall be derived as follows:
 - i. The HCFA Hospital Market Basket Index for the most recent year (in this case FY 1990-91) shall be used as the basis for the inflator.

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- ii. The HCFA Hospital Market Basket Index will be compared to the weighted average increase in the cost per discharge for each peer group. The weighted average increase will be determined by comparing the increase in costs from cost reports available for FYE 12/31/88. (In each subsequent fiscal year, the cost reports used for making the comparison shall be rolled forward by one year.)
 - iii. If the weighted average increase within each peer group in the cost per discharge is greater than the HCFA Hospital Market Basket Index, the difference between the figures will be added to the Market Basket Index to derive the annual inflator.
 - iv. Under no circumstances shall the annual weighted average increase in cost within any peer group driven by this calculation exceed a 7% limit.
 - v. The annual inflator is subject to changes in appropriations made by the General Assembly and the annual inflator may be adjusted by the Department accordingly. Prior to the start of the State Fiscal Year providers will receive a letter from the Department describing how the rate, including inflation, was calculated.
- c. On the third year (July, 1993) rates shall be calculated based upon the audited cost reports available for each facility for FYE 12/31/90. If the audited cost data show that the annual inflators were too high, or if they show the inflators were too low, the actual cost from the reports available for FYE 12/31/90 shall be used. There shall be NO retrospective changes to the rates if/when the "third year" rebased rates show that the 7% annual inflator was inaccurate.
 - d. Beginning July, 1993, rates shall be recalculated or rebased every third year and the annual inflator shall be used to increase the rates in the interim years.
 - e. In rebasing years, the initial base rate for pediatric specialty hospitals will be attributed to the routine, ancillary, capital, and medical education cost centers, proportionally, based on the actual costs from the most recently audited cost report. The cost per discharge for the medical education cost center, which is capped at 100 percent, will be deducted from the initial base rate and the remainder will be attributed to the other three costs centers in proportion to actual costs. These figures, which will add up to the total base rate, will represent the pediatric specialty hospital peer group caps for the routine, ancillary, and capital cost centers. These figures will be used as the starting point for subsequent payment cap adjustments as described in the previous definition of Base Rate.

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- 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.

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

TN No. 19-0025

Approval Date **DEC 17 2019** Effective Date 1/1/2020

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F. Adjustments For Out-of-State Providers

1. 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).
2. 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.
3. Effective January 1, 1992: When needed inpatient transplant services are not available at a Colorado Hospital, payment can be made at a higher rate (than 90% of the average Colorado Urban or Rural DRG payment rate) for non-emergent services if the provider chooses this payment method. When not reimbursed at a DRG payment rate the out-of-state hospital will be paid based upon the following criteria:
 - a. Payment shall be 100% of audited Medicaid costs.
 - b. In no case shall payment exceed \$1,000,000 per admission.
4. All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical, and financial data to the Colorado Hospital Association Data Bank Program. If a hospital does not report to the Colorado Hospital Association Data Bank, the State agency will send the required format for reporting this data.

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G. Per Diem Method of Payment (Designated Groups Only)

1. Free-Standing Psychiatric Hospitals (Excluding State Institutions):
 - a. Care provided in free-standing hospitals to Medicaid clients under the age of 21 is reimbursed using two per diem rates:
 - i. The initial per diem rate is paid during the first seven days of a client's stay. The second per diem rate begins on the eighth day of a client's stay and is paid for the remainder of the stay. This rate is lower than the initial per diem rate.
 - ii. Rationale: The Department analyzed historical Medicaid payment rate data and evaluated the relationship between hospital cost data and patient length of stay. Medicaid cost data from FY1987 revealed that costs for the first seven days of care were 38% higher than costs for the remainder of the certified stay. Based upon this cost relationship, the existing per diem payments made to these facilities were recalibrated to reflect a "step down" in payment after day 7. The two per diem rates, when paid for the entire 42-day average length of stay, will pay an average amount equal to previous payments to these facilities. This revision in payment methodology is designed to be revenue neutral while providing incentives for cost containment
 - b. Free-standing psychiatric hospital rates may be updated annually by the methodology outlined in Attachment 4.19-A, Section E (Adjustments for Exempt Providers), paragraph 1.
 - c. Effective October 1, 2010, any psychiatric hospital in the state of Colorado that meets all hospital enrollment requirements may be enrolled and eligible for reimbursement as a Colorado Medicaid provider.
2. Specialty-Acute Hospitals (Excludes Hospital Distinct Part Units and Hospital Satellite Locations):
 - a. Care provided in Specialty-Acute Hospitals to Medicaid clients is reimbursed using four per diem rates:
 - i. The initial per diem rate is paid during the first twenty-one days of a client's stay.
 - ii. The second per diem rate begins on day twenty-two to day thirty-five. This rate is five percent lower than the initial per diem rate.
 - iii. The third per diem rate begins on day thirty-six to day fifty-six. This rate is five percent lower than the second per diem rate.
 - iv. The fourth and final per diem rate begins on day fifty-seven through the remainder of the stay. This rate is five percent lower than the third per diem rate.
3. Rehabilitation Hospitals (Excludes Hospital Distinct Part Units and Hospital Satellite Locations):
 - a. Care provided in Rehabilitation Hospitals to Medicaid clients is reimbursed using four per diem rates:
 - i. The initial per diem rate is paid during the first six days of a client's stay.
 - ii. The second per diem rate begins on day seven to day ten. This rate is five percent lower than the initial per diem rate.
 - iii. The third per diem rate begins on day eleven to day fourteen. This rate is five

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- iv. percent lower than the second per diem rate.
 - v. The fourth and final per diem rate begins on day fourteen through the remainder of the stay. This rate is five percent lower than the third per diem rate.
1. Spine/Brain Injury Treatment Specialty Hospital (as Defined in Attachment 4.19-A, Section B):
- a. Care provided in Spine/Brain Injury Treatment Specialty Hospital to Medicaid clients is reimbursed using four per diem rates:
 - i. The initial per diem rate is paid during the first twenty-eight days of a client's stay.
 - ii. The second per diem rate begins on day twenty-nine to day forty-nine. This rate is five percent lower than the initial per diem rate.
 - iii. The third per diem rate begins on day fifty to day seventy-seven. This rate is five percent lower than the second per diem rate.
 - iv. The fourth and final per diem rate begins on day seventy-eight through the remainder of the stay. This rate is five percent lower than the third per diem rate.
2. To pay designated Inpatient Hospitals under a Classification per diem as defined above in Attachment 4.19-A, Section G, paragraphs 2-4, pages 10-10a, the Department of Health Care Policy and Financing:
- a. Assign each hospital, Specialty-Acute Hospitals and Rehabilitation Hospitals (Excludes Hospital Distinct Attached Part Units and Hospital Satellite Locations) to one of the following peer groups based on definitions from Attachment 4.19-A, Section B, paragraph 4(b-d), page 2.
 - i. Specialty-Acute Hospital
 - ii. Rehabilitation Hospital
 - iii. Spine/Brain Injury Treatment Specialty Hospital
 - b. Process Medicaid Inpatient hospital claims from state fiscal year 2017, known as the Base Year, though the methodology described in Attachment 4.19-A, Section G, paragraphs 2-4, pages 10-10a. Base per diems Budget Neutral to fiscal year 2017.
 - c. Base per diem additionally adjusted for state fiscal year increase for state fiscal year 2018 (1.4%), state fiscal year 2019 (1%) and state fiscal year 2020 (1%). Furthermore, the Medicaid Per Diem base rate, as determined in Attachment 4.19-A, Section G, paragraph S(a)(i-iii), page 10a, shall be adjusted by an equal percentage.
 - d. The following equation was utilized to calculate the base per diem from Fiscal Year (FY) 2017 (7/1/2016-06/30/2017) data. FY 2017 Total Medicaid FPS Reimbursed Dollars and Per Diem Days (as defined in Attachment 4.19A, Section G paragraphs 2-4) are customized for each of the three categories: Specialty-Acute, Rehabilitation and Spine/Brain Injury Treatment Specialty. Data is pulled from Colorado MMIS.

$$\frac{\text{FY 2017 Total Medicaid FPS Reimbursed Dollars}}{\text{Initial Per Diem Days} + (0.95^* \text{ Second Per Diem Days}) + (0.95^2 * \text{Third Per Diem Days}) + (0.95^3 * \text{Fourth Per Diem Days})}$$
 - e. Effective July 1, 2020, all rates as calculated in sections a-d of this subsection will be decreased by 1 %.

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H. Public Process for Hospital Rate-Setting

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

I. Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs incurred by an individual hospital for Medicaid managed care clients are carved out of managed care payments and shall be paid directly to Hospitals with a Graduate Medical Education program rather than to managed care organizations (MCOs) and regional accountable entities (RAEs) for Inpatient Services. GME, like other allowable costs, is a component of the hospital base rate. State University Teaching Hospitals' GME Inpatient costs are also carved out of managed care payments and paid through Family Medicine Program's State University Teaching Hospital Payment.

1. The most recently audited Hospital Medicare/Medicaid Cost Report (CMS 2552) available as of March 1 each fiscal year shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals.
2. MCOs and RAEs shall provide reports to the Department consisting of Inpatient day utilization by Hospital for discharges (net of adjustments) on a quarterly basis. To provide more time for claim runout, these reports shall be provided to the Department no later than 120 days after the close of each calendar year quarter (see table below for exact dates).

Calendar Year - Quarter	Reports contain utilization for	Due Date: (120 days after end of quarter)
Calendar Year-Q1	January - March	July 31st
Calendar Year-Q2	April - June	October 31st
Calendar Year-Q3	July - September	January 31st
Calendar Year-Q4	October - December	April 30th

3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs and RAEs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. Please see tables 1 and 2 which identify the data sources and calculations used to create GME MCO hospital payments.

The GME reimbursement will be paid at least annually through a lump sum payment to each Hospital by June 30th of each year.

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TABLE 1: Calculations for Outpatient (OP) Cost to Charge Ratio, Inpatient (IP) Graduate Medical Education (GME) Cost/Day and Inflation Factor for Current Year

Data Point	Data Point Name	Sample Data	Data Source / Calculations
F	Total GME Routine Costs	\$75,000.00	CMS 2552: Worksheet B Part I, Columns 21 and 22 (Interns and Residents), Inpatient Routine Service Cost Centers.
G	Total GME Ancillary Costs	\$24,000.00	CMS 2552: Worksheet B Part I, Columns 21 and 22 (Interns and Residents), Ancillary Service Cost Centers plus Outpatient Service Cost Centers (<u>allowable cost centers only</u>).
H	Inpatient Ratio	0.247101	CMS 2552: Equals: Worksheet C Part I, Title XIX, Column 6 (Inpatient Charges) Line 202 (Total) divided by Worksheet C Part I, Title XIX, Column 8 (Total Charges) Line 202 (Total).
I	Inpatient Ancillary Costs	\$5,930.42	CMS 2552: Equals: Column G (Total GME IP Ancillary Costs) times Column H (IP Ratio).
J	Total GME Costs	80,930.42	CMS 2552: Equals: Column F (Total GME Routine Costs) plus Column I (IP Ancillary Costs).
N	Total Inpatient Days	1,000	CO MMIS: Medicaid Internal Reports Total IP Days on Paid Claims based on same time period of most recently audited CMS 2552.
O	Total Billed Charges	16,836,437	CO MMIS: CO MMIS Internal Reports Total OP Charges on Paid Claims based on same time period of most recently audited CMS 2552.
Q	Outpatient Cost to Charge Ratio	0.000352	Calculation: Outpatient Cost to Charge Ratio (Column J / Column O)
R	Inpatient Graduate Medical Expense Cost/Day	\$5.93	Calculation: Inpatient GME Cost/Day (Column J / Column N)
S	Inflation Factor Current Year	1.03	Calculation: Actual Regulation Market Basket Updates from CMS (Inpatient Hospital PPS Table)

This report includes input from hospitals' most recently audited CMS 2552 cost report as of March 1 in current year as well as Medicaid program days from the State's MMIS system.

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TABLE 2: SAMPLE GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE UTILIZATION

Provider Name	HOSPITAL ABC	Calculations & Data Sources used to create MCO utilization GME payment
Provider Number	99999999	Colorado Medicaid Provider Number
NPI	99999999999	National Provider Identifier (NPI)
Quarter/Year	Q1-2019	Quarter and Year based on Calendar Year
MCO A Inpatient Days	1	Number produced from quarterly utilization reports created by Managed Care Organization A
MCO A Outpatient Charges	\$10,000.00	Number produced from quarterly utilization reports created by Managed Care Organization A
MCO B Inpatient Days	1	Number produced from quarterly utilization reports created by Managed Care Organization B
MCO B Outpatient Charges	\$10,000.00	Number produced from quarterly utilization reports created by Managed Care Organization B
Total Inpatient Days	2	Add all inpatient days from MCE utilization for Hospital ABC together here
Total Outpatient Charges	\$20,000.00	Add all outpatient charges from MCE utilization for Hospital ABC together here
Inpatient Rate	\$80.93	IP GME Cost/Day from Table 1
Outpatient Reimbursement Rate	72%	Percentage of reimbursement see Attachment 4.19-B; Item 2a. Outpatient Hospital Services; paragraph 10.c.
Outpatient Cost to Charge Ratio	0.00481	OP Cost to charge Ratio from Table 1
Inflation Factor	1.03000	Inflation Factor Current Fiscal Year from Table 1
Inflated Inpatient Rate	\$83.36	Inflated Inpatient Rate (Inpatient Rate * Inflation Factor)
GME Inpatient Payment	\$166.72	Total Inpatient Days * Inflated Inpatient Rate
GME Outpatient Payment	\$69.22	Total Outpatient Charges * Outpatient Reimbursement Rate * Outpatient Cost to Charge Ratio
GME TOTAL PAYMENT	\$235.94	Hospital ABC's Total Payment for Quarter
The calculation includes input from the hospitals' most recently audited CMS 2552 cost report as of March 1 in current year as well as Medicaid program days from the State's MMIS system.		

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II. Family Medicine Program

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the Major Teaching Hospital program, it is not eligible for this program. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Program will be \$213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Program will be \$228,379. The annual payment shall change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

The Family Medicine Residency Program payment is calculated on a State Fiscal Year (July 1 through June 30) basis and is distributed equally to all qualified providers in 12 equal monthly installments. Payments will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology. Total funds available by state fiscal year (SFY) for this payment are as follows:

SFY 2003-04: \$1,524,626	SFY 2004-05: \$1,444,944	SFY 2005-06: \$1,576,502
SFY 2006-07: \$1,703,558	SFY 2007-08: \$1,868,307	SFY 2008-09: \$1,798,015
SFY 2009-10: \$1,738,846	SFY 2010-11: \$1,738,846	SFY 2011-12: \$1,391,077
SFY 2012-13: \$1,741,077		

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- iv. percent lower than the second per diem rate.
 - v. The fourth and final per diem rate begins on day fourteen through the remainder of the stay. This rate is five percent lower than the third per diem rate.
4. Spine/Brain Injury Treatment Specialty Hospital (as Defined in Attachment 4.19-A, Section B):
- a. Care provided in Spine/Brain Injury Treatment Specialty Hospital to Medicaid clients is reimbursed using four per diem rates:
 - i. The initial per diem rate is paid during the first twenty-eight days of a client's stay.
 - ii. The second per diem rate begins on day twenty-nine to day forty-nine. This rate is five percent lower than the initial per diem rate.
 - iii. The third per diem rate begins on day fifty to day seventy-seven. This rate is five percent lower than the second per diem rate.
 - iv. The fourth and final per diem rate begins on day seventy-eight through the remainder of the stay. This rate is five percent lower than the third per diem rate.
5. To pay designated Inpatient Hospitals under a Classification per diem as defined above in Attachment 4.19-A, Section G, paragraphs 2-4, pages 10-10a, the Department of Health Care Policy and Financing:
- a. Assign each hospital, Specialty-Acute Hospitals and Rehabilitation Hospitals (Excludes Hospital Distinct Attached Part Units and Hospital Satellite Locations) to one of the following peer groups based on definitions from Attachment 4.19-A, Section B, paragraph 4(b-d), page 2.
 - i. Specialty-Acute Hospital
 - ii. Rehabilitation Hospital
 - iii. Spine/Brain Injury Treatment Specialty Hospital
 - b. Process Medicaid Inpatient hospital claims from state fiscal year 2017, known as the Base Year, though the methodology described in Attachment 4.19-A, Section G, paragraphs 2-4, pages 10-10a. Base per diems Budget Neutral to fiscal year 2017.
 - c. Base per diem additionally adjusted for state fiscal year increase for state fiscal year 2018 (1.4%), state fiscal year 2019 (1%) and state fiscal year 2020 (1%). Furthermore, the Medicaid Per Diem base rate, as determined in Attachment 4.19-A, Section G, paragraph 5(a)(i-iii), page 10a, shall be adjusted by an equal percentage.
 - d. The following equation was utilized to calculate the base per diem from Fiscal Year (FY) 2017 (7/1/2016-06/30/2017) data. FY 2017 Total Medicaid FFS Reimbursed Dollars and Per Diem Days (as defined in Attachment 4.19A, Section G paragraphs 2-4) are customized for each of the three categories: Specialty-Acute, Rehabilitation and Spine/Brain Injury Treatment Specialty. Data is pulled from Colorado MMIS.

FY 2017 Total Medicaid FFS Reimbursed Dollars

*Initial Per Diem Days + (0.95 * Second Per Diem Days) + (0.95² * Third Per Diem Days) + (0.95³ * Fourth Per Diem Days)*

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I. Family Medicine Program

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. Family Medicine programs meeting these criteria shall be eligible for an additional payment adjustment as follows:

The Family Medicine Residency Program Payment is calculated on a state fiscal year (July 1 through June 30) basis and is distributed to all qualified providers in monthly installments. Payments will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider, and other relevant figures specific to each provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that the payment was not calculated correctly given the established funds and rate setting methodology. Total funds available by state fiscal year (SFY) for this payment are as follows:

SFY 2003-04: \$1,524,626	SFY 2004-05: \$1,444,944	SFY 2005-06: \$1,576,502
SFY 2006-07: \$1,703,558	SFY 2007-08: \$1,868,307	SFY 2008-09: \$1,798,015
SFY 2009-10: \$1,738,846	SFY 2010-11: \$1,738,846	SFY 2011-12: \$1,391,077
SFY 2012-13: \$1,741,077	SFY 2013-14: \$2,371,077	SFY 2014-15: \$2,371,077
SFY 2015-16: \$5,114,422	SFY 2016-17: \$5,114,422	SFY 2017-18: \$4,565,753
SFY 2018-19: \$5,030,890	SFY 2019-20: \$5,030,890	

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Effective May 23, 2008, the Family Medicine Residency Program Payment for providers that qualify to receive the State University Teaching Hospital Payment is suspended.

Effective May 23, 2008, when state owned government hospitals, non-state owned government hospitals, and privately owned hospitals meet the criteria for being a State University Teaching Hospital, they will qualify to receive additional Medicaid reimbursement for services provided to Medicaid recipients. The additional Medicaid reimbursement will be commonly referred to as the "State University Teaching Hospital Payment", which will be established on an annual state fiscal year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The State University Teaching Hospital Payment is made only if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program).

A State University Teaching Hospital is defined as a Colorado hospital which meets the following criteria:

1. Provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education.
2. More than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Qualified providers and the total yearly payments to those are as follows:

SFY 2009-10	SFY 2010-11
Denver Health Medical Center: \$1,831,714	Denver Health Medical Center: \$1,831,714
University of Colorado Hospital: \$700,935	University of Colorado Hospital: \$676,785

SFY 2011-12	SFY 2012-13
Denver Health Medical Center: \$1,831,714	Denver Health Medical Center: \$1,831,714
University of Colorado Hospital: \$633,314	University of Colorado Hospital: \$633,314

SFY 2013-14	SFY 2014-15
Denver Health Medical Center: \$1,831,714	Denver Health Medical Center: \$2,804,714
University of Colorado Hospital: \$633,314	University of Colorado Hospital: \$633,314

SFY 2015-16	SFY 2016-17
Denver Health Medical Center: \$2,804,714	Denver Health Medical Center: \$2,804,714
University of Colorado Hospital: \$633,314	University of Colorado Hospital: \$633,314

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SFY 2017-18	SFY 2018-19
Denver Health Medical Center: \$2,804,714	Denver Health Medical Center: \$2,804,714
University of Colorado Hospital: \$1,331,983	University of Colorado Hospital: \$1,647,612

SFY 2019-20	
Denver Health Medical Center: \$2,804,714	
University of Colorado Hospital: \$1,797,612	

Effective July 1, 2013, a privately-owned hospital that receives the Family Medicine Residency Payment or the Pediatric Major Teaching Payment authorized in this Attachment 4.19A, and is selected by the Commission on Family Medicine Residency Training Programs for the development and maintenance of family medicine residency training programs in rural areas, will qualify to receive additional Medicaid reimbursement. This reimbursement will be commonly referred to as the "Rural Family Medicine Residency Development Payment". The Rural Family Medicine Residency Development Payment is made only if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a diagnosis-related group and/or per diem reimbursement paid under the Medicaid program).

The Rural Family Medicine Residency Development Payment is disbursed on a state fiscal year basis (July 1 - June 30). The Rural Family Medicine Residency Development Payment will be paid quarterly. Total funds available for this payment per state fiscal year are as follows:

SFY 2013-14	SFY 2014-15
\$1,000,000	\$3,030,766
SFY 2015-16	SFY 2016-17
\$3,030,766	\$3,030,766
SFY 2017-18	SFY 2018-19
\$3,030,766	\$3,000,000
SFY 2019-20	
\$3,000,000	

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Episode Based Payments

Purpose: Medicaid has established Colorado-specific Episode-Based Payments. Episode Based Payments:

1. Support Colorado's shift to value-based purchasing by rewarding high quality care and outcomes;
2. Encourage clinical effectiveness;
3. Encourage referral to providers who deliver high-quality care, when provider referrals are necessary;
4. Use episode-based data to evaluate the costs and quality of care delivered and to apply incentive payments; and
5. Establish Principal Accountable Providers (PAPs) for defined episodes of care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive payments are available at the Colorado Medicaid Bundled Payment website available at www.colorado.gov/hcpf/committees-boards-and-collaboration and are effective for the performance period beginning October 1st, 2020.

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

Episodes: An "episode" is 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 Colorado Bundled Payment website located at www.colorado.gov/hcpf/committees-boards-and-collaboration.

PAPs: A PAP is the provider who is held accountable for both the quality and cost of care delivered to a patient for an entire episode. The State, in consultation with clinical experts, designates a PAP based on factors such as decision-making responsibilities, influence over other providers, and episode expenditures.

Payments: Subject to the incentive payments described below, providers, including PAPs, deliver care to eligible beneficiaries and are paid in accordance with the Medicaid reimbursement methodology in effect on the date of service.

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. Thresholds may be reviewed annually by the State using historical data that is at a minimum, two years prior to the performance period, in order to account for updates to the episode definitions or changes in practice patterns.

- The commendable benchmark is the specific dollar value for each episode such that a provider with a reimbursement below the dollar value is eligible for a positive incentive payment if all quality metrics linked to the incentive payment are met. This value is set based on a PAPs historical experience with a minimum savings rate factored in. PAPs are compared to thresholds posted on the website at www.colorado.gov/hcpf/committees-boards-and-collaboration

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Episode Risk Adjustment: Each episode will be evaluated for the need of risk adjustment by actuarial experts. For episodes, which actuarial experts determine that risk adjustment is necessary, adjustments will be applied to enable comparison of a PAP's episodes to their Thresholds if there is high variability in episode costs. Risk adjustments are episode specific as described on the Colorado Medicaid Bundled Payment website at www.colorado.gov/hcpf/committees-boards-and-collaboration .

Incentive Payments: Episode Based 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 the episode. 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 and equal 50% of the difference between the average episode expenditures and the applicable threshold as described below. The 50% risk-sharing percentage applies to positive incentive payments. 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.

- **Positive Incentive Payments:** If the PAP's average episode reimbursement is lower than commendable threshold and the PAP meets the quality requirements established by Medicaid for a given episode type, Medicaid will issue an incentive payment to the PAP. This incentive payment will be based on the difference between the PAP's average episode reimbursement and their specific commendable threshold. The commendable threshold for positive incentive payments will have minimum savings rate applied to ensure PAPs are lowering costs and improving the quality of care delivered. 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.
- **No Incentive Payments:** If the average episode reimbursement is between the acceptable and commendable thresholds, the PAP will not incur a positive incentive payment.

Episodes: Effective for those specific episodes with an end date on or after October 1st, 2020, 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 Bundled Payment website available at www.colorado.gov/hcpf/committees-boards-and-collaboration.

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III. Disproportionate Share Hospital Adjustment

A. Federal regulations require that hospitals which provide services to a disproportionate share of Medicaid recipients, shall receive an additional payment amount to be based upon the following minimum criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and
2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area, (that is an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
3. Number 2 above does not apply to a hospital in which:
 - a. The inpatients are predominantly under 18 years of age; or
 - b. Does not offer non-emergency obstetric services as of December 21, 1987.

The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

The calculation of the Medicaid inpatient utilization rate will include managed care patient days.

4. For purposes of paragraph 8.A.1., the term "low income utilization rate" means, for a hospital, the sum of:
 - a. The fraction (expressed as a percentage)
 - i. The numerator of which is the sum (for a period) of (I) total revenues paid the hospital for patient services under a State Plan under this title and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

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- ii. The denominator of which is the total amount of revenues of the hospital for patient service (including the amount of such cash subsidies) in the period; and
- b. The fraction (expressed as a percentage)
 - i. The numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (i) (II) of subparagraph (A) (of section 1923 of the Social Security Act) in the period reasonably attributable to inpatient hospital services, and
 - ii. The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approach under this title).

5. The calculation of the low income utilization rate will include revenues paid the hospital from managed care entities on behalf of Medicaid beneficiaries.

B. Colorado determination of Individual Hospital Disproportionate Payment Adjustment.

Effective January 1, 1991, hospitals deemed eligible for minimum disproportionate share payment will receive the following payment adjustment:

1. Hospitals with a Medicaid inpatient utilization rate in excess of one standard deviation above the State's mean Medicaid patient day utilization rate will receive a minimum of a 2 1/2% increase in the calculated base or per diem rate. To pay hospitals proportionally for their level of Medicaid inpatient utilization the following schedule will be applied to each specific Medicaid utilization rate:

<u>STANDARD DEVIATION LEVEL ABOVE MEAN</u>	<u>INCREASE IN MEDICAID PAYMENT</u>
1.0-1.19	2.5%
1.2-1.39	3.0%
1.4 -1.59	3.5%
1.6 -1.79	4.0%
1.8 -1.99	4.5%
2.0 -2.19	5.0%

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2.2 -2.39	5.5%
2.4 -2.59	6.0%
2.6 -2.79	6.5%
2.8 -2.99	7.0%
3.0 -3.19	7.5%
3.2 -3.39	8.0%
3.4 -3.59	8.5%
3.6 -3.79	9.0%
3.8 -3.99	9.5%
4.0 +	10.0%

2. Hospitals qualifying under the low-income utilization rate formula, but not under the Medicaid inpatient utilization rate formula, will receive at a minimum 0.1% increase in payment. To pay hospitals proportionately for their level of low-income utilization, the following schedule will be applied to each specific low-income utilization rate:

<u>LOW-INCOME UTILIZATION PERCENT</u>	<u>INCREASE IN MEDICAID PAYMENT</u>
25% - 49.99%	0.10%
50% - 74.99%	0.15%
75% - 99.99%	0.20%
100% +	0.25%

3. Hospitals qualifying under both formulae will receive only the Medicaid inpatient utilization adjustment.
4. Effective January 1, 1994, no hospital can be considered to be a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of at least one-percent.

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5. Disproportionate share amounts shall be based upon the recalculated base rate for affected facilities (prospectively determined annually in conjunction with base rate changes.) The percentage of Medicaid patients in each facility used to calculate the appropriate disproportionate share payments (if any) shall be based upon the most recent Colorado Hospital Association Data Bank information available, and information from hospitals not participating in the Data Bank describing total patient days and Medicaid days. This information received by the department will be used to assure that all Colorado hospitals receiving Medicaid payments will be included in the calculation of disproportionate share amounts. Data Bank information will be subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care.
6. Effective February 22, 2002, the payment adjustment, as described above in this subsection and commonly known as Pre-Component 1, is suspended.
7. Effective July 1, 2002, the Individual Hospital Disproportionate Share Payment Adjustment calculation, as described above in this subsection and commonly known as Pre-Component 1, is superseded by a new payment method. Hospitals with a Medicaid inpatient utilization rate in excess of one standard deviation above the State's Medicaid patient day utilization rate will receive a predetermined reimbursement for the entire fiscal year distributed on a quarterly basis. This predetermined yearly reimbursement will be based on self-pay and others patient day utilization, excluding Colorado Indigent Care Program days, adjusted for each facility's Colorado Medicaid fee-for-service case mix and the appropriated dollars by the General Assembly. Self-pay and others patient day utilization will be as reported by the most recently available Colorado Hospital Association Data Bank information. Others patient day utilization excludes clients reported as Medicare, Medicaid, Champus, Managed Care and Commercial. The Colorado Indigent Care Program days will be as reported in the corresponding Colorado Indigent Care Program annual report. The Colorado Medicaid fee-for-service case mix will be obtained from the Colorado Foundation for Medical Care corresponding submitted report to the Department and will be set equal to one if unavailable. If the eligible hospital does not report to the Colorado Hospital Association Data Bank, the self-pay and others patient day utilization will be directly reported by the hospital to the Department. An eligible hospital will receive a percentage of the appropriated dollars equal to that hospital's percentage of the self-pay and others patient day utilization, excluding Colorado Indigent Care Program days, adjusted for each facility's Colorado Medicaid fee-for-service case mix relative to all eligible hospitals.

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8. Effective July 1, 2003, the payment adjustment, as described above in this subsection and commonly known as Pre-Component 1, is suspended.
9. Effective July 1, 2003, Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a Low-Income payment.
10. Effective July 1, 2003, Hospitals deemed eligible for minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "Low-Income Shortfall payment," which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations this payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider. Self Pay Days, Other Days and Medicaid Days will be reported by the provider for the most recent year for which data are available. As required by Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific uncompensated costs.

For this section, Self Pay Days, Other Paid Days, Medicaid Days and Total Days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report the requested Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

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The funds available for the Low-Income Shortfall payment under the Disproportionate Share Hospital Allotment are limited by the regulations set by and federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	\$66,710
State Fiscal Year 2004-05	\$113,312
State Fiscal Year 2005-06	\$145,470
State Fiscal Year 2006-07	\$189,588
State Fiscal Year 2007-08	\$530
State Fiscal Year 2008-09	\$176,324

11. Effective July 1, 2009, the payment adjustment, as described above in this subsection and commonly known as Low-Income Shortfall payment, is suspended.
12. Effective July 1, 2009, Hospitals deemed eligible for minimum disproportionate share payment and participate in the Colorado Indigent Care Program will receive a CICP Disproportionate Share Hospital payment.
13. Effective July 1, 2009, Hospitals deemed eligible for minimum disproportionate share payment and do not participate in the Colorado Indigent Care Program will receive an Uninsured Disproportionate Share Hospital payment.
14. Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "CICP Disproportionate Share Hospital payment" is suspended.
15. Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Uninsured Disproportionate Share Hospital payment" is suspended.
16. Effective October 1, 2014, Hospitals deemed eligible for the minimum disproportionate share payment shall receive a Disproportionate Share Hospital payment.

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C. Colorado determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program and Bad Debt.

1. Effective July 1, 1993 Component 1 shall be superseded by a Disproportionate Share Adjustment payment method (herein described as Component 1a) which shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, disproportionate Share Hospital Adjustments, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:
 - a. Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Programs reimbursements.
 - b. For each hospital that qualifies under this section D, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year. This cost data will be inflated forward from the year of the most recent available report (using the CPI-W, Medical Care for Denver) through June 30 of the fiscal year payment period. The Colorado Indigent Care Program costs, patient payments, and Program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Program, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit. Aggregate disproportionate share hospital payments will not exceed the published disproportionate share hospital limitations.
2. Effective for the period from June 1, 1994 to June 30, 1994: each facility will receive a payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program Patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered

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proportionately from all participating hospitals. The State will use historical data from the SFY 91/92 Colorado Indigent Care Program Annual Report to develop the prospective payment rate. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State, (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).

3. Effective for the period from July 1, 1994 to June 30, 1995, each facility will receive a payment proportional to the level of low income care services provided, as measured by 200% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, disproportionate Share Hospital Adjustments, paragraph (A)).
4. Effective July 1, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).
5. Effective July 1, 2003 the Disproportionate Share Hospital adjustment commonly referred to as "Component 1a" is suspended.

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6. Effective June 1 through June 30, 1995, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 200% of the hospital's reported Colorado Hospital Association bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report available before rate setting by the Department, inflated from the year of the annual report to June, 1995 using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, and reduced by estimated patient payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).
7. Effective from July 1, 1998, through September 30, 1998, and from October 1, 1998 through September 30, 1999, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of \$93 million in Federal Fiscal Year 1998, and \$85 million in Federal Fiscal Year 1999. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).

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8. Effective from September 1, 2000, through September 30, 2000, each government hospital will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of \$79 million in Federal Fiscal Year 2000. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any government disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)). Effective June 1, 2001, this bad debt Disproportionate Share Adjustment payment to government hospitals is extended to an annual basis, and is subject to the Federal Funds limits of the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The limit for 2001 is \$81.765 million.
9. Effective July 1, 2003 the Bad Debt Disproportionate Share Adjustment payment to government hospitals is modified as follows and is commonly referred to as the "Bad Debt payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed as an annual payment prior to June 30 of each state fiscal year. This payment is available to non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals whose percent of Medicaid days relative to total days equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association.

As required by federal regulations the sum of this payment, the Low-Income Shortfall payment and the Low-Income payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The Bad Debt payment is only made if there is available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment and the Low-Income payment.

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The amount of available federal funds remaining under the Disproportionate Share Hospital allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt Costs for qualified providers. Available Bad Debt charges are converted to Bad Debt costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

Available funds under the Disproportionate Share Hospital Allotment are multiplied by the percentage resulting from dividing the hospital specific Bad Debt costs by the sum of all Bad Debt costs for qualified providers to calculate the Bad Debt payment for the specific provider. As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific Bad Debts costs.

The funds available for the Bad Debt payment under the Medicare Disproportionate Share Hospital Allotment are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	\$4,591,800
State Fiscal Year 2004-05	\$1,857,450
State Fiscal Year 2005-06	\$280,832
State Fiscal Year 2006-07	\$448,474
State Fiscal Year 2007-08	\$113,045
State Fiscal Year 2008-09	\$756,931

10. Effective July 1, 2009 the Disproportionate Share Hospital adjustment commonly referred to as "Bad Debt payment" is suspended.

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D. Colorado determination of Individual Hospital Disproportionate Payment Adjustment
Associated with the Colorado Indigent Care Program

1. Effective July 1, 1994, an additional Disproportionate Share Adjustment payment method will apply to any Outstate Disproportionate Share hospitals meeting the Medicaid inpatient utilization rate formula. Effective February 26, 1997, an additional Disproportionate Share Adjustment payment method will apply to any Specialty Hospital meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent. These hospitals do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition, and if they do, they are excluded from receiving this adjustment. Providers currently participating in other disproportionate share refinancing programs, or who are not participating in the Colorado Indigent Care Program, are excluded from receiving this adjustment. Outstate hospitals are defined as those Colorado hospitals that are outside the City and County of Denver, and who participate in the Colorado Indigent Care Program. Specialty Indigent Care Program providers are defined by the Colorado Indigent Care Program as those providers which either offer unique specialized services or serve a unique population.
2. Effective July 1, 2001, Outstate Disproportionate Share hospitals which do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition will be separated into the Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals. Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are owned by a state, county or local government entity. Non-Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are not owned by a state, county or local government entity.

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3. These hospitals must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area, (that is, an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.
4. Hospitals must participate in the Colorado Indigent Care Program, and must meet the separate annual audit requirements of the Colorado Indigent Care Program; and must supply data per the Colorado Indigent Care Program guidelines on total charges, total third party collections, total patient liability and write-off charges to the Colorado Indigent Care Program. Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to its uncompensated medically indigent costs, as calculated by the Colorado Indigent Care Program. These uncompensated costs will be calculated by taking total medically indigent charges, subtracting total third party collections and total patient liability to obtain write-off charges, and then multiplying write-off charges by the cost-to-charge ratio as defined by the Colorado Indigent Care Program, to calculate medically indigent write-off costs. The cost-to-charge ratio is defined by the Colorado Indigent Care Program as that cost-to-charge ratio calculated using the most recently submitted Medicare Cost Report for each hospital.

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For each hospital which qualifies under this section, these payments for indigent care costs will be calculated based upon historical data and the amount of funds appropriated annually by the General Assembly. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year. This cost data will be inflated forward from the year of the most recent available report (using the CPI-W, Medical Care for Denver) through June 30 of the fiscal year payment period. The percentage of uncompensated cost reimbursed will be based on appropriations for Outstate Medically Indigent hospitals, but Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals may have different calculated total reimbursement percentages of uncompensated costs. The Disproportionate Share hospital payment will not exceed uncompensated costs as defined in the Social Security Act, SEC.1923(g)(1)(A). Adjustments will be made to the monthly payments based on interim recalculations performed by the Colorado Indigent Care Program.

5. Effective July 1, 2003, payments under this section D are suspended.
6. Effective July 1, 2003, hospitals with a percent of Medicaid days relative to total days equal to or greater than 1% and participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "Low-Income payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of March 1 each fiscal year. Medically indigent costs are inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

- a. The request budget year medically indigent costs are weighted (increased) by the following factors to measure the relative Medicaid and low-income care to total care provided. Each provider's specific medically indigent costs are inflated (increased) by the following factors:

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- i. Percent of Medicaid (fee-for-service and managed care) days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.
 - ii. Percent of medically indigent days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.
- b. The request budget year provider specific medically indigent costs are weighted (increased) by the following factors, if they qualify, to account for disproportionately high volumes of Medicaid and low-income care provided. If the provider qualifies, the provider specific medically indigent costs are further inflated (increased) by the following factors:
- i. Disproportionate Share Hospital Factor. To qualify for the Disproportionate Share Hospital Factor, the provider's percent of Medicaid days relative to total days must equal or exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.

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If the provider does qualify, then the Disproportionate Share Hospital Factor will equal the provider's specific percent of Medicaid days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Disproportionate Share Hospital Factor is equal to the provider's specific percent of Medicaid days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of the Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services. If the provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.

- ii. Medically Indigent Factor. To qualify for the Medically Indigent Factor, the provider's percent of medically indigent days relative to total inpatient days must equal or exceed the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.

If the provider does qualify, then the Medically Indigent Factor equals the provider specific percent of medically indigent days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Medically Indigent Factor is equal to the provider's specific percent of medically indigent days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government

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hospitals, the Medically Indigent Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services. If the provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.

There will be two allotments for the Low-Income payment: state owned government hospitals plus non-state owned government hospitals, and privately owned hospitals. For state-owned government hospitals plus non-state owned government hospitals, the allotment is the available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment, while for privately owned hospitals the allotment is further limited by the level of General Fund established and amended by the General Assembly.

The available allotments under the Disproportionate Share Hospital Allotment are multiplied by the hospital specific Weighted Medically Indigent Costs divided by the summation of all Weighted Medically Indigent Costs for qualified providers in each specific allotment to calculate the Low-Income payment for the specific provider. As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific medically indigent costs, as defined in this section, inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

For this section, Medicaid days, medically indigent days and total inpatient days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

As required by federal regulations the sum of this payment and the Low-Income Shortfall payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The Low-Income payment is made only if there is available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment.

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The funds available for the Low-Income payment under the Medicare Disproportionate Share Hospital Allotment are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal

State Fiscal Year 2003-04	\$163,616,330
State Fiscal Year 2004-05	\$172,284,442
State Fiscal Year 2005-06	\$173,828,898
State Fiscal Year 2006-07	\$173,679,266
State Fiscal Year 2007-08	\$174,000,854
State Fiscal Year 2008-09	\$181,190,648

7. Effective July 1, 2009 the Disproportionate Share Hospital adjustment commonly referred to as "Low-Income payment" is suspended
8. Effective July 1, 2009, hospitals that participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "CICP Disproportionate Share Hospital payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal monthly installments

Effective October 1, 2010, the CICP Disproportionate Share Hospital payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

To qualify for the CICP Disproportionate Share Hospital payment a Colorado hospital shall meet the following criteria

- a Is licensed or certified as a General Hospital or Critical Access Hospital by the Colorado Department of Public Health and Environment; and
- b Does participate in the Colorado Indigent Care Program

The CICP Disproportionate Share Hospital payment is a prospective payment calculated using historical data, with no reconciliation to actual data or costs for the payment period. Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific

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audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of May 1 each fiscal year. Medically indigent costs are inflated forward to payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

Qualified hospitals shall receive a payment calculated as a percent of inflated medically indigent costs. There will be three categories for qualified hospitals: state-owned government hospitals, non-state-owned government hospitals, and private-owned hospitals. The percent of inflated medically indigent costs shall be calculated for each category. The percent of inflated medically indigent costs shall be the aggregate of all inflated medically indigent costs for qualified providers in the category divided State's annual Disproportionate Share Hospital allotment allocated to the CICP Disproportionate Share Hospital payment for that category.

Percent of the State's annual Disproportionate Share Hospital Allotment allocated to the CICP Disproportionate Share Hospital payment by category			
State Fiscal Year	State-Owned Government Hospitals	Non-State-Owned Government Hospitals	Private-Owned Hospitals
State Fiscal Year 2009-10	5.06%	40.00%	35.00%
State Fiscal Year 2010-11 July 1 – September 30, 2010	5.06%	40.00%	35.00%
Federal Fiscal Year 2010-11	9.86%	45.00%	25.00%
Federal Fiscal Year 2011-12	15.00%	42.00%	23.00%
Federal Fiscal Year 2012-13	20.47%	32.28%	25.98%
Federal Fiscal Year 2013-14	19.67%	49.18%	29.51%

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit (as specified in federal regulations). If upon review, the CICP Disproportionate Share Hospital payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific DSH limit retroactively. The amount of the retroactive reduction shall be then retroactively distributed to the other qualified hospitals in the category based on the qualified hospital proportion of medically indigent cost relative to the aggregate of medically indigent costs of all qualified providers in the category who do not exceed their hospital-specific Disproportionate Share Hospital limit.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after an CICP Disproportionate Share Hospital payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

9. Effective October 1, 2014, the Disproportionate Share Hospital adjustment commonly referred to as "CICP Disproportionate Share Hospital payment" is suspended.

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2. Effective October 1, 2014, qualified hospitals shall receive a disproportionate share hospital payment commonly referred to as the “Disproportionate Share Hospital Supplemental payment”, which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

To qualify for the Disproportionate Share Hospital payment a Colorado hospital shall meet one of the following criteria:

- a. Is not a licensed or certified Psychiatric Hospital, is a Colorado Indigent Care Program (CICP) provider, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act; or
- b. Is not a licensed or certified Psychiatric Hospital, has a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act; or
- c. Effective October 1, 2019, is a Critical Access Hospital and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act.

Effective October 26, 2015, CICP-participating hospitals with CICP write-off costs as published in the most recent CICP Annual Report greater than or equal to 750% of the statewide average will receive a payment equal to their estimated hospital-specific Disproportionate Share Hospital limit. CICP-participating hospitals with CICP write-off costs as published in the most recent CICP Annual Hospital Report less than 750% but greater than 200% of the statewide average will receive a payment equal to 96% of their estimated hospital-specific Disproportionate Share Hospital limit.

All remaining qualified hospitals shall receive a payment calculated as a percent of uninsured costs multiplied by the remaining amount of the state’s annual Disproportionate Share Hospital allotment. The percent of uninsured costs shall be the total of all uninsured costs for a remaining qualified hospital divided by the total uninsured costs for all remaining qualified hospitals.

Effective October 26, 2016, all qualified hospital shall receive a payment calculated as a percent of uninsured costs multiplied by the state’s annual Disproportionate Share Hospital allotment. The percent of uninsured costs shall be the total of all uninsured costs for a qualified hospital divided by the total uninsured costs for all remaining qualified hospitals.

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit as specified in federal regulation. A respiratory hospital’s Disproportionate Share Hospital limit shall be limited to 60%. A new CICP hospital’s Disproportionate Share Hospital limit shall be limited to 20%. If upon review, the Disproportionate Share Hospital Supplemental payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider’s payment shall be reduced to the hospital-specific Disproportionate Share Hospital limit. The reduction shall then be redistributed to the other qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital limit

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based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital Limit.

Effective October 1, 2017, total funds for the Disproportionate Share Hospital (DSH) payment shall be \$172,633,510.

CICP-participating hospitals with CICP write-off costs, as published in the most recent CICP Annual Report, greater than or equal to 950% of the statewide average shall receive a payment equal to 85.5% to their estimated hospital-specific DSH limit. A Respiratory Hospital shall receive a payment equal to 45% of their estimated hospital-specific DSH limit.

A Respiratory Hospital is defined as a hospital primarily specializing in respiratory related diseases.

All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. A hospital's uninsured costs shall be for their Cost Report Year End 2015 period.

Effective July 1, 2018, an additional DSH payment shall be made such that Colorado will fully expend its final DSH allotment for federal fiscal year 2017-18.

The additional DSH payment shall be made only to qualified hospitals below 96% of their estimated hospital-specific DSH limit allocated such that hospitals with CICP write-off costs greater than 900% of the statewide average shall receive 92% of their estimated hospital-specific DSH limit, hospitals with CICP write-off costs greater than 400% of the statewide average and a Medicaid Inpatient Utilization Rate (MIUR) greater than 35% shall receive 92% of their estimated hospital-specific DSH limit, Pediatric Specialty Hospitals and hospitals with CICP write-off costs between 105% and 400% of the statewide average shall receive 30% of their estimated hospital-specific DSH limit, Critical Access Hospitals shall receive 96% of their estimated hospital-specific DSH limit, and Respiratory Hospitals shall receive 49.5% of their estimated hospital-specific DSH limit. Any remaining available DSH funds shall be allocated to qualified hospitals proportionate to their uninsured costs to total uninsured costs for all remaining qualified hospitals.

Effective October 11, 2018, total funds for the DSH payment shall be \$212,928,574.

A Respiratory Hospital shall receive a payment equal to 75% of their estimated hospital-specific DSH limit. A Pediatric Specialty Hospital shall receive a payment equal to 45% of their estimated hospital-specific DSH limit. A hospital with a MIUR less than or equal to 15% shall receive a payment equal to 10% of their estimated hospital-specific DSH limit. New CICP-participating hospitals shall receive a payment equal to 10% of their estimated hospital-specific DSH limit.

All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. A hospital's uninsured costs shall be for their Cost Report Year End 2016 period.

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Effective October 1, 2019, total funds for the DSH payment shall equal an amount such that federal DSH funds shall not exceed the allowable FFY 2019-20 Colorado DSH allotment.

Qualified hospitals with CICIP write-off costs greater than or equal to 1,000% of the statewide average and qualified Critical Access Hospitals shall receive a payment equal to at least 90% of their estimated hospital-specific DSH limit but not exceeding 100% of their estimated hospital-specific DSH limit.

Remaining qualified hospitals shall receive a payment equal to their percent of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. No remaining qualified hospital shall receive a payment exceeding 96% of their hospital-specific DSH limit as specified in federal regulation. If a remaining qualified hospital's DSH Supplemental payment exceeds 96.00% of their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital-specific DSH limit. The reduction shall then be redistributed to other remaining qualified hospitals not exceeding 96.00% of their hospital-specific DSH limit based on the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals not 96.00% of exceeding their hospital-specific DSH limit.

Notwithstanding the above, a qualified hospital with a MIUR less than or equal to 15% shall have their hospital-specific DSH limit equal to 10%. A qualified new CICIP-participating hospital shall have their hospital-specific DSH limit equal to 10%.

The state shall not exceed the total of all the hospital-specific DSH limits even if the total reimbursement is below the state's annual DSH allotment.

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Uninsured Disproportionate Share Hospital Payment

Fiscal Year	Percent of the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital payment
State Fiscal Year 2009-10	19.94%
State Fiscal Year 2010-11 July 1 - September 30, 2010	19.94%
Federal Fiscal Year 2010-11	23.14%
Federal Fiscal Year 2011-12	20.00%
Federal Fiscal Year 2012-13	21.28%
Federal Fiscal Year 2013-14	1.64%

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit (as specified in federal regulations). If upon review or audit, the Uninsured Disproportionate Share Hospital payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific DSH limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to the other qualified hospitals based on the qualified hospital proportion of uninsured cost relative to aggregate of uninsured costs of all qualified providers who do not exceed their hospital-specific Disproportionate Share Hospital limit.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after an Uninsured Disproportionate Share Hospital payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

2. Effective October 1, 2014, the Disproportionate Share Hospital adjustment commonly referred to as "Uninsured Disproportionate Share Hospital payment" is suspended.

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IV. MEDICARE UPPER PAYMENT LIMIT

- A. Effective July 1, 2001, non-state owned Government hospitals will receive additional Medicaid reimbursement up to the allowable percentage of each hospital's inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The payment will be calculated based on each hospital's inpatient Medicare base rate multiplied by the allowable Medicare Upper Payment Limit percentage, less the Medicaid base rate, times the Medicaid case mix index times the number of Medicaid discharges. In no case will the payment plus the Medicaid reimbursement exceed the funds appropriated by the Colorado General Assembly in the fiscal year for which the payments are made. Additional payments made to Government Outstate Disproportionate Share Hospitals which participate in the Colorado Indigent Care Program as defined in Attachment 4.19A (subsection Disproportionate Share Hospital Adjustments) will reduce the Disproportionate Share Hospital payments to these Government Outstate Disproportionate Share hospitals by an equal amount. Effective July 1, 2003 the payment described in this section is suspended.
- B. Colorado Determination of Individual Hospital Inpatient Medicare Upper Payment Limit Addition Reimbursement who Participate in the Colorado Indigent Care Program
1. Effective July 1, 2003 state owned government hospitals, non-state owned government hospitals and privately owned hospitals, which participate in the Colorado Indigent Care Program, will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "High-Volume payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations, there will be three allotments of the High-Volume payment: state owned government hospitals, non-state owned government hospitals and privately owned hospitals. In no case will the High-Volume payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment exceed any of these allotments. The High-Volume payment is only made if there is available federal financial participation under these allotments after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment. The High-Volume payment calculation process is outlined as follows:

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Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of March 1 each fiscal year. Medically indigent costs are inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

- a. The request budget year medically indigent costs are weighted (increased) by the following factors to measure the relative Medicaid and low-income care to the total care provided. Each provider's specific medically indigent costs are inflated (increased) by the following factors:
 - i. Percent of Medicaid (fee-for-service and managed care) days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.
 - ii. Percent of medically indigent days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.
- b. The request budget year provider specific medically indigent costs are weighted (increased) by the following factors, if they qualify, to account for disproportionately high volumes of Medicaid and low-income care provided. If the provider qualifies, the provider specific medically indigent costs are further inflated (increased) by the following factors:

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- i. **Disproportionate Share Hospital Factor.** To qualify for the Disproportionate Share Hospital Factor, the provider's percent of Medicaid days relative to total days must equal or exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.

If the provider does qualify, then the Disproportionate Share Hospital Factor will equal the provider's specific percent of Medicaid days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Disproportionate Share Hospital Factor is equal to the provider's specific percent of Medicaid days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services. If the provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.

- ii. **Medically Indigent Factor.** To qualify for the Medically Indigent Factor, the provider's percent of medically indigent days relative to total inpatient days must equal or exceed the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.

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If the provider does qualify, then the Medically Indigent Factor equals the provider specific percent of medically indigent days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Medically Indigent Factor is equal to the provider's specific percent of medically indigent days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals, the Medically Indigent Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services. If the provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.

The available allotments under the Medicare Upper Payment Limit are multiplied by the hospital specific Weighted Medically Indigent Costs divided by the summation of all Weighted Medically Indigent Costs for qualified providers in each specific allotment to calculate the High-Volume payment for the specific provider.

The High-Volume payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) plus any Pediatric Major Teaching payment will not exceed inpatient hospital Medicaid costs for Non-state owned and state owned government hospitals. Inpatient hospital Medicaid costs will be the larger of the amount of the billed charges from inpatient claims paid in the most recently available State Fiscal Year multiplied by the cost-to-charge ratio (as defined in this section) or an amount certified by the provider for the most recently available State Fiscal Year, such that both figures will be inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year. Any amount of the calculated High-Volume payment, as defined above, that exceeds inpatient hospital Medicaid costs will be added to the Low-Income payment.

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For this section, Medicaid days, medically indigent days and total inpatient days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report the requested Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

The term allotment in this section refers to the funds available under the three different Medicare UPL provider categories of state owned government hospitals, non-state owned government hospitals and privately owned hospitals. The funds available for the High-Volume payment under the Medicare Upper Payment Limit are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	\$96,515,460
State Fiscal Year 2004-05	\$81,026,824
State Fiscal Year 2005-06	\$113,040,874
State Fiscal Year 2006-07	\$105,677,834
State Fiscal Year 2007-08	\$105,953,937
State Fiscal Year 2008-09	\$114,495,800

Effective July 1, 2009 the Supplemental Medicaid Payment commonly referred to as "High-Volume payment" is suspended.

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2. Effective July 1, 2003, state owned and non-state owned Government hospitals, which participate in the Colorado Indigent Care Program, will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). This additional Medicaid reimbursement will be commonly referred to as the "UPL payment" which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed as an annual payment prior to June 30 of each state fiscal year.

As required by federal regulations, there would be two allotments for the UPL payment: state owned government hospitals and non-state owned government hospitals. In no case will the UPL payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the High Volume payment and the Pediatric Major Teaching payment exceed any of these allotments. The UPL payment is made only if there is available federal financial participation under these allotments after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the High Volume Payment and the Pediatric Major Teaching payment.

The UPL payment is calculated as the difference between the Medicare UPL provider specific allotment minus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the High Volume payment. The Medicare UPL provider specific allotment is a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare Payment Principles. The Medicare UPL provider specific allotment is made on an annual State Fiscal Year (July 1 through June 30) basis.

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The term allotment in this section refers to the funds available under the two different Medicare UPL provider categories of state owned government hospitals and non-state owned government hospitals. The funds available for the UPL payment under the Medicare UPL are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that the provider may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	\$0
State Fiscal Year 2004-05	\$0
State Fiscal Year 2005-06	\$0
State Fiscal Year 2006-07	\$0
State Fiscal Year 2007-08	\$0
State Fiscal Year 2008-09	\$0

Effective July 1, 2009 the Supplemental Medicaid Payment commonly referred to as "UPL payment" is suspended.

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3. Effective July 1, 2009, state-owned government hospitals, non-state-owned government hospitals and private-owned hospitals, which participate in the Colorado Indigent Care Program (CICP), will qualify to receive additional Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the inpatient Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "CICP Supplemental Medicaid payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal monthly installments.

Effective October 1, 2010, the CICP Supplemental Medicaid payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

The CICP Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

To qualify for the CICP Supplemental Medicaid payment a Colorado hospital shall meet the following criteria:

- a. Is licensed or certified as a General Hospital or Critical Access Hospital by the Colorado Department of Public Health and Environment; and
- b. Does participate in the Colorado Indigent Care Program.

The CICP Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data or costs for the payment period. Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of May 1 each fiscal year. Medically indigent costs are inflated forward to payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

Qualified hospitals shall receive a payment equal to the percent of inflated medically indigent costs multiplied by the hospital specific inflated medically indigent costs minus the hospital specific payment received under the CICP Disproportionate Share Hospital Payment (as described under Attachment 4.19A, Section III.D.8 Colorado Determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program). Effective October 1, 2012, hospitals can qualify for up to two increases to weight their inflated CICP costs. Weighted CICP costs are calculated separately for Urban and Rural hospitals. Urban hospitals are defined as those hospitals that are located within a federally

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designated Metropolitan Statistical Area. Rural hospitals are defined as those hospitals that are not located within a federally designated Metropolitan Statistical Area. Qualifying for, and weighting inflated CICP costs for are determined and calculated as follows:

1. CICP Cost as a Percentage of Total Cost

a. Urban hospitals whose CICP costs as a percentage of Total Costs is greater than the mean plus one standard deviation percentage for all Urban hospitals will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

b. Rural hospitals whose CICP costs as a percentage of Total Costs is greater than the mean plus one standard deviation percentage for all Rural hospitals will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

2. Medicaid and CICP Days as a Percentage of Total Days

a. Urban hospitals whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all Urban hospitals will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

b. Rural hospitals whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all Rural hospitals will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

c. For those facilities that qualify for both CICP Inflated Cost weightings, the inflated CICP cost will be increased by 2% first, and the resulting weighted CICP costs will then be increased by 5%.

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The percent of inflated medically indigent costs shall be:

- a. Effective July 1, 2009, Qualified hospitals that are classified as High Volume Medicaid and CACP Hospitals will receive 75% of their inflated medically indigent costs.

Effective October 1, 2010, Qualified hospitals that are classified as High Volume Medicaid and CACP Hospitals will receive 64% of their inflated medically indigent costs.

Effective October 1, 2011, Qualified hospitals that are classified as High Volume Medicaid and CACP Hospitals will receive 52.5% of their inflated medically indigent costs.

Effective October 1, 2012, Qualified hospitals that are classified as High Volume Medicaid and CACP Hospitals will receive 53.0% of their inflated medically indigent costs.

Effective October 1, 2013, Qualified hospitals that are classified as High Volume Medicaid and CACP Hospitals will receive 52.45% of their inflated medically indigent costs.

High Volume Medicaid and CACP Hospitals are defined as those hospitals which participate in CACP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days.

- b. Effective July 1, 2009, Qualified hospitals in a rural area (a hospital not located within a federally designated Metropolitan Statistical Area) or classified as a Critical Access Hospital will receive 100% of their inflated medically indigent costs.

Effective October 1, 2011, Qualified hospitals in a rural area (a hospital not located within a federally designated Metropolitan Statistical Area) or classified as a Critical Access Hospital will receive 75% of their inflated medically indigent costs.

Effective October 1, 2012, Qualified hospitals in a rural area (a hospital not located within a federally designated Metropolitan Statistical Area) or classified as a Critical Access Hospital will receive 70% of their inflated medically indigent costs.

Effective October 1, 2013, Qualified hospitals in a rural area (a hospital not located within a federally designated Metropolitan Statistical Area) or classified as a Critical Access Hospital will receive 77.45% of their inflated medically indigent costs.

- c. Effective July 1, 2009, All other qualified hospitals will receive 90% of their inflated medically indigent costs.

Effective October 1, 2010, All other qualified hospitals will receive 75% of their inflated medically indigent costs.

Effective October 1, 2011, All other qualified hospitals will receive 60% of their inflated medically indigent costs

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Effective October 1, 2012, All other qualified hospitals will receive 54% of their inflated medically indigent costs.

Effective October 1, 2013, All other qualified hospitals will receive 50% of their inflated medically indigent costs.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "CICP Supplemental Medicaid payment" is suspended.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a CICP Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

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- C. [Historical Reference: effective July 1, 2003 this section moved from Attachment 4.19A, Page 5-6, number 7.A. Original TN No. 97-007, superseded TN No. 95-002, Approved 11/5/97, effective 7/1/97]

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies a Major Teaching Hospital when its Medicaid days combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available.

1. A Major Teaching Hospital is defined as a Colorado hospital which meets the following criteria:
 - a. Maintains a minimum of 110 total Intern and Resident F.T.E.'s.
 - b. Maintains a minimum ratio of .30 Intern and Resident F.T.E.'s per licensed bed.
 - c. Meets the Department's eligibility requirement for disproportionate share payment.

2. The additional major teaching payment is calculated as follows:
$$MTHR = ((ICD + MD) / TPD) \times MIAF$$

Where:

MTHR = Major Teaching Hospital Rate
ICD = Indigent Care Days
MD = Medicaid Days
TPD = Total Patient Days
MIAF = Medically Indigent Adjustment Factor

To further clarify this formula the State describes the MIAF as follows:

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It is the State's intention to pay no hospital a Major Teaching Hospital Allocation that would cause a qualifying hospital to receive an average payment per Medicaid discharge which would exceed the facility's Medicare payment. The MIAF is a number which when multiplied by the numerical quotient derived from ((MD+ICD)/TPD) results in a rate which permits the State to pay a Major Teaching Hospital Allocation at a payment amount which, by design, will not exceed each individual facility's Medicare payment (applied by the State as an individual facility upper limit). The MIAF is derived from calculation of the amount determined by subtracting the average Medicaid payment per case from the average Medicare payment per case for the calculation period, and multiplying this amount by the number of Medicaid patient discharges occurring during that period.

The MIAF is based on the facility's Intern and Residents FTEs:

Intern and Resident FTEs	MIAF - 7/1/93 to 6/30/94	7/1/94 to 6/30/95
110 TO 150	.7209	.5683
151 TO 190	.3301	.9352

3. Payment calculation for hospitals which qualify for the additional Major Teaching Hospital payment shall be as follows:
 - a. Based upon data available at the beginning of each fiscal year, Colorado shall determine each hospital's ICD, MD and TPD. ICD will be extracted from the most recent available Colorado Indigent Care Program Interim Report to the Colorado General Assembly, submitted by the University of Colorado Health Sciences Center. MD and TPD will be extracted from the most recent available Colorado Hospital Association annual Data Bank information subject to validation through use of data from the Department and the Colorado Foundation for Medical Care. In addition, each hospital's Medicaid payment for the previous fiscal year shall be estimated.
 - b. Multiply the Medicaid payment by the calculated MTHR to determine the additional major teaching hospital payment.
 - c. Payment shall be made monthly. [End of Historical Reference]

Effective July 1, 2003 the Major Teaching Hospital payment described in this section is suspended.

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- D. Effective July 1, 2003 state owned government hospitals, non-state owned government hospitals and privately owned hospitals, when they meet the criteria for being a Pediatric Major Teaching Hospital will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "Pediatric Major Teaching Hospital payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations, there will be three allotments of the Pediatric Major Teaching Hospital payment: state owned government hospitals, non-state owned government hospitals and privately owned hospitals. In no case will the Pediatric Major Teaching payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) exceed any of these allotments. The Pediatric Major Teaching payment is only made if there is available federal financial participation under these allotments after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program.)

On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for a Major Pediatric Teaching Hospital payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. A Major Pediatric Teaching Hospital is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. The hospital Medicaid days combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available; and
3. Has a percentage of Medicaid days relative to total days that exceed the mean for the prior state fiscal year, or the most recent year for which data are available; and

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4. Maintains a minimum of 110 total Intern and Resident F.T.E.'s; and
5. Maintains a minimum ratio of .30 Intern and Resident F.T.E.'s per licensed bed; and
6. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

The Pediatric Major Teaching Payment is distributed equally to all qualified providers. The funds available for the Pediatric Major Teaching Payment under the Medicare Upper Payment Limit are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider, and other relevant figures specific to the provider so that providers may understand and independently calculate their payment.

Total funds available for this payment are as follows:

FY 2003-04 \$6,119,760	FY 2004-05 \$6,119,760
FY 2005-06 \$11,571,894	FY 2006-07 \$13,851,832
FY 2007-08 \$34,739,562	FY 2008-09 \$39,851,166
FY 2009-10 as follows:	
July 1, 2009-February 28, 2010	\$14,098,075
March 1, 2010-June 30, 2010	\$33,689,236
FY 2009-10 total payment:	\$47,787,311
FY 2010-11	\$48,810,278
FY 2011-12	\$38,977,698
FY 2012-13	\$18,919,698
FY 2013-14	\$17,919,698
FY 2014-15	\$19,574,772
FY 2015-16	\$19,574,772
FY 2016-17	\$19,574,772
FY 2017-18	\$19,574,772
FY 2018-19	\$19,545,908
FY 2019-20	\$19,494,398

Effective October 1, 2013, an additional \$1,000,000 Pediatric Major Teaching Payment will be made to qualifying providers on a Federal Fiscal Year (FFY) basis.

Effective October 1, 2014, the additional \$1,000,000 Pediatric Major Teaching Payment is suspended.

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E. Urban Safety Net Provider Payment

Effective April 1, 2007, non-state owned government hospitals, when they meet the criteria for being an Urban Safety Net Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide a partial reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. The additional supplemental Medicaid reimbursement will be commonly referred to as the "Urban Safety Net Provider payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Urban Safety Net Provider payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

The qualifying criteria for the Urban Safety Net Provider payment will not directly correlate to the distribution methodology of the payment. On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for an Urban Safety Net Provider payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. An Urban Safety Net Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. The hospital's Medicaid days plus Colorado Indigent Care Program (CICP) days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty-seven percent; and
3. Medicaid days and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by the Department prior to March 1 of each year for July 1 rates.

The Urban Safety Net Provider payment is distributed equally among all qualified providers. The funds available for the Urban Safety Net Provider payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services

Total funds available for this payment equal:

FY 2006-07 \$2,693,233	FY 2007-08 \$5,400,000
FY 2008-09 \$5,400,000	March 1, 2010 – June 30, 2010 \$5,410,049
FY 2010-2011 \$6,217,131	FY 2011-12 \$4,702,000
FY 2012-13 \$0	FY 2013-14 \$0

This payment is no longer funded and the information contained in this section is for historical record only.

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G. Inpatient Hospital Payment for Health Care Services

Effective April 1, 2007, State-owned government hospitals, non-State owned government hospitals, and private hospitals, when they meet the criteria for being a Provider of Inpatient Hospital Health Care Services, shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide reimbursement for uncompensated care costs related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. The additional supplemental Medicaid reimbursement will be commonly referred to as the "Inpatient Hospital Payment for Health Care Services", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The qualifying criteria for the payment will not directly correlate to the distribution methodology of the payment. The Inpatient Hospital Payment for Health Care Services is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

A Provider of Inpatient Hospital Health Care Services is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Owns and operates primary care clinics.

The funds available for the Inpatient Hospital Payment for Health Care Services under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

Payments shall be distributed based on a qualified Hospital Provider ratio of unique low-income clients who received primary care services in the previous State fiscal year relative to the total unique number of low-income clients who received primary care services for all qualified Hospital Providers in the previous State fiscal year multiplied by the appropriation for the related State Fiscal Year.

Effective July 1, 2008, payments shall be distributed based on a qualified Hospital Provider ratio of unique low-income clients who received primary care services in the previous State fiscal year and their number of visits relative to the total unique number of low-income clients who received primary care services for all qualified Hospital Providers in the previous State fiscal year multiplied by the appropriation for the related State Fiscal Year.

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Total funds available for this payment equal:

State Fiscal Year 2006-07	\$1,104,226
State Fiscal Year 2007-08	\$4,428,000
State Fiscal Year 2008-09	\$3,690,000
State Fiscal Year 2008-09	\$0

Effective September 1, 2009, this payment is suspended.

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H. Rural Hospital Payment

Effective July 1, 2007, non-state owned governmental hospitals and privately owned hospitals, when they meet the criteria for being a Rural Hospital Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. This additional supplemental Medicaid reimbursement will be commonly referred to as the "Rural Hospital payment" and will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Rural Hospital payment is made only if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

The qualifying criteria for the Rural Hospital payment will not directly correlate to the distribution methodology of the payment. A Rural Hospital Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Is not located within a federally designated Metropolitan Statistical Area (MSA); and
3. Has 60 or fewer beds.

The Rural Hospital payment is distributed based on a qualifying hospital's prior year Weighted Medically Indigent Costs relative to the sum of the total Weighted Medically Indigent Costs for all qualifying hospitals, multiplied by the appropriation for the related State Fiscal Year, as defined for the High-Volume payment. Weighted Medically Indigent Costs will be inflated forward to the payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average. The funds available for the Rural Hospital payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

Total funds available for this payment equal:

State Fiscal Year 2007-08	\$1,455,954
State Fiscal Year 2008-09	\$2,500,000
State Fiscal Year 2008-09	\$0

Effective September 1, 2009, this payment is suspended.

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I. Public Hospital Payment

Effective July 1, 2007, State owned and non-state owned government hospitals, when they meet the criteria for being a Public Hospital Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. This additional supplemental Medicaid reimbursement will be commonly referred to as the "Public Hospital payment" which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Public Hospital payment is made only if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Rural Hospital payment, and the Pediatric Major Teaching payment.

The qualifying criteria for the Public Hospital payment will not directly correlate to the distribution methodology of the payment. A Public Hospital Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Is a State-owned or non-state owned government hospital.

The Public Hospital payment is distributed based on a qualifying hospital's prior year Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualifying hospitals, multiplied by the appropriation for the related State Fiscal Year, as defined for the High-Volume payment. Weighted Medically Indigent Costs will be inflated forward to the payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average. The funds available for the Public Hospital payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

Total funds available for this payment equal:

State Fiscal Year 2007-08	\$1,455,954
State Fiscal Year 2008-09	\$2,500,000
State Fiscal Year 2008-09	\$0

Effective September 1, 2009, this payment is suspended.

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J. Inpatient Hospital Base Rate Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals paid on the Medicaid Prospective Payment System (PPS Hospitals) shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Inpatient Hospital Base Rate Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

Effective October 1, 2010, the Inpatient Hospital Base Rate Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

The Inpatient Hospital Base Rate Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment and the CICP Supplemental Medicaid payment.

Effective October 1, 2014 the Inpatient Hospital Base Rate Supplemental Medicaid Payment shall be only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), Pediatric Major Teaching payment, State University Teaching Hospital payment, and Family Medicine Residency payment.

To qualify for the Inpatient Hospital Base Rate Supplemental Medicaid payment a hospital shall meet the following criteria:

1. Has an established Medicaid base rate, as specified under 4.19A I. Methods and Standards for Established Prospective Payments Rates – Inpatient Hospital Services of this State Plan; and
2. Is not a free-standing psychiatric facility, which is exempt from the DRG-based prospective payment system.

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The Inpatient Hospital Base Rate Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be equal to the Medicaid Base Rate without Add-ons, multiplied by a percentage adjustment factor, multiplied by Medicaid discharges, multiplied by average Medicaid case mix.

Hospital specific data used in the calculation of the Inpatient Hospital Base Rate Supplemental Medicaid payment (expected Medicaid discharges, average Medicaid case mix, and the Medicaid base rate calculated prior to any Medicaid hospital specific cost add-ons) shall be the same as that used to calculate Budget Neutrality under 4.19A I. Methods and Standards for Established Prospective Payments Rates – Inpatient Hospital Services of this State Plan.

For the Inpatient Hospital Base Rate Supplemental Medicaid payment, the following definitions apply:

1. "Medicaid Base Rate without Add-ons" means the Medicaid base rate calculated prior to any Medicaid hospital specific cost add-ons.

In the event that Inpatient Hospital Base Rate Supplemental Medicaid payment calculation errors are realized after an Inpatient Hospital Base Rate Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

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Effective July 1, 2009:

1. Pediatric Specialty Hospitals shall have a 13.756% increase
2. Urban Center Safety Net Specialty Hospitals shall have a 5.830% increase
3. Rehabilitation, Specialty Acute, Rural and Urban Hospitals shall have a 18.100% increase

Effective October 1, 2010:

1. Pediatric Specialty Hospitals shall have a 16.80% increase
2. State University Teaching Hospitals shall have a 16.0% increase
3. Rehabilitation, Specialty Acute, Rural and Urban Hospitals shall have a 35.0% increase

Effective October 1, 2011:

1. Pediatric Specialty Hospitals shall have a 20.00% increase
2. State University Teaching Hospitals shall have a 31.30% increase
3. Rehabilitation and Specialty Acute Hospitals shall have a 25.00% increase
4. Rural hospitals shall have a 60.00% increase
5. Urban Hospitals shall have a 51.30% increase

Effective October 1, 2012:

1. Pediatric Specialty Hospitals shall have a 16.00% increase
2. State University Hospitals shall have a 23.00% increase
3. Urban Safety Net Hospitals shall have a 15.00% increase
4. Rehabilitation and Specialty Acute Hospitals shall have a 10.00% increase
5. Rural hospitals shall have a 75.00% increase
6. Urban Hospitals shall have a 45.00% increase

Effective October 1, 2013:

1. Pediatric Specialty Hospitals shall have a 9.50% increase
2. State University Hospitals shall have a 20.00% increase
3. Urban Safety Net Hospitals shall have a 36.00% increase
4. Rehabilitation and Specialty Acute Hospitals shall have a 10.00% increase
5. Rural hospitals and Critical Access Hospitals in Teller County shall have a 73.00% increase
6. Urban Hospitals shall have a 38.00% increase

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Effective October 1, 2014 for each qualified hospital, the percentage adjustment factor shall vary for state-owned, non-state government owned, and private hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Safety Net Specialty Hospitals, or for other hospital classifications such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit.

The percentage adjustment factor for each qualified hospital effective October 11, 2018 shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at www.colorado.gov/hcpf/bulletins.

Effective October 1, 2019 the Supplemental Medicaid Payment commonly referred to as "Inpatient Base Rate Supplemental Hospital Medicaid Payment" is suspended.

Inpatient Supplemental Medicaid Payment

Effective October 1, 2019, qualified hospitals shall receive an additional supplemental Medicaid payment commonly referred to as "Inpatient Supplemental Medicaid Payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Inpatient Supplemental Medicaid Payment is made only if there is available federal financial participation under the Inpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

The Inpatient Supplemental Medicaid Payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Inpatient Supplemental Medicaid Payment a hospital shall meet the following criteria:

1. Is licensed as a General Hospital, Critical Access Hospital, Children's Hospital, Rehabilitation Hospital, or Long Term Care Hospital by the Colorado Department of Public Health & Environment. Psychiatric Hospitals are not qualified for this payment.

For a qualified hospital, the payment shall equal total Medicaid patient days multiplied by an adjustment factor. The adjustment factor shall vary for certain hospital classifications/groups such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit.

The adjustment factor for each qualified hospital effective October 1, 2019 shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at: www.colorado.gov/hcpf/bulletins.

If Inpatient Supplemental Medicaid payment calculation errors are realized after the payment has been made, adjustments shall be made to a hospital's payment retroactively.

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K. High-Level NICU Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are certified as Level IIb or IIc Neo-Natal Intensive Care Unit (NICU) shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "High-Level NICU Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

Effective October 1, 2010, the High-Level NICU Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

The High-Level NICU Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment and the Inpatient Hospital Base Rate Supplemental Medicaid payment.

To qualify for the High-Level NICU Supplemental Medicaid payment a hospital shall meet the following criteria:

- a. Is certified as Level IIb or IIc Neo-Natal Intensive Care Unit (NICU) according to American Academy of Pediatrics guidelines by the Colorado Perinatal Care Council;
- b. Is not a High Volume Medicaid and CICP Hospital, as defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days; and
- c. Is licensed or certified as a General Hospital or Critical Access Hospital by the Colorado Department of Public Health Environment.

The High-Level NICU Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated on a per Medicaid day basis as follows:

- a. Effective July 1, 2009, qualified hospitals shall receive \$450 per Medicaid Nursery day, which includes Medicaid fee for service days and Medicaid managed-care days.
- b. Effective October 1, 2010, qualified hospitals shall receive \$2,100 per Medicaid NICU day. A Medicaid NICU day is a paid Medicaid non-managed care day for DRG 801 up to the average length of stay. Effective October 1, 2011, qualified hospitals shall receive \$2,500 per Medicaid NICU day. Effective October 1, 2012, High Volume Medicaid and CICP Hospitals can qualify for the High-Level NICU Supplemental payment if the other qualifying criteria are met.
- c. Effective October 1, 2013, qualified hospitals shall receive \$2,400 per Medicaid NICU day. A Medicaid NICU day is a paid Medicaid non-managed care day for APR-DRGs 588 (Neonate, w/ ECMO), 591 (Neonate, Birthwt 500-749G w/o Major Procedure), 593 (Neonate, Birthwt 750-999G w/o Major Procedure), 602 (Neonate, Birthwt 1000-1249G w/ Resp Dist Synd/Oth Maj Resp

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Or Maj Anom), 609 (Neonate, BWT 1500-2499G W Major Procedure), 630 (Neonate, BWT > 2499G W Major Cardiovasc Procedure), and 631 (Neonate, BWT > 2499G W Other Major Procedure) up to the average length of stay.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "High-Level NICU Supplemental Medicaid payment" is suspended.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a High-Level NICU Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

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L. State Teaching Hospital Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals qualify as a State Teaching Hospital shall receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "State Teaching Hospital Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

Effective October 1, 2010, the State Teaching Hospital Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

The State Teaching Hospital Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment, the Inpatient Hospital Base Rate Supplemental Medicaid payment and High-Level NICU Supplemental Medicaid payment.

To qualify for the State Teaching Hospital Supplemental Medicaid payment a hospital shall meet the following criteria:

- a. Is a State University Teaching Hospital, as defined under Attachment 4.19A, Section II Family Medicine Program of this State Plan;
- b. Is a High Volume Medicaid and CICP Hospital, as defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days; and
- c. Is licensed or certified as a General Hospital by the Colorado Department of Public Health Environment.

The State Teaching Hospital Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated on a per Medicaid day basis as follows:

- a. Effective July 1, 2009, qualified hospitals shall receive \$75 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).
- b. Effective October 1, 2010, qualified hospitals shall receive \$125 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days). Effective October 1, 2011, qualified hospitals shall receive \$100 per Medicaid day. Effective October 1, 2012, the State Teaching Supplemental Medicaid payment is \$0.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a State Teaching Hospital Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "State Teaching Hospital Supplemental Medicaid payment" is suspended.

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M. Acute Care Psychiatric Supplemental Medicaid Payment

Effective October 1, 2010, Colorado hospitals shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient psychiatric services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Acute Care Psychiatric Supplemental Medicaid payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Acute Care Psychiatric Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment, the Inpatient Hospital Base Rate Supplemental Medicaid payment, the High-Level NICU Supplemental Medicaid payment, and the State Teaching Hospital Supplemental Medicaid payment.

The Acute Care Psychiatric Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Acute Care Psychiatric Supplemental Medicaid payment a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health Environment.
2. Is not a free-standing psychiatric facility, which is exempt from the DRG-based prospective payment system.

Effective October 1, 2010, Qualified hospitals shall receive \$150 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care days.

Effective October 1, 2011, to qualify for the Acute Care Psychiatric Supplemental Medicaid Payment, a hospital must have a licensed distinct-part psychiatric unit. Qualified hospitals shall receive \$200 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care days.

Effective October 1, 2013, qualified hospitals shall receive \$100 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care.

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Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Acute Care Psychiatric Supplemental Medicaid payment" is suspended.

- J. Effective October 26, 2015, qualified hospitals with uninsured costs shall receive an additional supplemental Medicaid reimbursement commonly referred to as "Uncompensated Care Supplemental Hospital Medicaid payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Uncompensated Care Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Uncompensated Care Supplemental Medicaid payment a hospital shall meet the following criteria:

1. Is not licensed or certified as Psychiatric or Rehabilitation Hospital, nor is licensed as a General Hospital with a Medicare Certification Long Term by the Colorado Department of Public Health and Environment.

Qualified hospitals with twenty-five or fewer beds shall receive a payment calculated as the percentage of beds to total beds for qualified hospitals with twenty-five or fewer beds multiplied by \$23,500,000. Qualified hospitals with greater than twenty-five beds shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for qualified hospitals with greater than twenty-five beds multiplied by \$91,980,176.

Effective October 26, 2016, qualified Essential Access hospitals shall receive a payment calculated as the percentage of beds to total beds for qualified Essential Access hospitals with twenty-five or fewer beds multiplied by \$15,000,000. Qualified non-Essential Access hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for qualified non-Essential Access hospitals multiplied by \$100,480,176.

An Essential Access hospital is defined as a Colorado hospital which meets the following criteria:

1. Is a Rural Hospital or CICP Hospital, and
2. Has less than or equal to 25 beds.

Effective October 1, 2017, qualified Essential Access hospitals shall receive a payment calculated as the percentage of beds to total beds for qualified Essential Access hospitals with twenty-five or fewer beds multiplied by \$15,000,000. Qualified non-Essential Access hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for qualified non-Essential Access hospitals multiplied by \$95,480,180.

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Effective October 11, 2018, qualified Essential Access hospitals shall receive a payment calculated as the percentage of beds to total beds for qualified Essential Access hospitals with twenty-five or fewer beds multiplied by \$15,000,000. Qualified non-Essential Access hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for qualified non-Essential Access hospitals multiplied by \$92,980,176.

Effective October 1, 2019 the Supplemental Medicaid Payment commonly referred to as “Uncompensated Care Supplemental Hospital Medicaid Payment” is suspended.

Essential Access Supplemental Medicaid Payment

Effective October 1, 2019, qualified hospitals shall receive an additional supplemental Medicaid payment commonly referred to as “Essential Access Supplemental Medicaid Payment” which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Essential Access Supplemental Medicaid Payment is made only if there is available federal financial participation under the Inpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

The Essential Access Supplemental Medicaid Payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Essential Access Supplemental Medicaid Payment a hospital shall meet the following criteria:

1. Is a Rural Hospital or Critical Access Hospital; and
2. Has less than or equal to 25 licensed beds.

For a qualified hospital, the payment shall equal the percent of licensed beds to total licensed beds for all qualified hospitals, multiplied by the available Essential Access funds.

The Essential Access funds effective October 1, 2019 shall be published to the Colorado Medicaid Provider Bulletin found on the Department’s website at: www.colorado.gov/hcpf/bulletins.

If Essential Access Supplemental Medicaid Payment calculation errors are realized after the payment has been made, adjustments shall be made to a hospital’s payment retroactively.

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O. Additional Supplemental Medicaid Payments

1. Large Rural Hospital Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are located in a rural area and have 26 or more licensed beds shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Large Rural Hospital Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

Effective October 1, 2010, the Large Rural Hospital Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

To qualify for the Large Rural Hospital Supplemental Medicaid payment a hospital shall meet the following criteria:

- a. Is located in a rural area (a hospital not located within a federally designated Metropolitan Statistical Area);
- b. Have 26 or more licensed beds; and
- c. Is licensed or certified as a General Hospital by the Colorado Department of Public Health Environment.

The Large Rural Hospital Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated on a per Medicaid day basis as follows:

- a. Effective July 1, 2009, qualified hospitals shall receive \$315 per Medicaid day.
- b. Effective October 1, 2010, qualified hospitals shall receive \$600 per Medicaid day.
- c. Effective October 1, 2011, qualified hospitals shall receive \$750 per Medicaid day.
- d. Effective October 1, 2012, qualified hospitals shall receive \$750 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will receive an additional \$100 per Medicaid Day.

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- e. Effective October 1, 2013, qualified hospitals shall receive \$525 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICIP Days to Total Days is in the top 25% of all providers will receive an additional \$50 per Medicaid Day.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Large Rural Hospital Supplemental Medicaid payment" is suspended.

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2. Denver Metro Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are located in the Denver Metro Area will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement will be commonly referred to as the "Denver Metro Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

Effective October 1, 2010, the Denver Metro Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

To qualify for the Denver Metro Supplemental Medicaid payment a hospital shall meet the following criteria:

- a. Is located in the Denver Metro Area defined as Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County; and
- b. Is licensed as a General Hospital by the Colorado Department of Public Health Environment.

The Denver Metro Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each hospital, this payment shall be calculated on a per Medicaid day basis as follows:

- a. Effective July 1, 2009, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of \$400 per Medicaid day.
- b. Effective October 1, 2010, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of \$675 per Medicaid day.
- c. Effective October 1, 2011, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of \$800 per Medicaid day
- d. Effective October 1, 2012, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of \$800 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CIP Days to Total Days is in the top 25% of all providers will receive an additional \$100 per Medicaid Day.
- e. Effective October 1, 2013, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of \$770 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CIP Days to Total Days is in the top 25% of all providers will receive an additional \$50 per Medicaid Day.
- f. Effective July 1, 2009, qualified hospitals located in Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County shall receive an additional \$510 per Medicaid day

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- g. Effective October 1, 2010, qualified hospitals located in Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County shall receive an additional \$700 per Medicaid day.
- h. Effective October 1, 2011, qualified hospitals located in Boulder County, Broomfield County, Jefferson County, or Douglas County shall receive an additional \$1100 per Medicaid day.
- i. Effective October 1, 2012, qualified hospitals located in Boulder County, Broomfield County, Jefferson County, or Douglas County shall receive an additional \$1075 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICIP Days to Total Days is in the top 25% of all providers will receive an additional \$100 per Medicaid Day.
- j. Effective October 1, 2013, qualified hospitals located in Boulder County, Broomfield County, Jefferson County, or Douglas County shall receive an additional \$770 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICIP Days to Total Days is in the top 25% of all providers will receive an additional \$50 per Medicaid Day.
- k. Effective October 1, 2011, qualified hospitals located in Denver County shall receive an additional \$900 per Medicaid day.
- l. Effective October 1, 2012, qualified hospitals located in Denver County shall receive an additional \$865 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICIP Days to Total Days is in the top 25% of all providers will receive an additional \$100 per Medicaid Day.
- m. Effective October 1, 2013, qualified hospitals located in Denver County shall receive an additional \$755 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICIP Days to Total Days is in the top 25% of all providers will receive an additional \$50 per Medicaid Day.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Denver Metro Supplemental Medicaid payment" is suspended.

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3. Metropolitan Statistical Area Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are located in a federally designated Metropolitan Statistical Area outside the Denver Metro Area shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Metropolitan Statistical Area Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

Effective October 1, 2010, the Metropolitan Statistical Area Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

To qualify for the Metropolitan Statistical Area Supplemental Medicaid payment a hospital shall meet the following criteria:

- a. Is located in a federally designated Metropolitan Statistical Area outside the Denver Metro Area; and
- b. Is licensed as a General Hospital by the Colorado Department of Public Health Environment.

The Metropolitan Statistical Area Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each hospital, this payment shall be calculated on a per Medicaid day basis as follows:

- a. Effective July 1, 2009, qualified hospitals shall receive \$310 per Medicaid day
- b. Effective October 1, 2010, qualified hospitals shall receive \$600 per Medicaid day.
- c. Effective October 1, 2011, qualified hospitals shall receive \$650 per Medicaid day.
- d. Effective October 1, 2013, qualified hospitals shall receive \$550 per Medicaid day.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Metropolitan Statistical Area Supplemental Medicaid payment" is suspended.

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4. Supplemental Medicaid Payments Conditions

For the Supplemental Medicaid Payments listed in this Section (Rural Hospital Supplemental Medicaid payment, Denver Metro Supplemental Medicaid payment and Metropolitan Statistical Area Supplemental Medicaid payment) the following shall apply:

- a. The Supplemental Medicaid Payments are only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment and the Inpatient Hospital Base Rate Supplemental Medicaid payment, High-Level NICU Supplemental Medicaid payment, the State Teaching Hospital Supplemental Medicaid payment, and the Acute Care Psychiatric Supplemental Medicaid payment.
- b. Medicaid days include Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).
- c. Hospitals that qualify to receive a Supplemental Medicaid Payment shall only receive payment from one Supplemental Medicaid Payment described in this Section.
- d. Hospitals licensed or certified as psychiatric or rehabilitation, or are licensed as General Hospital with a Medicare Certification Long Term, shall not qualify to receive a Supplemental Medicaid Payment described in this Section.
- e. High Volume Medicaid and CICP Hospitals shall not qualify to receive a Supplemental Medicaid Payment described in this Section. High Volume Medicaid and CICP Hospitals are defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days.
- f. A hospital located in the Denver Metro Area is a hospital that is located in one of the following counties: Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County.
- g. In calculating the Supplemental Medicaid Payments, Medicaid days for the prior calendar year will be submitted by hospitals to the Department by April 30 of each year.
- h. In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a Supplemental Medicaid Payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

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P. Hospital Quality Incentive Payments

Effective October 1, 2012, Colorado hospitals that provide services to improve the quality of care and health outcomes for their patients may qualify to receive an additional monthly supplemental Medicaid payment. This additional supplemental Medicaid payment shall be commonly referred to as the "Hospital Quality Incentive Payment" (HQIP) which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The HQIP shall be made only if there is available federal financial participation under the Inpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

The HQIP is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for HQIP a hospital shall meet the following criteria:

1. Is licensed as a General Hospital, Critical Access Hospital, Children's Hospital, Rehabilitation Hospital, or Long Term Care Hospital by the Colorado Department of Public Health & Environment.

For each qualified hospital, the payment shall equal adjusted discharge points multiplied by dollars per-adjusted discharge point.

1. Adjusted discharge points shall equal normalized points awarded multiplied by adjusted Medicaid discharges.
 - a. Normalized points awarded shall equal the sum of points awarded, normalized for measures a hospital is not eligible to complete.
 - b. Adjusted Medicaid discharges shall equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.
 - i. The discharge adjustment factor shall equal total Medicaid charges divided by inpatient Medicaid charges. The discharge adjustment factor shall be limited to 5.
 - ii. Inpatient Medicaid discharges shall be multiplied by 125% for qualified hospitals with less than 200 inpatient Medicaid discharges.
2. Dollars per-adjusted discharge point shall be determined using a qualified hospital's normalized points awarded. Dollars per-adjusted discharge point are tiered so that qualified hospitals with more normalized points awarded receive more dollars per-adjusted point.

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Effective October 26, 2015, HQIP measures include five (5) base measures and four (4) optional measures. Hospitals can report data on up to five (5) measures annually. Hospitals that choose to participate in HQIP must report all of the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.

The base measures for HQIP are:

1. Emergency department process measure,
2. Rate of elective deliveries between 37 and 39 weeks gestation,
3. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,
4. Rate of thirty (30) day all-cause hospital readmissions, and
5. Percentage of patients who gave the hospital an overall rating of "9" or "1 O" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.

The optional measures for HQIP are:

1. Culture of safety,
2. Active participation in the Regional Care Collaborative Organization (RCCO),
3. Advance care planning, and
4. Screening for tobacco use.

The dollars per discharge point will be tiered such that hospitals with higher quality point scores will receive higher points per discharges. The dollar amount per discharge point for five (5) tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	\$13.18
2	11-20	\$14.50
3	21-30	\$15.82
4	31-40	\$17.13
5	41-50	\$18.45

Effective October 26, 2016, HQIP measures include five (5) base measures and three (3) optional measures. Hospitals can report data on up to five (5) measures annually. Hospitals that choose to participate in HQIP must report all of the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.

The base measures for HQIP are:

1. Emergency department process measure,
2. Rate of Cesarean section deliveries
3. Rate of thirty (30) day all-cause hospital readmissions,
4. Percentage of patients who gave the hospital an overall rating of "9" or "1 O" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey,
5. Culture of safety.

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The optional measures for HQIP are:

- I. Active participation in the Regional Care Collaborative Organization (RCCO),
2. Advance care planning, and
3. Screening for tobacco use.

The dollar amount per discharge point for five (5) tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	\$5.67
2	11-20	\$8.51
3	21-30	\$11.34
4	31-40	\$14.18
5	41-50	\$17.01

Effective October 1, 2017, HQIP includes seven (7) measures. Hospitals can report data on up to four (4) measures. Hospitals that choose to participate in HQIP are required to report for the first and second measures. A hospital must report data for the remaining measures in sequence. If a hospital is not eligible for a measure, then the next measure is reported. A hospital's score is normalized to a SO-point scale by dividing the hospital's earned points by 40 and multiplying by 50. Effective October 1, 2017, the measures for HQIP are:

1. Culture of safety,
2. Active participation in the Regional Care Collaborative Organization (RCCO),
3. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,
4. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey,
5. Emergency department process,
6. Advance care planning, and
7. Screening and intervention for tobacco use.

The dollar per discharge point for five (5) tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	\$5.69
2	11-20	\$8.54
3	21-30	\$11.38
4	31-40	\$14.23
5	41-50	\$17.07

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Effective October 11, 2018, HQIP includes nine (9) measures. Hospitals can report data on up to five (5) measures. Hospitals that choose to participate in HQIP are required to report for the first and second measures. A hospital must report data for the remaining measures in sequence. If a hospital is not eligible for a measure, then the next measure is reported. The measures for HQIP are:

1. Active participation in the Regional Accountable Entity and Behavioral Health Organization (BHO) activities,
2. Culture of safety/patient safety,
3. Discharge Planning (Advance Care Planning (ACP)/Transition Activities),
4. Rate of Cesarean section,
5. Breastfeeding Practices,
6. Tobacco and substance use screening and follow-up,
7. Emergency Department Process,
8. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the HCAHPS Survey, and
9. 30-day all-cause readmissions.

The dollar amount per discharge point for five (5) tiers of quality points between 0 and 80 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	0-19	\$0.00
2	20-35	\$3.13
3	36-50	\$6.26
4	51-65	\$9.39
5	66-80	\$12.52

Effective October 1, 2019, HQIP includes fifteen (15) measures separated into six (6) measure groups. A hospital is requested to complete all measures but is not required to complete a measure if they are not eligible. The HQIP measure groups and measures are:

Maternal Health and Perinatal Care Measure Group

1. Exclusive Breast Feeding
2. Cesarean Section
3. Perinatal Depression and Anxiety
4. Maternal Emergencies
5. Reproductive Life/Family Planning

Patient Safety Measure Group

6. Clostridium Difficile
7. Adverse Event
8. Falls with Injury
9. Culture of Safety Survey

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Patient Experience Measure Group

10. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

11. Advance Care Plan

Regional Accountable Entity (RAE) Engagement Measure Group

12. RAE engagement on Physical and Behavioral Health

Substance Abuse Measure Group

13. Substance Use Disorder Composite

14. Alternatives to Opioids

Addressing Cost of Care Measure Group

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The dollar amount per-adjusted discharge point for five (5) tiers of normalized points awarded between 0 and 100 are shown in the table below:

Tier	Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
1	0-19	\$0.00
2	20-39	\$2.04
3	40-59	\$4.08
4	60-79	\$6.12
5	80-100	\$8.16

Total Funds for this payment equal:

FFY 2012-13	\$32,000,000	FFY 2015-16	\$84,810,386	FFY 2018-19	\$90,496,734
FFY 2013-14	\$34,388,388	FFY 2016-17	\$89,775,895	FFY 2019-20	\$90,778,024
FFY 2014-15	\$61,488,873	FFY 2017-18	\$97,553,767		

In the event that HQIP payment calculation errors are realized after HQIP payments have been made, reconciliations and adjustments to impacted hospitals will be made retroactively.

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8. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the HCAHPS Survey, and
9. 30-day all-cause readmissions.

The dollar amount per discharge point for five (5) tiers of quality points between 0 and 80 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	0-19	\$0.00
2	20-35	\$3.13
3	36-50	\$6.26
4	51-65	\$9.39
5	66-80	\$12.52

Total Funds for this payment equal:

FFY 2012-13	\$32,000,000	FFY 2015-16	\$84,810,386	FFY 2018-19	\$90,496,734
FFY 2013-14	\$34,388,388	FFY 2016-17	\$89,775,895		
FFY 2014-15	\$61,488,873	FFY 2017-18	\$97,553,767		

In the event that HQIP payment calculation errors are realized after HQIP payments have been made, reconciliations and adjustments to impacted hospitals will be made retroactively.

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Q. Public High Volume Medicaid and CICIP Hospital Payment

Effective July 1, 2010, Colorado public hospitals that meet the definition of a High Volume Medicaid and CICIP Hospital shall qualify to receive an additional supplemental Medicaid reimbursement for uncompensated inpatient hospital care for Medicaid clients. This additional supplemental shall commonly be referred to as the "Public High Volume Medicaid and CICIP Hospital Payment."

Effective July 1, 2017, Colorado public hospitals that meet the definition of a High Volume Medicaid and CICIP Hospital shall qualify to receive an additional supplemental Medicaid reimbursement for uncompensated inpatient hospital care for Fee-For-Service (FFS) Medicaid clients, to qualify for the Public High Volume Medicaid and CICIP Hospital Payment, a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health and Environment.
2. Classified as a state-owned government or non-state owned government hospital.
3. Have at least 27,000 Medicaid Inpatient Days per year that provide over 30% of total inpatient days to Medicaid and CICIP patients.

The Public High Volume Medicaid and CICIP Hospital Payments will only be made if uncompensated Medicaid costs for inpatient hospital services calculated on a federal fiscal year basis is available for a qualified Hospital provider. Uncompensated Medicaid inpatient costs for a qualified Hospital provider is calculated as the available Medicaid inpatient Hospital costs less Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program and payments defined in Attachment 4.19A pgs. 30-57c). Total Public High Volume Medicaid and CICIP Hospital Payments will not exceed the Upper Payment Limit that has been demonstrated for the same federal fiscal year in which the uncompensated Medicaid inpatient costs has been calculated.

The Interim Payment to qualified providers will be calculated using the filed CMS 2552-10 Medicare Cost Report, or its successor, for the actual expenditure period that corresponds to the federal fiscal year used in demonstrating the Upper Payment Limit for inpatient hospital services. The Interim Payment will be disbursed annually after the actual expenditure period. Interim Payments for uncompensated Medicaid inpatient hospital costs will be calculated each federal fiscal year and paid by the following September 30th of each federal fiscal year. Uncompensated costs for providing inpatient hospital services for Medicaid clients will be calculated according to the methodology outlined below, using the filed CMS 2552-10 Medicare Cost Report, or its successor.

Final payments will be made for qualified hospitals within six months after all eligible providers have submitted their audited CMS 2552-10 Medicare Cost Report, or its successor, for the actual expenditure period.

Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed for each provider for purposes of authorizing certification. Each qualified provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Public High Volume Medicaid and CICIP Hospital Payment. The Public High Volume Medicaid and CICIP Hospital Payment will be distributed to qualified providers based on each provider's proportion of uncompensated costs for qualified providers in the class, multiplied by the available Upper Payment Limit for the class. A qualified provider shall not receive aggregated inpatient hospital Medicaid payments that exceed its certified uncompensated costs.

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Final Payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to each provider shall equal the lower of the Payment amount calculated based on uncompensated costs calculated through audited cost reports or the available amount remaining of the Medicare Upper Payment Limit for inpatient hospital services for that provider class. If payments are made in excess of a provider's uncompensated care costs. The Federal share of Final Payments made in excess of the cost of Medicaid services will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

Methodology for Calculating Uncompensated Costs for Medicaid Inpatient Hospital Services Using CMS 2552-10:

Calculating Total Inpatient Hospital Costs

Total Inpatient Hospital Routine Costs equal costs as reported on CMS 2552-10 Worksheet C, Part I, Column 1, lines 30 – 43, plus allowable costs for interns and residents costs reported on Columns 21 and 22 of Worksheet B, Part I. For hospitals that use the Special Title XIX Worksheet, which adds back the allowable interns and residents costs from Columns 21 and 22 of Worksheet B, Part I to the costs reported on the regular Worksheet C, Part I, Column 1, only the costs as reported on Special Title XIX Worksheet C, Part I, Column 1 are used. Costs recorded on lines 44 – 46 are excluded because they pertain to nursing facilities, skilled nursing facilities and long term care—none of which are inpatient hospital services.

Total Inpatient Days by Routine Cost Center are reported on Worksheet S-3, Part 1, Column 8. Observation Bed Days are to be reclassified to be included in Adults and Pediatrics. Labor and Deliver Days are also to be reclassified to be included in Adults and Pediatrics.

The Cost Per-Diem by Routine Cost Center equals Total Inpatient Hospital Routine Costs divided by Total Inpatient Days. The Adult and Pediatric Routine Center Cost Per Diem includes Observation Bed Days. Swing Beds, Nursing Facility Costs and non-medically necessary Private Room Differential Costs are excluded.

Total Inpatient Hospital Ancillary Costs are reported on Worksheet C, Part 1, Column 1, lines 50 - 92. For hospitals that use the Special Title XIX Worksheet, which adds back the allowable interns and residents costs from Columns 21 and 22 of Worksheet B, Part I to the costs reported on the regular Worksheet C, Part I, Column 1, only the costs as reported on Special Title XIX Worksheet C, Part 1, Column 1 are used.

Total Inpatient Hospital Ancillary Charges are reported on Worksheet C, Part 1, Column 8, lines 50 – 92.

The Cost-to Charge Ratio by Inpatient Hospital Ancillary Cost Center is calculated by dividing each cost center's Inpatient Hospital Ancillary Costs by its Inpatient Hospital Ancillary Charges.

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Calculating Medicaid Costs

Medicaid Patient Days for Inpatient Hospital Services are defined as paid Header Number of Service Days as reported in the MMIS for dates of service that correspond to the hospital's cost report period. The Total Header Number of Service Days is then multiplied by the percentage of Total Inpatient Days by Routine Cost Center for each cost center using Title XIX Days, Worksheet S-3, Pt. 1, Column 7, from CMS 2552-10, or its successor, to allocate inpatient days to the appropriate cost centers. University Hospital is on a State Fiscal Year, Denver Health is on a calendar year, and University of Colorado Health – Memorial Health System (UCH-MHS) is on a State Fiscal Year. Secondary Medicaid Days are defined as those days paid for Medicaid clients with a non-Medicare third party payer and are included for allowed Medicaid services under State Plan Amendment Attachment 4.19A. Medicare-Medicaid Dual Eligible Days are excluded for those days for which Medicaid reimburses only its share of the Medicare coinsurance or deductible.

Medicaid Allowable Charges for Inpatient Hospital Services are as reported in the MMIS for dates of service that correspond to the hospital's cost report period for paid charges for allowable inpatient hospital services under State Plan Amendment Attachment 4.19A. Medicaid allowable charges for Observation Beds are included in line 92. Charges for outpatient hospital services, professional services or non-hospital component services such as hospital-based providers are excluded. Allowable charges are mapped from the revenue code identified in the MMIS to the CMS cost report ancillary cost center. Medicaid Observation Bed outpatient charges that have been inaccurately recorded in inpatient cost centers are to be reclassified under Observation Bed (cost center 92) outpatient charges.

Medicaid Routine Cost Center Costs are calculated by multiplying Medicaid Patient Days by the Cost Per-Diem by Routine Cost Center.

Medicaid Ancillary Cost Center Costs are calculated by multiplying the Cost-to-Charge Ratio by Inpatient Hospital Ancillary Cost Center by the Medicaid Allowable Charges.

Medicaid Organ Acquisition Costs

Medicaid Usable Organs are identified in the provider's records as the number of Medicaid recipients who received an organ transplant.

Total Usable Organs are as reported from Worksheet D-4, Part III under the Part B cost column line 62.

Medicaid Usable Organs Ratio is calculated by dividing Medicaid Usable Organs by the hospital's Total Usable Organs.

Total Organ Acquisition Costs are from Worksheet D-4, Part III, under the Part A cost column line 61.

Medicaid Organ Acquisition Costs equal the Medicaid Usable Organs Ratio multiplied by Total Organ Acquisition Costs.

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Medicaid Inpatient Hospital Provider Fee Costs

For those hospitals that do not include hospital provider fees as an expense in their CMS 2552-10 Medicare Cost Report, or its successor, Medicaid Inpatient Provider Fee Costs are calculated separately by multiplying the total inpatient hospital provider fees collected by the State from the qualified provider multiplied by the ratio of Medicaid Patient Days for Inpatient Hospital Services as reported in the MMIS to Total Inpatient Days by Routine Cost Center as reported on Worksheet S-3, Part 1, Column 8.

Medicaid Uncompensated Inpatient Hospital Costs

Total Medicaid Inpatient Hospital Costs are the sum of Medicaid Routine Cost Center Costs, Medicaid Ancillary Cost Center Costs, Medicaid Organ Acquisition Costs, and Medicaid Inpatient Hospital Provider Fee Costs. Medicaid Inpatient Hospital Provider Fee Costs are calculated separately only for those hospitals that do not include hospital provider fees as an expense in their CMS 2552-10 Medicare Cost Report, or its successor.

Medicaid Uncompensated Inpatient Hospital Costs equal Total Medicaid Inpatient Hospital Costs less Medicaid payments from the MMIS, Medicaid supplemental payments referenced in this Attachment 4.19A, third party liability reported in the MMIS, client payments reported in the MMIS, and patient Medicaid copayments reported in the MMIS.

Federal Fiscal Year Realignment Methodology for Reported Costs

Realigns a PHV hospital's costs submitted on their Medicare Cost Report (CMS 2552-10 Form, or its successor) to a Federal Fiscal Year schedule (October 1st to September 30th). This realignment is dependent upon the PHV hospital's stated fiscal year. The following three examples will illustrate this realignment:

Example 1: Realigning PHV Hospital Costs from a Calendar Year Schedule

Suppose a PHV hospital's Cost Report Year follows a Calendar Year Schedule, as defined by January 1st to December 31st. Also, suppose the following two Cost Reports are given for this provider: Cost Report Year End (CRYE) 12/31/16 and CRYE 12/31/17.

To calculate the total costs for this PHV hospital for the Federal Fiscal Year (FFY) 2016-17. Take $\frac{1}{4}$ (October – December) of the total costs from the Cost Report for CRYE 12/31/16 and add this to $\frac{3}{4}$ (January – September) of the total costs from the Cost Report for CRYE 12/31/17. The resulting sum is the total costs for FFY 2016-17.

Example 2: Realigning PHV Hospital Costs from a State Fiscal Year Schedule

Suppose a PHV hospital's Cost Report Year follows a State Fiscal Year Schedule, as defined by July 1st to June 30th. Also, suppose the following two Cost Reports are given for this provider: CRYE 06/30/17 and 06/30/18.

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To calculate the total costs for this PHV hospital for FFY 2016-17. Take $\frac{3}{4}$ (October – June) of the total costs from the Cost Report for CRYE 06/30/17 and add this to $\frac{1}{4}$ (July – September) of the total costs from the Cost Report for CRYE 06/30/18. The resulting sum is the total costs for FFY 2016-17.

Example 3: Realigning PHV Hospital Costs from a Non-Familiar Fiscal Year Schedule

Suppose we have a PHV hospital whose Cost Report Year follows a Non-Familiar Fiscal Year Schedule, as defined as neither following a Calendar Year, State Fiscal Year, or Federal Fiscal Year Schedule. In this example, we'll be using a PHV hospital with a CRYE 04/30. Suppose the following two Cost Reports are given for this provider: CRYE 04/30/17 and CRYE 04/30/18.

To calculate the total costs for this PHV hospital for FFY 2016-17. Take $\frac{7}{12}$ (October – April) of the total costs from the Cost Report for CRYE 04/30/17 and add this to $\frac{5}{12}$ (May – September) of the total costs from Cost Report for CRYE 04/30/18. The resulting sum is the total costs for FFY 2016-17.

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services or non-hospital component services such as hospital-based providers are excluded. Allowable charges are mapped from the revenue code identified in the MMIS to the CMS cost report ancillary cost center. Medicaid Observation Bed outpatient charges that have been inaccurately recorded in inpatient cost centers are to be reclassified under Observation Bed (cost center 92) outpatient charges.

Medicaid Routine Cost Center Costs are calculated by multiplying Medicaid Patient Days by the Cost Per-Diem by Routine Cost Center.

Medicaid Ancillary Cost Center Costs are calculated by multiplying the Cost-to Charge Ratio by Inpatient Hospital Ancillary Cost Center by the Medicaid Allowable Charges.

Medicaid Organ Acquisition Costs

Medicaid Usable Organs are identified in the provider's records as the number of Medicaid recipients who received an organ transplant.

Total Usable Organs are as reported from Worksheet D-4, Part III under the Part B cost column line 62.

Medicaid Usable Organs Ratio is calculated by dividing Medicaid Usable Organs, by the hospital's Total Usable Organs.

Total Organ Acquisition Costs are from Worksheet D-4, Part III, under the Part A cost column line 61.

Medicaid Organ Acquisition Costs equal the Medicaid Usable Organs Ratio multiplied by Total Organ Acquisition Costs.

Medicaid Inpatient Hospital Provider Fee Costs

For those hospitals that do not include hospital provider fees as an expense in their CMS 2552-10 Medicare Cost Report, or its successor, Medicaid Inpatient Provider Fee Costs are calculated separately by multiplying the total inpatient hospital provider fees collected by the State from the qualified provider multiplied by the ratio of Medicaid Patient Days for Inpatient Hospital Services as reported in the MMIS to Total Inpatient Days by Routine Cost Center as reported on Worksheet S-3, Part 1, Column 8.

Medicaid Uncompensated Inpatient Hospital Costs

Total Medicaid Inpatient Hospital Costs are the sum of Medicaid Routine Cost Center Costs, Medicaid Ancillary Cost Center Costs, Medicaid Organ Acquisition Costs, and Medicaid Inpatient Hospital Provider Fee Costs. (Medicaid Inpatient Hospital Provider Fee Costs are calculated

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separately only for those hospitals that do not include hospital provider fees as an expense in their CMS 2552-10 Medicare Cost Report, or its successor.)

Medicaid Uncompensated Inpatient Hospital Costs equal Total Medicaid Inpatient Hospital Costs less Medicaid payments from the MMIS, Medicaid supplemental payments referenced in this Attachment 4.19A, third party liability reported in the MMIS, client payments reported in the MMIS, and patient Medicaid copayments reported in the MMIS.

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Inpatient Hospital Services

There may be positive incentive payments, based on provider performance for episodes of care as described in Attachment 4.19-A, Episode Based Payments.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
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Effective Dates for Reimbursement Rates for Specified Services

Reimbursement rates for the services listed below on this Attachment 4.19-B introduction page are effective for services provided on or after the corresponding effective date. All payment rates can be found on the official website of the Department of Health Care Policy and Financing at <https://www.colorado.gov/hcpf/provider-rates-fee-schedule>

Service	Attachment	Effective Date
3. Laboratory and Radiology Services	Attachment 4.19-B	July 1, 2020
4.b. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	Attachment 4.19-B, Page 1 of 1	January 1, 2021
4.c. Family Planning	Attachment 4.19-B	July 1, 2020
4.d. Tobacco Cessation Counseling for Pregnant Women	Attachment 4.19-B	July 1, 2020
5.a.2.a. Physician Services – Comprehensive fee schedule	Attachment 4.19-B	July 1, 2020
5.a.2.b. Physician Services – Alternative Payment Model Code Set	Attachment 4.19-B	July 1, 2020
5.b. Medical and Surgical Services Furnished by a Dentist	Attachment 4.19-B, Page 1 of 1	July 1, 2020
6.d. Services Provided by Non-Physician Practitioners	Attachment 4.19-B	July 1, 2020
7.A.-B. Home Health Care Services	Attachment 4.19-B, Page 1 of 7	July 1, 2020
7.C. Durable Medical Equipment	Attachment 4.19-B, Pages 2a and 2b of 7	July 1, 2020
8. Private Duty Nursing Services	Attachment 4.19-B	July 1, 2020

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Service	Attachment	Effective Date
9. Clinic Services	Attachment 4.19-B, Page 1-3 of 4	July 1, 2020
10. Dental Services	Attachment 4.19-B, Page 1 of 3	July 1, 2020
11. Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services	Attachment 4.19-B	July 1, 2020
12.b. Dentures	Attachment 4.19-B	July 1, 2020
12.c. Prosthetics	Attachment 4.19-B	July 1, 2020
12.d. Eyeglasses and Contact Lenses	Attachment 4.19-B	July 1, 2020
13.c. Preventive Services - Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Attachment 4.19-B	July 1, 2020
13.d. Rehabilitative Services: Substance Use Disorder Treatment	Attachment 4.19-B	January 1, 2021
13.d. Rehabilitative Services: Behavioral Health Services	Attachment 4.19-B	April 1, 2021
13.d. Rehabilitative Services: Mental Health and Substance Abuse Rehabilitation Services for Children	Attachment 4.19-B, Page 1-2 of 2	July 1, 2020
19. Targeted Case Management: Persons with a Developmental Disability	Attachment 4.19-B, Page 1-2 of 2	July 1, 2020
19.a. Targeted Case Management: Outpatient Substance Use Disorder Treatment	Attachment 4.19-B, Page 1 of 2	July 1, 2020
19.b. Targeted Case Management: Transition Services	Attachment 4.19-B, Page 1 of 1	July 1, 2020

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Effective Dates for Reimbursement Rates for Specified Services

Service	Attachment	Effective Date
20. Extended Services for Pregnant Women (Prenatal Plus Program)	Attachment 4.19-B	July 1, 2020
24.a. Transportation	Attachment 4.19-B	July 1, 2020
28. Freestanding Birth Center Services	Attachment 4.19-B	July 1, 2020

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER
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2a. OUTPATIENT HOSPITAL SERVICES (continued)

1. Medicaid Outpatient Hospital Reimbursements for Colorado Providers Effective October 31, 2016.

The Agency uses the Enhanced Ambulatory Patient Groups (EAPG) to classify OPPS services. Under the EAPG system, the payment of outpatient hospital services will include packaging of like services into groups (EAPGs) with similar resource use.

The EAPG Payment formula per line is as follows:

The lower submitted charges or the EAPG Adjusted Relative Weight multiplied by the Hospital-specific Base Rate.

a. To pay outpatient services under EAPG, the Department of Health Care Policy and Financing:

i. Uses a combination of sources for the calculation of EAPG Relative Weights, which describe relative resource intensity of services covered within the EAPG system. The Department of Health Care Policy and Financing calculates an EAPG Relative Weight using billed charges from MMIS outpatient hospital claims data and CMS-2552-10 Cost Report information. If insufficient claims data exist to calculate an EAPG Relative Weight, the Department of Health Care Policy and Financing uses a national standard EAPG Relative Weight developed by the 3M Corporation for the EAPG software version currently in use. Any modified EAPG Relative Weight for the purposes of payment calculation becomes the EAPG Adjusted Relative Weight. The EAPG Relative Weights effective October 31, 2016 are published at www.colorado.gov/hcpf.

ii. Calculates Hospital-specific Base Rate for each hospital using the following method:

1. Assign each hospital to one of the following peer groups based on hospital type and location. Pediatric hospitals are always assigned to the Pediatric Hospitals peer group, regardless of location:
 - a. Pediatric Hospitals
 - b. Urban Hospitals
 - c. Rural Hospitals
2. Process state fiscal year 2015 outpatient hospital claims using Colorado EAPG specifications and the EAPG Relative Weights calculated in the

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Episode Based Payments

Purpose: Medicaid has established Colorado-specific Episode-Based Payments. Episode Based Payments:

1. Support Colorado's shift to value-based purchasing by rewarding high quality care and outcomes;
2. Encourage clinical effectiveness;
3. Encourage referral to providers who deliver high-quality care, when provider referrals are necessary;
4. Use episode-based data to evaluate the costs and quality of care delivered and to apply incentive payments; and
5. Establish Principal Accountable Providers (PAPs) for defined episodes of care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive payments are available at the Colorado Medicaid Bundled Payment website available at www.colorado.gov/hcpf/committees-boards-and-collaboration and are effective for the performance period beginning October 1st, 2020.

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

Episodes: An "episode" is 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 Colorado Bundled Payment website located at www.colorado.gov/hcpf/committees-boards-and-collaboration.

PAPs: A PAP is the provider who is held accountable for both the quality and cost of care delivered to a patient for an entire episode. The State, in consultation with clinical experts, designates a PAP based on factors such as decision-making responsibilities, influence over other providers, and episode expenditures.

Payments: Subject to the incentive payments described below, providers, including PAPs, deliver care to eligible beneficiaries and are paid in accordance with the Medicaid reimbursement methodology in effect on the date of service.

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. Thresholds may be reviewed annually by the State using historical data that is at a minimum, two years prior to the performance period, in order to account for updates to the episode definitions or changes in practice patterns. PAPs are compared to the thresholds posted on the website at www.colorado.gov/hcpf/committees-boards-and-collaboration.

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- The commendable benchmark is the specific dollar value for each episode such that a provider with a reimbursement below the dollar value is eligible for a positive incentive payment if all quality metrics linked to the incentive payment are met. This value is set based on a PAP's historical experience with a minimum savings rate factored in.

Episode Risk Adjustment: Each episode will be evaluated for the need of risk adjustment by actuarial experts. For episodes, which actuarial experts determine that risk adjustment is necessary, adjustments will be applied to enable comparison of a PAP's episodes to their Thresholds if there is high variability in episode costs. Risk adjustments are episode specific as described on the Colorado Medicaid Bundled Payment website at www.colorado.gov/hcpf/committees-boards-and-collaboration.

Incentive Payments: Episode Based 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 the episode. 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 and equal 50% of the difference between the average episode expenditures and the applicable threshold as described below. The 50% risk-sharing percentage applies equally to both positive incentive payments. 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.

- **Positive Incentive Payments:** If the PAP's average episode reimbursement is lower than commendable threshold and the PAP meets the quality requirements established by Medicaid for a given episode type, Medicaid will issue an incentive payment to the PAP. This incentive payment will be based on the difference between the PAP's average episode reimbursement and their specific commendable threshold. The commendable threshold for positive incentive payments will have minimum savings rate applied to ensure PAPs are lowering costs and improving the quality of care delivered. 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.
- **No Incentive Payments:** If the average episode reimbursement is between the acceptable and commendable thresholds, the PAP will not incur a positive incentive payment.

Episodes: Effective for those specific episodes with an end date on or after October 1st, 2020, 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 Bundled Payment website available at www.colorado.gov/hcpf/committees-boards-and-collaboration.

- Maternity

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER
TYPES OF CARE**

2a. OUTPATIENT HOSPITAL SERVICES (continued)

weight development process. For lines with incomplete data, estimations of EAPG Adjusted Relative Weights will be used.

3. Calculate costs from hospital charge data obtained from Colorado's MMIS using the computation of the ratio of costs to charges from the CMS-2552- 10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Relative Weights are aggregated by peer group and are used to form peer group base rates.
4. For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Relative Weights. If the projected payment exceeds a +/-10% difference from the proportion of that hospital's costs to peer group costs applied to the outpatient budget, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%.
 - a. Out of State hospitals will be designated to a Rural or Urban peer group depending on location and will receive a base rate of 90% of the respective peer group base rate. No cost-dependent cap will be applied.
5. Effective July 1, 2017, all hospital-rates as calculated in sections 1-4 of this subsection will be increased by 1.4%.
6. Effective July 1, 2018, all hospital-rates as calculated in sections 1-5 of this subsection will be increased by 1%.
7. Effective July 1, 2019, all hospital-rates as calculated in sections 1-6 of this subsection will be increased by 1%.
8. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided at Critical Access Hospitals and Medicare Dependent Hospitals and decreased by 3.47% for drugs provided at non-independent urban hospitals.
9. Effective July 1, 2020, all hospital-rates as calculated in sections 1-8 of this subsection will be decreased by 1%.

III. Uses the EAPG software to assign line items to EAPGs. EAPGs can have the following types:

1. Per Diem
2. Significant Procedure. Subtypes of Significant Procedures are:
 - a. General Significant Procedures
 - b. Physical Therapy and Rehabilitation
 - c. Mental Health and Counseling
 - d. Dental Procedure
 - e. Radiologic Procedure
 - f. Diagnostic Significant Procedure
3. Medical Visit
4. Ancillary

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2a. OUTPATIENT HOSPITAL SERVICES (continued)

5. Incidental
 6. Drug
 7. Durable Medical Equipment
 8. Unassigned
-
- iv. Uses the EAPG software to determine when payment for a line assigned a Significant Procedure EAPG type should be consolidated. A consolidated payment will be calculated using an EAPG Adjusted Relative Weight of 0. Payment may not be consolidated when a procedure or service is distinct or independent from other services performed on the same day. Otherwise, a payment is consolidated when:
 1. The same Significant Procedure EAPG is present on another line for that visit, or
 2. The procedure is determined to be clinically similar to another EAPG present for that visit on the claim.
 - v. Uses the EAPG software to determine when payment should be packaged. A packaged payment will be calculated using an EAPG Adjusted Relative Weight of 0. A payment for a line is packaged when:
 1. The assigned EAPG is considered an ancillary service to a Significant Procedure or Medical Visit EAPG present on the claim for that visit and its cost is included into the EAPG Relative Weight, except for instances of additional undifferentiated medical visits/services present on the claim, or
 2. The assigned EAPG is a Medical Visit and is present with a Significant Procedure EAPG.
 - a. Lines assigned a Medical Visit EAPG are not packaged when only Physical Therapy and Rehabilitation or Radiologic Significant Procedure EAPG types are present on other lines for that visit.
 - vi. Uses the EAPG software to calculate the following discounts for any non-packaged or non-consolidated payments. The types of discounting and percentages are as follows:
 1. Multiple Surgery / Significant Procedure – 100%, 50%, then 25%
 - a. For Multiple Significant Procedures of the same subtype on the same visit:

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2a. OUTPATIENT HOSPITAL SERVICES (continued)

- i. Payment for a line assigned the Significant Procedure EAPG of that subtype with the highest EAPG Relative Weight will be calculated using an EAPG Adjusted Relative Weight of 100% of that EAPG's Relative Weight.
 - ii. Payment for a line assigned the Significant Procedure EAPG of that subtype with the next highest EAPG Relative Weight will be calculated using an EAPG Adjusted Relative Weight of 50% of that EAPG Relative Weight.
 - iii. Payment for all remaining lines assigned Significant Procedure EAPGs of that subtype will be calculated using an EAPG Adjusted Relative Weight of 25% of that EAPG's Relative Weight.
- 2. Bilateral Pricing – 150%
 - a. Payments for lines describing bilateral services may be calculated using an EAPG Adjusted Relative Weight of 150% of that EAPG Relative Weight or EAPG Adjusted Relative Weight calculated by discounting. Bilateral discounting occurs after Multiple Significant Procedure Discounting.
- 3. Repeat Ancillary Procedures – 50%, then 25%
 - a. For multiple lines assigned the same ancillary procedure EAPGs on a visit on a claim:
 - i. Payment for the first occurrence will be calculated using an EAPG Adjusted Relative Weight of 100% of the EAPG Relative Weight.
 - ii. Payment for the second occurrence will be calculated using an EAPG Adjusted Weight of 50% of the EAPG Relative Weight.

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2.a. OUTPATIENT HOSPITAL SERVICES (continued)

4. Terminated Procedures – 50%

- a. Payment for lines describing terminated procedures may be calculated using an EAPG Adjusted Relative Weight of 50% of that EAPG's Relative Weight. Terminated procedures cannot be considered bilateral procedures for the purpose of discounting. Terminated procedures are not subject to other types of discounting.

5. 340B Drug Discounting – 80%

- a. Payment for lines describing 340B drugs may be calculated using an EAPG Adjusted Relative Weight of 80% of that EAPG's Relative Weight.
- ii. Uses the EAPG software to determine if multiple visits are present on the claim. Visits are differentiated based on the date of service of each line item. Claims with revenue codes describing emergency room or specialty services may be considered single visits.
- b. Outpatient physical therapy services shall be reimbursed under the EAPG methodology.
- c. Outpatient occupational therapy services shall be reimbursed under the EAPG methodology.
- d. Outpatient speech/language therapy services shall be reimbursed under the EAPG methodology.
- e. Outpatient laboratory/pathology services shall be reimbursed under the EAPG methodology.
- f. Outpatient radiology services shall be reimbursed under the EAPG methodology.

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2a. OUTPATIENT HOSPITAL SERVICES (continued)

- e. Outpatient laboratory/pathology services shall be reimbursed under the EAPG methodology.
 - f. Outpatient radiology services shall be reimbursed under the EAPG methodology.
 - g. Outpatient nuclear medicine/computerized tomography scans shall be reimbursed under the EAPG methodology.
 - h. Any service not listed here is reimbursed under the existing state plan methodology elsewhere in this section.
2. Effective August 11, 2018, for services meeting the criteria of select Outpatient Hospital Physician Administered Drugs, as defined by the list of drugs included in the Colorado Department of Health Care Policy and Financing's billing manual accessed through the Department's web site, that would have otherwise been compensated through the EAPG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved and the drug is administered to the patient, then the hospital must submit an invoice showing the actual acquisition cost of the drug before payment will rendered by the Department. The Department will pay the provider 72% of the net invoice cost.
- 3-6. These sections are reserved for future use.

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OUTPATIENT HOSPITAL SERVICES (continued)

7. Public Hospital Outpatient Adjustment

Effective October 10, 2001, all publicly owned (state and local) hospitals shall qualify for a public hospital outpatient rate adjustment up to the allowable percentage of each hospital's outpatient Medicare Upper Payment Limit. For purposes of this rate adjustment, the Medicare Upper Payment Limit will be equal to a reasonable estimate of the amount that would be paid for these services using Medicare payment principles."

The payment will be calculated based on each hospital's inflated outpatient charges, times the Medicare ratio of cost to charges, times the net difference between the allowable percentage of the Medicare Upper Payment Limit and the Medicaid outpatient reimbursement percentage of 72%.

This is a prospective payment system. The charge and payment data will be two-year old historical data available at the time of rate setting. This cost and payment data will be inflated forward to the payment period using the most recent available CPI-W, Medical Care for Denver. The cost to charge ratios will be historical data from the most recently audited Medicare cost reports available at the time of rate setting.

Any other Medicare Upper Payment Limit reimbursements and Disproportionate Share Hospital reimbursements to that hospital for the same services will be subtracted from the amount available for additional reimbursement. The reimbursement will be an amount that will not exceed the allowable percentage of the Medicare Upper Payment Limit for outpatient services. The allowable percentage of the Medicare Upper Payment Limit will not exceed 100%, unless a higher percentage is allowed by an Act of Congress or the Centers for Medicare and Medicaid Services.

Effective July 1, 2009 the Outpatient Hospital adjustment commonly referred to as "Public Hospital Outpatient Adjustment" is suspended.

8. Supplemental Medicaid Outpatient Hospital Payment

Colorado hospitals shall qualify to receive an additional supplemental Medicaid reimbursement for outpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Upper Payment Limit for outpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Supplemental Medicaid Outpatient Hospital payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Supplemental Medicaid Outpatient Hospital payment is only made if there is available federal financial participation under the Upper Payment Limit for outpatient hospital services after the

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Medicaid reimbursement (as defined under number 1 of this Section of attachment 4.19B as a Medicaid Outpatient Hospital Reimbursements for Colorado Providers).

To qualify for the Supplemental Medicaid Outpatient payment a hospital shall meet the following criteria:

- a. Is licensed or certified as a General Hospital by the Colorado Department of Public Health and Environment; and
- b. Provides outpatient hospital services to Medicaid clients.

Inflated hospital specific outpatient billed costs are calculated by converting hospital specific outpatient hospital billed charges (as extracted from the MMIS Decision Support System [DSS]) multiplied by the ancillary cost center cost-to-charge ratio (CCR) calculated from the hospital's most recently filed CMS 2552-96 or CMS 2552-10 available as of the time of payment calculation and inflated forward to the payment year using by the Outpatient Hospital PPS Market Basket and adjusted by the utilization adjustment factor. The utilization adjustment factor is the predicted change in outpatient hospital utilization as a function of changes in Medicaid caseload, and is calculated as follows:

Using ordinary least-squares linear regression, a trend line is established using

- Outpatient hospital visits extracted from the MMIS-DSS from state fiscal year 2005 to the most recent state fiscal year,
- Medicaid caseload excluding dual eligibles from state fiscal year 2005 to the most recent state fiscal year as published in the Department's annual February 15 Budget Amendments, and
- The Medicaid caseload estimate excluding dual eligibles for the payment year as published in the Department's annual February 15 Budget Amendments.

The percent change in the trend line for outpatient hospital visits will be the utilization adjustment factor.

For each qualified hospital, the Supplemental Medicaid Outpatient Hospital payment shall be calculated as inflated hospital specific outpatient costs multiplied by a percentage adjustment factor. The percentage adjustment factor may vary for state-owned, non-state government owned, and private hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. By December 1 of the payment year the percentage adjustment factor for each hospital will be published in the Colorado Medicaid Provider Bulletin.

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Payment to Urban Center Safety Net Specialty hospitals may be dispensed such that more than one installment may be paid in one month. At no time will payments be disbursed prior to the state fiscal year or federal fiscal year for which they apply.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a Supplemental Medicaid Payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

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OUTPATIENT HOSPITAL SERVICES (continued)

9. Supplemental Medicaid Outpatient High-Volume Small Rural Hospital Payment

Effective October 1, 2011, the Supplemental Medicaid Outpatient High-Volume Small Rural Hospital Payment is suspended.

10. Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs incurred by an individual hospital for Medicaid managed care clients are carved out of managed care payments and shall be paid directly to Hospitals with a Graduate Medical Education program rather than to regional accountable entities (RAEs) and managed care organizations (MCOs) for Outpatient Services. GME, like other allowable costs, is a component of the hospital base rate.

- a. The most recently audited Hospital Medicare/Medicaid Cost Report (CMS 2552) available as of March 1 each fiscal year shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are recalculated each year.
- b. MCOs and RAEs shall provide reports to the Department consisting of Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service on a quarterly basis. To provide more time for claim runoff, these reports shall be provided to the Department no later than 120 days after the close of each calendar year quarter (see table below for exact dates).

Calendar Year - Quarter	Reports contain utilization for	Due Date: (120 days after end of quarter)
Calendar Year-Q1	January - March	July 31st
Calendar Year-Q2	April - June	October 31st
Calendar Year-Q3	July - September	January 31st
Calendar Year-Q4	October - December	April 30th

- c. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs and RAEs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. Please see tables 1 and 2 which identify the data sources and calculations used to create GME MCO hospital payments.

The GME reimbursement shall be paid at least annually through a lump sum payment to each Hospital by June 30th of each year.

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OUTPATIENT HOSPITAL SERVICES (continued)

TABLE 1: Calculations for Outpatient (OP) Cost to Charge Ratio, Inpatient (IP) Graduate Medical Education (GME) Cost/Day and Inflation Factor for Current Year			
Data Point	Data Point Name	Sample Data	Data Source / Calculations
F	Total GME Routine Costs	\$75,000.00	CMS 2552: Worksheet B Part I, Columns 21 and 22 (Interns and Residents), Inpatient Routine Service Cost Centers.
G	Total GME Ancillary Costs	\$24,000.00	CMS 2552: Worksheet B Part I, Columns 21 and 22 (Interns and Residents), Ancillary Service Cost Centers plus Outpatient Service Cost Centers (<u>allowable cost centers only</u>).
H	Inpatient Ratio	0.247101	CMS 2552: Equals: Worksheet C Part I, Title XIX, Column 6 (Inpatient Charges) Line 202 (Total) divided by Worksheet C Part I, Title XIX, Column 8 (Total Charges) Line 202 (Total).
I	Inpatient Ancillary Costs	\$5,930.42	CMS 2552: Equals: Column G (Total GME IP Ancillary Costs) times Column H (IP Ratio).
J	Total GME Costs	80,930.42	CMS 2552: Equals: Column F (Total GME Routine Costs) plus Column I (IP Ancillary Costs).
N	Total Inpatient Days	1,000	CO MMIS: Medicaid Internal Reports Total IP Days on Paid Claims based on same time period of most recently audited CMS 2552.
O	Total Billed Charges	16,836,437	CO MMIS: Medicaid Internal Reports Total OP Charges on Paid Claims based on same time period of most recently audited CMS 2552.
Q	Outpatient Cost to Charge Ratio	0.000352	Calculation: Outpatient Cost to Charge Ratio (Column J / Column O)
R	Inpatient Graduate Medical Expense Cost/Day	\$5.93	Calculation: Inpatient GME Cost/Day (Column J / Column N)
S	Inflation Factor Current Year	1.03	Calculation: Actual Regulation Market Basket Updates from CMS (Inpatient Hospital PPS Table)
This report includes input from hospitals' most recently audited CMS 2552 cost report as of March 1 in current year as well as Medicaid program days from the State's MMIS system.			

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OUTPATIENT HOSPITAL SERVICES (continued)

TABLE 2: SAMPLE GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE UTILIZATION		
Provider Name	HOSPITAL ABC	Calculations & Data Sources used to create MCO utilization GME payment
Provider Number	99999999	Colorado Medicaid Provider Number
NPI	99999999999	National Provider Identifier (NPI)
Quarter/Year	Q1-2019	Quarter and Year based on Calendar Year
MCO A Inpatient Days	1	Number produced from quarterly utilization reports created by Managed Care Organization A
MCO A Outpatient Charges	\$10,000.00	Number produced from quarterly utilization reports created by Managed Care Organization A
MCO B Inpatient Days	1	Number produced from quarterly utilization reports created by Managed Care Organization B
MCO B Outpatient Charges	\$10,000.00	Number produced from quarterly utilization reports created by Managed Care Organization B
Total Inpatient Days	2	Add all inpatient days from MCE utilization for Hospital ABC together here
Total Outpatient Charges	\$20,000.00	Add all outpatient charges from MCE utilization for Hospital ABC together here
Inpatient Rate	\$80.93	IP GME Cost/Day from Table 1
Outpatient Reimbursement Rate	72%	Percentage of reimbursement see Attachment 4.19-B; Item 2a. Outpatient Hospital Services; paragraph 10.c.
Outpatient Cost to Charge Ratio	0.00481	OP Cost to charge Ratio from Table 1
Inflation Factor	1.03000	Inflation Factor Current Fiscal Year from Table 1
Inflated Inpatient Rate	\$83.36	Inflated Inpatient Rate (Inpatient Rate * Inflation Factor)
GME Inpatient Payment	\$166.72	Total Inpatient Days * Inflated Inpatient Rate
GME Outpatient Payment	\$69.22	Total Outpatient Charges * Outpatient Reimbursement Rate * Outpatient Cost to Charge Ratio
GME TOTAL PAYMENT	\$235.94	Hospital ABC's Total Payment for Quarter
The calculation includes input from the hospitals' most recently audited CMS 2552 cost report as of March 1 in current year as well as Medicaid program days from the State's MMIS system.		

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

General:

1. All participating FQHCs, including freestanding and hospital-based centers, will be subject to the payment methodologies described in section 702(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106 – 554.
2. New freestanding FQHCs will file a preliminary FQHC cost report with the Colorado Department of Health Care Policy and Financing (Department). Cost and visit data from the preliminary report will be used to set the FQHC's reimbursement rate for the first year.
3. A physical health encounter, a dental encounter, and a specialty behavioral health encounter on the same day and at the same location shall count as three separate visits. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.
4. A FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for the pharmacy and shall be reimbursed for prescriptions through this number. A FQHC that operates its own pharmacy that serves Medicaid clients will not be reimbursed using the Prospective Payment System (PPS) described in the following section for pharmacy services.

Prospective Payment System (PPS):

5. PPS rates are increased annually by the Medicare Economic Index (MEI) inflation factor and adjusted to account for any increase or decrease in the scope of such services furnished by the center or clinic. Reference Approved State Plan Amendment, attachment 4.19-B, methods and standards for establishing payment rates – FQHCs, pages I-F – I-I, Paragraphs 19-27, for methodology for obtaining change to the PPS for a scope of service change.
6. The Department will use reasonable cost and visit data from the first cost report submitted with cost and visit data from the first full fiscal year after a freestanding FQHC enrolls with Colorado Medicaid to set the finalized PPS rate.
7. Reimbursement rates for out-of-state FQHCs will be their PPS per visit rate established by the state Medicaid agency in the state the FQHC is located.

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8. Certain services provided by a FQHC are not eligible for PPS rate reimbursement. These services provided by the FQHC are not considered FQHC services and are not to be considered in calculations pertaining to the PPS. In such cases, the Department will reimburse the FQHC at the Colorado Medicaid Fee Schedule rate. These services include, but are not limited to, the following:
- a. Services rendered in an inpatient hospital setting, reference Approved State Plan Amendment, attachment 4.19-B, item 5a, Physician Services, and attachment 4.19-B, item 6d, Services Provided by Non-Physician Practitioners, for respective payment methodologies;
 - b. Dental services provided in an outpatient hospital setting, reference Approved State Plan Amendment, attachment 4.19B, item 10, Dental Services, for dental services payment methodology;
 - c. The Prenatal Plus Program, reference Approved State Plan Amendment, attachment 4.19-B, item 20, extended services for pregnant women, for the Prenatal Plus Program payment methodology; and
 - d. The Nurse Home Visitor Program, reference Approved State Plan Amendment, attachment 4.19-B, item 19, methods for establishing payment rates for Nurse Home Visitor Program targeted case management services, for payment methodology.
 - e. Dentures and partial dentures, reference Approved State Plan Amendment, attachment 4.19-B, item 12b, Dentures, for dentures and partial dentures payment methodology.

Reimbursement for Items Outside of PPS

9. FQHCs are reimbursed for Long Acting Reversible Contraceptives (LARCs) separate from their PPS encounter rate. In addition to payment at the FQHC encounter rate for the insertion of the device(s), FQHCs are eligible to be reimbursed for the cost of the device(s); reference Approved State Plan Amendment, attachment 4.19-B, item 12a, Pharmaceutical Services, for payment methodology. The cost of LARC device(s) billed separate from the encounter rate will not be used to calculate the FQHC's APM rate.

Alternative Payment Methodology (APM) 1 – Value Based Payment:

10. All participating FQHCs, including freestanding and hospital-based centers, are required to file annual cost reports with the Department. Audited cost data from these reports will be used to set yearly FQHC reimbursement rates under an alternative payment method. The

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Department will determine and assure that the payments are based upon, and cover, the reasonable costs of providing services to Medicaid beneficiaries.

11. The alternative payment methodology will be agreed to by the Department and the FQHC, and will result in payment to the FQHC of an amount that is at least equal to the Prospective Payment System (PPS) rate.
12. Effective July 1, 2018, the APM rates are 100% of Reasonable Cost. Separate rates shall be calculated for dental services, physical health services, and specialty behavioral health services.
13. Beginning in State Fiscal Year 2020-2021, the State will change payment for the Physical Health and Specialty Behavioral Health encounter rates for FQHCs. A portion of the Physical Health and Specialty Behavioral Health cost based rates are at-risk based on the FQHC's quality modifier. A FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year. The quality indicators and calculation of the quality modifier are published at www.colorado.gov/hcpf. The baseline for the quality performance is the Calendar Year before the performance period. The State will provide a tool that FQHCs can use to determine the final Physical Health and Specialty Behavioral Health rates at www.colorado.gov/hcpf using the FQHC's quality modifier. An example timeline for the application of the quality modifier is listed below for State Fiscal Year 2020-2021:
 - a. In Calendar Year 2018, FQHCs will select quality measures through an online tool.
 - b. A Quality Modifier will be calculated based on performance on the selected quality measures in Calendar Year 2019.
 - c. The Department will notify each FQHC of their Quality Modifier prior to July 1, 2020.
 - d. In State Fiscal Year 2020-2021, the Quality Modifier will be multiplied to the Final Physical Health Rate and Specialty Behavioral Health rate to increase, maintain, or decrease the encounter payment for Physical Health and Specialty Behavioral Health Services.
14. The calculation methodology of the APM rate for both freestanding and hospital-based FQHCs is the same, and each FQHC will have its own rates calculated. The Department's hired cost report auditor will determine each FQHC's APM rates by utilizing the following steps:
 - a. Physical Health Rate

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- Step 1:** Calculate the Current Year Inflated Physical Health Rate. The Current Year Inflated Physical Health Rate is calculated by using the FQHC's current annual costs and visits from the most recent audited Medicaid cost report for physical health services and associated administrative costs and inflating that figure by the MEI inflation factor.
- Step 2:** Calculate the Inflated Physical Health Base Rate. The Physical Health Base Rate is calculated by taking a weighted average of the FQHC's costs and visits for the past three years. The Physical Health Base Rate is recalculated every year, and is inflated by the MEI to get the Inflated Physical Health Base Rate.
- Step 3:** Calculate the lower of the rate determined in Step 1 and Step 2 to establish a rate for 100% of Reasonable Costs. The rate for 100% of Reasonable Costs, the Physical Health APM rate, is calculated as the lesser of the Current Year Physical Health Inflated Rate and the Inflated Physical Health Base Rate.
- Step 4:** Effective July 1, 2020, adjust the Physical Health APM rate based on the FQHC's quality modifier.
- Step 5:** The FQHC will be reimbursed the Physical Health APM rate for physical health services.
- b. Specialty Behavioral Health Rate: The Specialty Behavioral Health rate shall be calculated utilizing the same methodology described in 14.a Physical Health utilizing costs and visits from the most recent audited cost report for specialty behavioral health services and associated administrative costs.
- c. Dental Rate: The Dental rate shall be calculated utilizing the same methodology as described in 14.a Physical Health using costs and visits from the most recent audited cost report for dental services and associated administrative costs. The Dental Rate shall not be adjusted by the FQHC's current quality modifier as described in Step 4.
- d. PPS Reconciliation
- Step 1:** Calculate the Current Year Inflated Rate. The Current Year Inflated Rate is calculated by using the FQHC's current annual costs and visits from the most recent audited Medicaid cost report for all services reimbursed by the Department and associated administrative costs and inflating that figure by the MEI inflation factor.

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Step 2: Calculate the Inflated Base Rate. The Base Rate is calculated by taking a weighted average of the FQHC's costs and visits for the past three years. The Base Rate is recalculated every year, and is inflated by the MEI to get the Inflated Base Rate.

Step 3: Calculate the lower of the rate determined in Step 1 and Step 2 to establish a rate for 100% of Reasonable Costs. The rate for 100% of Reasonable Costs, the APM rate, is calculated as the lesser of the Current Year Inflated Rate and the Inflated Base Rate.

Step 4: Effective July 1, 2020, adjust the APM rate based on the FQHC's quality modifier.

Step 5: Compare the APM rate to the PPS rate. If the APM rate is lower than the PPS rate, the Department will compare the amount paid under APM 1 to what would have been reimbursed under the PPS per visit encounter rate. If the amount paid is lower than the amount that would have been paid under the PPS per visit encounter rate, the Department will make an annual, one-time payment 6 months after the FQHC's rate period has ended to make up the difference.

15. FQHCs with no associated costs or visits for specialty behavioral health services and/or dental services shall be paid for these services, if provided, at the Physical Health Rate. A Specialty Behavioral Health Rate and/or Dental Rate will be set when associated costs and visits are included in the FQHC's annual cost report.
16. For new freestanding FQHCs, data from the preliminary cost report is used to set preliminary APM rates. Final APM rates will be set based on the FQHCs first full audited cost report showing actual data from its first fiscal year of operations as a FQHC.
17. If services furnished by a FQHC to a Medicaid eligible recipient are paid by a managed care entity at a rate less than the established rate, a supplemental payment equal to the difference between the rate paid by the managed care entity and the established rate times the number of visits shall be made quarterly by the managed care entity. When supplemental payments are made by the managed care entity to the FQHC, the individually affected FQHC must agree to this payment methodology. Managed care entities are required to reimburse FQHCs at an amount not less than the higher of the APM rate or the PPS rate. The Department will collect reporting no less than quarterly to ensure that full payment has been received by the FQHCs.
18. FQHCs that do not choose APM 1 will be paid their PPS per visit rate.

Scope-of-Service Rate Adjustments:

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19. If a FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate to adhere to Section 702(b) of BIPA.
20. A FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC, subject to all of the following:
- a. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.
 - b. The reported cost adheres to the reasonable cost principles set forth in 42 CFR §413 and 45 CFR §75.
 - c. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.
 - d. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.
21. A FQHC must apply to the Department by written notice within ninety (90) days of the end of the fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. For a scope-of-service rate adjustment to be considered, the change in scope of service must have existed for at least a full six (6) months. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.
22. Should the scope-of-service rate application for one year fail to reach the threshold described in Paragraph 20d above, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. A FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-

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service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

23. The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

- a. The Department's application form for a scope-of-service rate adjustment, which includes:
 - i. The provider number(s) that is/are affected by the change(s) in scope of service;
 - ii. A date on which the change(s) in scope of service was/were implemented;
 - iii. A brief narrative description of each change in scope of service, including how services were provided both before and after the change; and
 - iv. An attestation statement;
- b. The Department's data section form for a scope-of-service rate adjustment;
- c. Detailed documentation and/or cost reports that substantiate the data in the aforementioned forms; and,
- d. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, this may delay implementation of any approved scope-of-service rate adjustment.

24. The reimbursement rate for a scope-of-service change will be calculated as follows:

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- a. The Department will verify the total reasonable costs and visits associated with the change in scope, and use those data to develop a costs/visits rate associated with the change in scope.
 - b. The Department will calculate an adjusted PPS rate. This adjusted PPS rate will be the average of the current PPS rate and the rate associated with the change in scope, weighted by visits. The “current PPS rate” means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.
 - c. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate, and verify that the adjusted PPS rate meets the 3% threshold described in Paragraph 20d above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.
 - d. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.
25. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC’s fiscal year end.
26. Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified and calculated through an audit or review process.
- a. If this occurs, the Department may request the relevant documentation, as described in Paragraph 23 above, from the FQHC. The FQHC will then have ninety (90) days from the date of the request in which to provide the requested documentation.
 - b. The rate adjustment methodology will be the same as described in Paragraph 24 above.
 - c. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented.

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Included with the notification letter will be a rate-setting statement sheet, if applicable.

- d. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

27. A FQHC may appeal the Department's decision regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. If the Department fails to act on an application for a rate adjustment within one hundred twenty (120) days of submission by the FQHC, the application will be deemed to be denied. To appeal the decision, a FQHC must file a written appeal that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER
TYPES OF CARE**

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS (Page 1 of 2)

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

 Additional Other Provider-Preventable Conditions identified below: None. The State is adopting the baseline approach.

Payment Adjustment Methodology

The State uses the following methodology to adjust payments for the occurrence of provider-preventable conditions:

No payment is made for any medical service billed for Other Provider Preventable Conditions, which areas described in the "Other Provider Preventable Conditions" section. If, during retrospective review, the State finds any Other Provider Preventable Condition that was billed and reimbursed, the State will recover the reimbursement through a claim adjustment.

In the event that individual cases are identified before the provider-preventable conditions policy is fully implemented on July 1, 2012, the State shall adjust reimbursements according to the methodology above.

In compliance with 42 CFR 447.26(c), the State assures the following:

1. There is no reduction in payment for a Provider Preventable Condition that existed before treatment had begun for that patient by that provider.
2. The State reduces provider payment for Provider Preventable Conditions only when:

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2. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

c. Federally Qualified Health Center services – maternity services.

There may be positive incentive payments, based on provider performance for episodes of care as described in Attachment 4.19-B, Episode Based Payments.

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- a. The identified Provider Preventable Condition would otherwise result in an increase in payment.
 - b. The State can reasonably isolate for nonpayment the portion of the payment directly related to the Provider Preventable Condition and its treatment.
3. Non-payment for Provider Preventable Conditions does not prevent access to services for Medicaid beneficiaries.

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INDIAN HEALTH SERVICES**

Payments to Indian health facilities that are federally recognized and either tribally-operated or operated by the Indian Health Service shall be made according to the following categories of service:

**A. Outpatient Hospital, Clinic, Independent Laboratory, Outpatient Pharmacy and EPSDT
Categories of Service –**

Payments to Indian health facilities under these categories of service shall be per visit/encounter and based upon the approved rates published each year in the *Federal Register* by the U.S. Department of Health and Human Services' Indian Health Service, under the authority of Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). The Department shall accept submission of and make payments for multiple visit/encounter claims for different types of service provided to a client on the same date of service by the same Indian health facility only if the services provided are different or are for different diagnosis codes with the exception of pharmacy claims. A maximum of one encounter payment per client per date of service will be provided for pharmacy claims. The pharmacy encounter rate includes reimbursement for the dispensing fee, ingredient cost, and any necessary counseling by the pharmacist. Different types of service shall include but not be limited to general practitioner services, mental health services, podiatry services, optometry services, radiology services, laboratory services, and dental services.

B. Inpatient Hospital Category of Service –

Payments to Indian health facilities under this category of service shall be per date of inpatient stay and based upon the approved rates published each year in the *Federal Register* by the U.S. Department of Health and Human Services' Indian Health Service, under the authority of Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). The Department shall make only one payment per date of service per client.

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5. Reimbursement for Prostheses

Prostheses are reimbursed the lower of charges or maximum reasonable cost. Reasonable cost is defined as the maximum allowable amount established by the Department or, when a maximum allowable amount has not been established for an item, provider's invoice cost plus 20% plus freight.

6. Billing and payment of oxygen supplies and services for nursing facility Medicaid residents.

A. Effective with the service month of March 1, 1991, all oxygen supplies except oxygen provided by oxygen concentrators (when owned by nursing facilities) shall no longer be reimbursed by the Medicaid program on the nursing home claim form. Oxygen concentrator expenses (when owned by the nursing facility), shall continue to be reimbursed on the nursing home claim as specified in Section X.1.B. below.

1. Liquid, piped in and gaseous oxygen, as well as equipment and supplies provided by the medical equipment supplier for administration in a nursing facility, shall be billed directly to the Department's Fiscal Agent by the medical supply provider.
2. The Medicaid supplier shall bill the Medicaid program based upon information provided by the nursing home, using the appropriate HCPCS codes relating to liquid/gaseous oxygen or the equipment/supplies necessary for its administration. Reimbursement shall be made in accordance with the Department's fee schedule or the provider's usual and customary charges, whichever is lower.

B. Oxygen concentrators purchased by nursing facilities.

1. Oxygen concentrators purchased by nursing home providers on or after March 1, 1991 shall be billed on the nursing home claim form at a fee of \$175.00 per month of service. All supplies, equipment and service costs associated with the concentrators (purchased after March 1, 1991) are to be covered by the \$175.00 per month fee.
2. Payment of the \$175.00 per month fee shall only continue through service date February 28, 1992. After this date payment through the nursing home claim form shall no longer be made.

TN # 96001
SUPERSEDES TN # 91-10 APPROVAL DATE 01/11/94 EFFECTIVE DATE 7/1/95
10/01/95

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8. Rural Health Clinic Services-Reimbursement shall be made according to the following:
- A. For provider clinics, payment will be made on a cost per visit basis according to the principles specified in the appropriate Medicare regulations. A "provider clinic" is a clinic which is an integral part of an institution which participates in Medicare. Such a clinic must also be operated under common licensure, governance and professional supervision with other departments of the institution.
 - B. For any clinic that is not a "provider clinic," and does not furnish any ambulatory services other than rural health clinic services, payment will be at the reasonable cost per visit rate established for the clinic by the Medicare carrier.
 - C. Ambulatory services covered by the program which are not rural health services will be reimbursed according to the approved level for such services. Rural health clinic services, however, will be paid at the Medicare reimbursement rate as specified above.
 - D. The rural health clinic service rate per visit will be subject to reconciliation after the close of the reporting period.
 - E. The rural health clinic service rate per visit is also subject to HHS screening guidelines or tests of reasonableness.
 - F. Effective January 1, 2001, the payment methodologies for rural health clinics will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554. The State will continue paying a per visit rate to each rural Health clinic based on 100% of reasonable cost as the allowed alternative payment methodology, but reserves the right to conform to the BIPA 2000 requirements Prospective Payment System (PPS). The alternative payment methodology will be agreed to by the State and the rural health clinic, and will result in payment to the rural health clinic of an amount that is at least equal to the Prospective Payment System payment rate. The State will annually recalculate the clinic or center reasonable cost per visit for fiscal years 1999 and 2000 plus the Medicare Economic Index for primary care

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services to insure that the alternative rate is at least equal to or greater than the PPS rate. New rural health clinics will be paid at the appropriate Medicare rate.

- G. In the case of any rural health clinic that contracts with a managed care organization, supplemental payments will be made pursuant to a payment schedule agreed to by the State and the rural health clinic, but in no case less frequently than every 4 months, for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the higher of the alternative payment methodology and the prospective payment system.
- H. Effective April 1, 2015, the Department of Health Care Policy and Financing will reimburse Long Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices separate from the Rural Health Clinic per visit rate. Reimbursement will be the lower of: 340B acquisition costs; Submitted charges; or, fee schedule for LARC or transcervical permanent contraceptive devices as determined by the Department of Health Care Policy and Financing. Rural Health Clinics will be paid using the Medicaid fee schedule rates posted at <https://www.colorado.gov/hcpf/provider-rates-fee-schedule> and last updated July 1, 2014.

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3. LABORATORY AND RADIOLOGY SERVICES

A. Laboratory services shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Fee schedule for laboratory services as determined by the Department of Health Care Policy and Financing.

B. Radiology services shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Fee schedule for radiology services as determined by the Department of Health Care Policy and Financing.

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.

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METHODS AND STANDARDS FORESTABLISHING PAYMENT RATES

A. Reimbursement Methodology for School-Based Health and Related Services

School-based services, known as School Health Services (SHS) in Colorado, are delivered by the school districts, Boards of Cooperative Educational Services (BOCES) and K-12 educational institutions (herein after referred to as "providers" for this section of the State Plan), and include the following Medicaid 1905(a) services:

1. Physicians Services
2. Nursing Services
3. Personal Care Services
4. Psychology Services
5. Counseling Services
6. Social Work Services
7. Orientation, Mobility, and Vision Services
8. Speech-Language Services
9. Audiology Services
10. Occupational Therapy (OT)
11. Physical Therapy (PT)
12. Specialized Transportation

All costs described within this methodology are for Medicaid services provided by qualified personnel or a qualified health care professional that have been approved under Attachment 3.1-A of the Medicaid state plan.

B. Direct Medical Payment Methodology

Providers will be paid on a cost basis. Providers will be reimbursed interim rates for SHS direct medical services. On an annual basis a district-specific cost reconciliation and cost settlement for all over and under payments will be processed.

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The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The provider-specific interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period.

Participating SHS districts are reimbursed interim payments based on a monthly rate calculated according to a one-twelfth methodology. The monthly rate shall be based on the districts actual, certified costs identified in their most recently filed annual cost reports from prior fiscal years. For a new participating district, the monthly rate shall be calculated based on statewide historical data. Interim payments shall be tied to claims submissions by the district. Interim payments under the SHS Program are calculated prior to the school year beginning and are divided into twelve equal monthly installments, to be paid July 1 through June 30.

C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:
 - a. School Health Services cost reports received from school districts, BOCES, and K-12 educational institutions;
 - b. Colorado Department of Education (CDE) Unrestricted Indirect Cost Rate (UICR);
 - c. Random Moment Time Study (RMTS) Activity Code 4B (Direct Medical Services), Activity Code 4C (Free Care or Direct Medical Service pursuant to other medical plans of care) and Activity Code 10 (General Administration):
 - i. Direct Medical Services RMTS percentage
 - ii. Free Care RMTS percentage
 - d. School district, BOCES, and K-12 educational institutions specific Medicaid Ratios:
 - i. Medicaid Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) Ratio
 - ii. Medicaid Ratio for Other Medical Plan(s) of Care

D. Data Sources and Cost Finding Steps

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The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Costs for transportation personnel are reported as defined in Section E. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts, BOCES, and K-12 educational institutions in the Code of Colorado Regulations, excluding transportation personnel. These direct costs will be calculated on a district-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically related purchased services, supplies and materials. These direct costs are accumulated on the annual School Health Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited Chart of Account records kept at the school district, BOCES, and K-12 educational institutions level. The Chart of Accounts is uniform throughout the state of Colorado. Costs will be reported on an accrual basis.

- a. Direct Medical Services
Non-federal cost pool for allowable providers consists of:
 - i. Salaries;
 - ii. Benefits;
 - iii. Medically-related purchased services; and
 - iv. Medically-related supplies and materials

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2. Indirect Costs: Indirect costs are determined by applying the school district's specific Unrestricted Indirect Cost Rate (UICR) to its adjusted direct costs. Colorado public school districts and BOCES use predetermined fixed rates for indirect costs. Colorado Department of Education (CDE) has, in cooperation with the United States Department of Education (DOE), developed an indirect cost plan to be used by school districts and BOCES in Colorado. Pursuant to the authorization in 34 CFR §75.561(b), CDE approves unrestricted indirect cost rates for school districts for the DOE, which is the cognizant agency for school districts. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate

- a. Apply the Colorado Department of Education Cognizant Agency UICR applicable for the dates of service in the rate year.
 - b. The UICR is the unrestricted indirect cost rate calculated by the Colorado Department of Education.
3. Time Study Percentages: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on IEP/IFSP, other medical plans of care, or where medical necessity has been otherwise established direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The RMTS methodology will utilize one cost pool for direct medical services which includes all eligible staff and other medical services providers. The RMTS will generate the Direct Medical Services time study percentages; one for Direct Medical Services pursuant to an IEP/IFSP and one for Direct Medical Services pursuant to other medical plans of care. The two Direct Medical Service time study percentages will be applied to only those costs associated with direct medical services to generate a Direct Medical Service cost amount for services provided pursuant to an IEP/IFSP and a Direct Medical Services cost amount for services provided pursuant to other medical plans of care for each cost pool. The direct medical services costs and time study results must be aligned to ensure proper cost allocation. The CMS approval letter for the time study will be maintained by the State of Colorado and CMS.
 4. Medicaid Ratio Determination: Two distinct Medicaid ratios will be established for each participating school district. When applied, these ratios will discount the associated Direct Medical Service cost pools by the percentage of Medicaid enrolled students.

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- a. Medicaid IEP Ratio: The Medicaid IEP Ratio will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to an IEP/IFSP. The names, gender, and birthdates of students with an IEP/IFSP will be identified from the December 1 Count Report and matched against the Medicaid enrollment file to determine the percentage of those that are enrolled for Medicaid. The numerator of the rate will be the number of Medicaid enrolled students with an IEP/IFSP and the denominator will be the total number of students with an IEP/IFSP. The IEP ratio will be calculated for each district/BOCES or K-12 educational institutions participating in the SHS program on an annual basis.
 - b. Medicaid Enrollment Ratio for Other Medical Plans of Care: The Medicaid Enrollment Ratio for Other Medical Plans of Care will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to medical plans of care other than an IEP/IFSP. The names, gender, and birthdates of all students from the October 1 Count Report and matched against the Medicaid enrollment file to determine the percentage of those that are enrolled for Medicaid. The numerator of the rate will be the number of Medicaid enrolled students and the denominator will be the total number of students. The Medicaid Enrollment Ratio for Other Medical Plans of Care will be calculated for each district/BOCES or K-12 educational institutions participating in the SHS program on an annual basis.
5. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each school district, BOCES, or K-12 educational institutions for Direct Medical Services.
- E. Specialized Transportation Services Payment Methodology
- Providers will be paid on a cost basis. Providers will be reimbursed interim rates for SHS Specialized Transportation services at the lesser of the provider's billed charges or the statewide enterprise interim rate. Interim payments are based on a monthly rate calculated according to a one-twelfth methodology further described in section B of this document. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.
- Transportation may be claimed as a Medicaid service when the following conditions are met:
1. Special transportation is specifically listed in the IEP as a required service;

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2. The child required transportation in a vehicle adapted to serve the needs of an individual with a disability;
3. A Medicaid eligible service is provided on the day that the specialized transportation is billed; and
4. The service billed only represents the costs associated with the one-way trip on the specially adapted transportation for direct medical services as listed in the IEP/IFSP.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Insurance
8. Contract Use Cost
9. Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district, BOCES, and K-12 educational institutions level. The Chart of Accounts is uniform throughout the State of Colorado. Costs will be reported on an accrual basis.

Special education transportation costs include those for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities (Colorado State Board of Education, Department of Education 2251-R-4 Rules).

When school districts, BOCES, or K-12 educational institutions are not able to discretely identify the special education transportation cost from the general education transportation costs, a special education transportation cost discounting methodology will be applied. A rate will be established and applied to the total transportation cost of the school district, BOCES, or K-12 educational institutions. This rate will be based on the Total IEP Special Education Students in District Receiving Specialized Transportation divided by the Total Students in District Receiving Transportation. The result of this rate (%) multiplied by the Total School District, BOCES, or K-12 Educational Institutions Transportation Cost for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of Medicaid Enrolled Special

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Education IEP One-Way Trips divided by the total number of Special Education IEP One-Way Trips. This data will be provided from bus logs. The process will ensure that only one-way trips for Medicaid enrolled Special Education children with IEP's are billed and reimbursed for.

F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal year. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the non-federal share.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due 120 days after the close of the quarter ending June 30. The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SHS Cost Reports are subject to a desk review by The Department or its designee.

H. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual SHS Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

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For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

I. The Cost Settlement Process

For services delivered for a period covering July 1st, through June 30th, the annual SHS Cost Report is due 120 days after the close of the quarter ending June 30, with the cost reconciliation and settlement processes completed no later than September 30th (15 months after the fiscal year end).

If a provider's interim payments exceed the actual, certified costs of the provider for school health services to Medicaid clients, the provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for school health services exceed the interim Medicaid payments, The Department will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

The Department shall issue a notice of settlement that denotes the amount due to or from the provider.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
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4.b EPSDT Services

A. For medically necessary services not otherwise provided under the State Plan but available to EPSDT participants, reimbursement shall be the lower of the following:

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

B. For medically necessary services provided by dentists and unsupervised licensed dental hygienists not otherwise provided under the State Plan but available to EPSDT participants, reimbursement shall be the lower of the following

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

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.

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4.c. Family Planning

A. Family planning services shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Fee schedule as determined by the Department of Health Care Policy Financing.

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.

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4.d. Tobacco Cessation Counseling for Pregnant Women

Tobacco Cessation Counseling for Pregnant Women is reimbursed at the lower of the following:

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

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
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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 and fee schedule. 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.
 1. PCMPs participating in the ACC and meeting an APM volume threshold of \$30,000 or more per year in payments for procedures in the APM Code Set rendered between March 1, 2017 and February 28, 2018 will be paid in accordance with paragraph 5.a.2.b in State Fiscal Year 2020-2021.
 2. PCMPs participating in the Statewide Innovation Model or the Comprehensive Primary Care Plus and receive payment equal to the highest payment available to any PCMP participating in the APM.

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- iv. Beginning State Fiscal Year 2019-2020, the Department will publish a fee schedule with the base rate for the procedure codes in the APM Code Set, which will be 96% of the Health First Colorado fee schedule rate for the procedure codes and is the minimum of what any PCMP participating in the APM may receive.
- v. 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 Calendar Year 2019.
 - 1. The baseline for the quality performance is Calendar Year 2018.
 - 2. Beginning October 1, 2019, PCMPs participating in the ACC and meeting an APM volume threshold of \$30,000 or more per year in payments for procedures in the APM Code Set, rendered between March 1, 2017 and February 28, 2018, will select quality measures through an online tool at <https://www.colorado.gov/pacific/hcpf/primary-care-payment-reform-3>. PCMPs may select their quality measures through January 31, 2020; 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 between April and June 2020, for each PCMP based on the PCMP's performance on the selected quality measures in Calendar Year 2019.
 - 4. Each PCMP will receive a letter with their quality modifier prior to July 1, 2020. 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.
- vi. Effective for dates of service provided on or after July 1, 2020, 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, but will not reduce rates for services within the APM Code Set to less than APM Code Set fee schedule rate. 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

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Health First Colorado fee schedule. Increases or decreases in provider rates will be made annually at the beginning of the state fiscal year (July 1) through provider specific changes per code. PCMPs participating in the Statewide Innovation Model or the Comprehensive Primary Care Plus will receive the highest payment available to any PCMP participating in the APM.

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

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.

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5. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

- a. Physician services – maternity services.

There may be positive incentive payments, based on provider performance for episodes of care as described in Attachment 4.19-B, Episode Based Payments.

Reimbursement Template -Physician Services**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415****Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate as provided by Deloitte that is identified as being in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

The supplemental payments will be calculated on a claim-by-claim basis. Quarterly supplemental payments will be the sum of the claim-by-claim calculated payments. For each claim, the total amount paid to the provider by all sources (Medicaid, Medicare, copay, and third party payors) will be used when calculating the supplemental payment. A supplemental payment of zero would be assigned for the claim if the provider has already received a total payment equal to or greater than the target rate. The target rate would be calculated as outlined in the 1202 final, corrected rule and will be determined to be the lesser of the two values described below:

1. the greater of the 2009 Medicaid rate and the applicable 2013 or 2014 Medicare rate (depending on date of service); or
2. the provider billed charges.

By comparing total payments made to the provider for the individual claim, the supplemental payment should not exceed the target rate. This protocol will, however, result in Part B payments that are higher than the lesser of payments stipulated in other parts of the State Plan. The intent of the 1202 supplemental payment is to provide higher payments to providers, so Part B claims for the designated CPT and HCPCs codes will be paid according to the 1202-related State Plan Amendment rather than the standard lesser of State Plan protocol.

The state does not plan to adjust the Medicare fee schedule during the calendar year.

- ☐ The rates reflect all Medicare site of service and locality adjustments.
- ☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- ☒ The rates reflect all Medicare geographic/locality adjustments.
- ☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

TN No. 13-004

Supersedes

TN No. NEWApproval Date 6/4/2013Effective Date 1/1/2013

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

- ☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- ☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19B Physician Services of the State plan and the minimum payment required at 42 CFR 447.205.

Supplemental payment is made: ☐ monthly ☒ quarterly

Primary Care Services Affected by this Payment Methodology

- ☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

- ☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99206-99210	99216	99227-99230	99237	99240	99246-99250	99256-99280	99286-99290
99293-99303	99311-99314	99317	99319-99323	99329-99333	99338-99340	99346	99351-99353
99358-99359	99361-99362	99365-99380	99388-99390	99398-99400	99405	99410	99413-99419
99421-99459	99470	99473-99474	99481-99484	99487-99499			

- ☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224-99226 (added 1/1/2011), 99406-99407 (1/1/2012), 99408-99409 (added 8/11/2010), 99420 (added 8/01/2011), 99485-99486 (added 1/1/2013)

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

TN No. 13-004

Supercedes

TN No. NEW

Approval Date 6/4/2013

Effective Date 1/1/2013

- ☐ Medicare Physician Fee Schedule rate
- ☒ State regional maximum administration fee set by the Vaccines for Children program
- ☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

- ☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.
- ☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \$6.50.
- ☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment**E & M Services**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published at <http://www.colorado.gov/hcpf>

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published at

<http://www.colorado.gov/hcpf>

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

TN No. 13-004

Supersedes

TN No. NEWApproval Date 6/4/2013Effective Date 1/1/2013

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6.d. SERVICES PROVIDED BY NON-PHYSICIAN PRACTITIONERS

Services provided by non-physician practitioners shall be reimbursed at the lower of the following:

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

Telemedicine Services

Distant Site Transmission Fee: Services provided via telemedicine by non-physician practitioners 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 services provided by non-physician practitioners 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.

TN: 18-0019

Approval Date: June 18, 2018

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Services Provided by Non-Physician Practitioners – maternity services.

There may be positive incentive payments, based on provider performance for episodes of care as described in Attachment 4.19-B, Episode Based Payments.

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METHODS AND STANDARDS FOR ESTABLISHING PROSPECTIVE PAYMENT RATES-
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6. Private Duty Nursing – Private Duty Nursing services provided to eligible clients by Medicaid certified home health agencies shall be reimbursed in units of one hour.

The unit rate is the lower of billed charges or the maximum rate established by the State Medicaid agency.

Unit rates were originally based on prevailing rates for private duty care in Colorado, adjusted to the client's acuity level. The acuity level for each client's care was calculated by the State Medicaid agency and a corresponding rate was applied. Over time, the acuity levels were adjusted to account for the increased cost of providing services, until all clients were at the maximum rate level.

There is a maximum rate for R.N. services and a maximum rate for L.P.N. services. The maximum rates are increased whenever the Colorado General Assembly authorizes and appropriates rate increases.

Reduced maximum rates are also established for one nurse providing Private Duty Nursing to more than one client at the same time in the same setting. These rates were originally based on eighty percent of the rates for one to one Private Duty Nursing, and are increased whenever the Colorado General Assembly authorizes and appropriates rate increases.

Effective March 15, 2002, public home health agencies shall be reimbursed for Private Duty Nursing Services up to 100% of the Medicare Home Health Prospective Payment System Low-Utilization Payment Adjustment for Skilled Nursing Services.

TN No. 02-005

Supersedes

TN No. 98-001

Approval Date 05/23/02 Effective Date 3/15/02

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7. HOME HEALTH CARE SERVICES

A. Payment rates for the home health services are established as follows:

1. The unit of reimbursement for skilled nursing, physical therapy, occupational therapy, and speech/language pathology home health services is one visit up to two and one half hours in length.
2. Home health aide services are billed in basic and extended units. A basic unit is the first part of a visit up to one hour. The extended units are additional increments up to one-half hour each for visits lasting more than one hour. All basic units and all extended units must be at least 15 minutes in length to be reimbursable.
3. The unit of reimbursement for Home Health Telehealth services is one calendar day. The Home Health Agency is reimbursed for one initial visit per client each time the monitoring equipment is installed in the home, and is reimbursed a daily rate for each day the telehealth monitoring equipment is used to monitor and manage the client's care.
4. The cost of supplies used during visits by home health agency staff for the practice of universal precautions, excluding gloves used for bowel programs and catheter care, is included in the maximum unit rate.

B. Home health care services provided by home health providers are reimbursed at the lower of the following:

1. Submitted charges; or
2. Home health fee schedule determined by the Department of Health Care Policy and Financing

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.

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7. HOME HEALTH CARE SERVICES

C. Durable medical equipment (DME) and supplies are reimbursed at the following:

1. Those DME items not subject to section 1903(i)(27) of the Social Security Act., and supplies, are reimbursed at the lower of the following:
 - a) Submitted charges; or
 - b) Fee schedule for durable medical equipment and supplies as determined by the Department of Health Care Policy and Financing.
2. DME subject to the limit described in Section 1903(i)(27) of the Social Security Act, are reimbursed at 100% of the applicable Medicare rates as published by Medicare effective January of 2018, June of 2018, and then January of each year after starting in 2019.
 - a) For items of DME provided in Medicare Competitive Bidding Areas (CBAs) where rates for specific items have been competitively bid under the Medicare program, the rate is set at the lower of the following:
 - i. The Medicare single payment amount specific to the Colorado geographic area where the item is being provided; or
 - ii. The submitted charge.
 - b) Reimbursement for DME provided in rural areas, the rate is set at the lower of the following:
 - i. The Medicare DMEPOS fee schedule rate for Colorado geographic, rural areas; or
 - ii. The submitted charge.
 - c) Reimbursement for DME provided in non-rural areas, is set at the lower of the following:
 - i. The Medicare DMEPOS fee schedule rate for the Colorado geographic, non-rural areas; or

TN# **18-0008**

APPROVAL DATE June 11, 2018

SUPERSEDES TN# **17-0044**

EFFECTIVE DATE: January 1, 2018

- ii. The submitted charge.
3. DME and supplies that require manual pricing are reimbursed at the lower of the following:
- a) Submitted charges;
 - b) Manufacturer's suggested retail price (MSRP) less 17.51 percent;
 - c) Actual invoiced acquisition cost plus 20.70 percent when no MSRP is available.

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.

TN# **18-0030**

SUPERSEDES TN# **18-0008**

APPROVAL DATE July 23, 2018

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7. HOME HEALTH CARE SERVICES

E. Supplemental Payments for Public Home Health Agencies

Effective July 1, 2008, public home health agencies will receive supplemental Medicaid payments (Public Home Health Agency Supplemental Payment) to provide reimbursement to public providers for uncompensated care related to home health services for Medicaid clients. Public home health agencies will certify their uncompensated cost for providing home health services for Medicaid clients based on the Department's demonstration of the uncompensated Medicaid cost calculations performed for each provider. Payments shall not exceed the Medicaid costs any public home health agency incurs providing home health services to Medicaid clients.

Interim Payments for the Payment calendar year (January through December) will be made by June 30 of the following calendar year using as-filed cost reports to calculate uncompensated costs. In the event that errors are detected, a revised cost report has been filed by the home health agency, or a change in the State Plan affects the Public Home Health Agency Supplemental Payment, adjustments to impacted provider payments will be made retroactively.

Uncompensated costs will be calculated for Final Payments using audited cost reports. Final Payments will be made by June 30 for those home health agencies for which the Department received an audited cost report between the previous November 2 and May 1. Final Payments will be made by December 31 for those home health agencies for which the Department received an audited cost report between the previous May 2 and November 1. Final Payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to each provider shall equal the Payment amount calculated based on uncompensated costs calculated through audited cost reports. In the event that data entry errors are detected after the Final Payment has been made, or other unforeseen payment calculation errors are detected after the Final Payment has been made, reconciliations and adjustments to impacted provider payments will be made retroactively. Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed to each provider for purposes of authorizing certification. Each provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Payment.

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7. HOME HEALTH CARE SERVICES

Uncompensated Medicaid costs are calculated as follows:

1. Skilled Nursing Care
 - a. For hospital-based home health agencies, total home health agency costs for skilled nursing care are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 3, line 1. For free-standing home health agencies, total home health agency costs for skilled nursing care are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 1.
 - b. For hospital-based home health agencies, total home health agency visits for skilled nursing care are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 4, line 1. For free-standing home health agencies, total home health agency visits for skilled nursing care are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 1.
 - c. Total Medicaid home health visits for skilled nursing care are as recorded in the Medicaid Management Information System (MMIS).
 - d. Total Medicaid home health payments for skilled nursing care are as recorded in the MMIS.
 - e. The average cost per home health visit for skilled nursing care is calculated by dividing total home health agency costs for skilled nursing care by total home health agency visits for skilled nursing care.
 - f. Total Medicaid home health costs for skilled nursing care are calculated by multiplying total Medicaid home health visits for skilled nursing care by the average cost per home health visit for skilled nursing care.
2. Physical Therapy
 - a. For hospital-based home health agencies, total home health agency costs for physical therapy are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 3, line 2. For free-standing home health agencies, total home health agency costs for physical therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 2.
 - b. For hospital-based home health agencies, total home health agency visits for physical therapy are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 4, line 2. For free-standing home health agencies, total home health agency visits for physical therapy are as reported on the CMS

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7. HOME HEALTH CARE SERVICES

1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 2.

- c. Total Medicaid home health visits for physical therapy are as recorded in the MMIS.
- d. Total Medicaid home health payments for physical therapy are as recorded in the MMIS.
- e. The average home health agency cost per visit for physical therapy is total home health agency costs for physical therapy divided by total home health agency visits for physical therapy.
- f. Total Medicaid home health costs for physical therapy is calculated by multiplying total Medicaid home health visits for physical therapy by the average home health agency cost per visit for physical therapy.

3. Occupational Therapy

- a. For hospital-based home health agencies, total home health agency costs for occupational therapy are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 3, line 3. For free-standing home health agencies, total home health agency costs for occupational therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 3.
- b. For hospital-based home health agencies, total home health agency visits for occupational therapy are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 4, line 3. For free-standing home health agencies, total home health agency visits for occupational therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 3.
- c. Total Medicaid home health visits for occupational therapy are as recorded in the MMIS.
- d. Total Medicaid home health payments for occupational therapy are as recorded in the MMIS.
- e. The average home health agency cost per visit for occupational therapy is total home health agency costs for occupational therapy divided by total home health agency visits for occupational therapy.
- f. Total Medicaid home health costs for occupational therapy is calculated by multiplying total Medicaid home health visits for occupational therapy by the average home health agency cost per visit for occupational therapy.

TN# 15-0037

APPROVAL DATE 10/29/15

SUPERSEDES TN# 11-025; 15-0015; 15-0022

EFFECTIVE DATE: January 1, 2016

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7. HOME HEALTH CARE SERVICES

4. Speech Pathology
 - a. For hospital-based home health agencies, total home health agency costs for speech pathology are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 3, line 4. For free-standing home health agencies, total home health agency costs for speech therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 4.
 - b. For hospital-based home health agencies, total home health agency visits for speech pathology are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 4, line 4. For free-standing home health agencies, total home health agency visits for speech pathology are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 4.
 - c. Total Medicaid home health visits for speech pathology are as recorded in the MMIS.
 - d. Total Medicaid home health payments for speech pathology are as recorded in MMIS.
 - e. The average home health agency cost per visit for speech pathology is total home health agency costs for speech pathology divided by total home health agency visits for speech pathology.
 - f. Total Medicaid home health costs for speech pathology is calculated by multiplying total Medicaid home health visits for speech pathology by the average home health agency cost per visit for speech pathology.
5. Home Health Aides
 - a. For hospital-based home health agencies, total home health agency costs for home health aides are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 3, line 6. For free-standing home health agencies, total home health agency costs for home health aides are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 6.
 - b. For hospital-based home health agencies, total home health agency visits for home health aides are as reported on the CMS 2552-10 Hospital Cost Report worksheet H-3, part I, column 4, line 6. For free-standing home health agencies, total home health agency visits for home health aides are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 6.

TN# 15-0037

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7. HOME HEALTH CARE SERVICES

- c. Total Medicaid home health visits for home health aides are as recorded in the MMIS.
- d. Total Medicaid home health payments for home health aides are as recorded in the MMIS.
- e. The average home health agency cost per visit for home health aides is total home health agency costs for home health aides divided by total home health agency visits for home health aides.
- f. Total Medicaid home health costs for home health aides is calculated by multiplying total Medicaid home health visits for home health aides by the average home health agency cost per visit for home health aides.

Total uncompensated Medicaid home health agency costs is the sum of the Medicaid home health agency costs for skilled nursing care, physical therapy, occupational therapy, speech pathology, and home health aides less the total Medicaid home health payments. Costs included on the CMS 2552-10 Hospital Cost Report worksheet H-3 and the CMS 1728-94 Home Health Agency Cost Report worksheet C for medical social services, medical supplies, drugs, and administration of vaccines are not included in the calculations for this Public Home Health Agency Supplemental Payment.

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42 CFR 440.80

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8. Private Duty Nursing Services

Private Duty Nursing services provided to eligible clients by Medicaid certified home health agencies are reimbursed in units of one hour.

There is a maximum statewide rate for R.N. services and a maximum rate for L.P.N. services.

Reduced maximum rates are also established for one nurse providing Private Duty Nursing to more than one client at the same time in the same setting. These rates were originally based on eighty percent of the rates for one-to-one Private Duty Nursing, and are increased whenever the Colorado General Assembly authorizes and appropriates rate increases.

Private Duty Nursing services provided by R.N. and L.P.N. providers are reimbursed at the lower of the following:

1. Submitted charges; or
2. Private duty nursing fee schedule determined by the Department of Health Care Policy and Financing.

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.

TN# 17-0005

APPROVAL DATE: September 21, 2017

Supersedes TN# 15-0019

EFFECTIVE DATE: July 1, 2017

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9. CLINIC SERVICES

Ambulatory Surgical Centers

Ambulatory Surgical Center (ASC) reimbursement for select surgical procedures is the lower of the following:

1. Submitted charges or
2. ASC fee schedule as determined by the Department of Health Care Policy and Financing under the ASC grouper payment system.

Services and items at minimum that are included in the ASC reimbursement are:

1. Use of the facility where the surgical procedure is performed
2. Nursing, technician, and related services
3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure
4. Diagnostic and therapeutic items and services directly related to the provision of the surgical procedure
5. Administrative, record-keeping, and housekeeping items and services
6. All blood products (whole blood, plasma, platelets, etc.)
7. Materials for anesthesia
8. Intra-ocular lenses
9. Supervision of the services of an anesthetist by the operating surgeon

Services and items that are not included in the ASC reimbursement rate and may be billed separately by the actual provider of the service include:

1. Physician services
2. Anesthetist services
3. Laboratory, radiology, or diagnostic procedures other than those directly related to performance of the surgical procedure
4. Surgically implanted prosthetics (except intra-ocular lenses)
5. Ambulance services
6. Artificial limbs
7. Durable medical equipment for use in the client's home

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.

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9. CLINIC SERVICES – Continued

Dialysis Centers

Routine dialysis center services are reimbursed at the lower of the following:

1. Submitted charges;
2. Dialysis Center Fee Schedule as determined by the Department of Health Care Policy and Financing. The rates are subject to a wage index multiplier plus a non-wage component.

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.

Routine dialysis center services are all items and services necessary for delivering dialysis including routinely provided drugs, laboratory tests, and supplies for dialysis-related services.

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9. CLINIC SERVICES – Continued

Treatment Services for Pregnant Women with Substance Use Disorders

Treatment services for pregnant women with substance use disorders (Special Connections Program) are reimbursed at the lower of the following:

1. Submitted charges, or
2. Market-based fee schedule as determined by the Department of Health Care Policy and Financing and the Department of Human Services' Division of Behavioral Health based on an analysis of private sector behavioral health care management corporation reimbursement rates and substance abuse treatment reimbursement rates of other states' public medical assistance programs.

Reimbursable treatment services for pregnant women with substance use disorders include the following:

1. Risk assessment where one unit of service equals one session
2. Individual counseling/therapy where one unit of service equals fifteen minutes
3. Group counseling/therapy where one unit of service equals fifteen minutes
4. Case management services where one unit of service equals fifteen minutes
5. Group health education/maintenance where one unit of service equals one hour
6. Residential services (excluding room and board) where one unit of service equals one day

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.

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9 Clinic Services

This page deleted and superseded in State Plan Amendment CO-19-0006, effective July 1, 2019.

TN 19-0006

Supersedes TN12-012

Approval Date July 15, 2019

Effective Date: 7/1/2019

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9. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Clinic services – maternity services.

There may be positive incentive payments, based on provider performance for episodes of care as described in Attachment 4.19-B, Episode Based Payments.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
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10. Dental Services

- a. Dental services for adults age 21 and over shall be reimbursed at the lower of the following:
 1. Submitted charges or
 2. Dental services fee schedule as determined by the Department of Health Care Policy and Financing.
- b. Dental services for adults accessing services through the state's Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) and Supported Living Services (HCBS-SLS) waivers shall be based on a separate fee schedule found on the official website of the Department of the Health Care Policy and Financing at www.colorado.gov/hcpf.
- c. Dental services for adults 21 years of age and older, except for services for the immediate relief of severe pain, alleviation of acute infection, or necessary because of trauma, are limited to a total of \$1,500 per adult Medicaid recipient per state fiscal year. Dentures (see 4.19-B section 12.b) are not subject to this \$1,500 limitation and are available to clients when medically necessary. Medically necessary services reimbursed under the Medical and Surgical Services Furnished by a Dentist benefit at Attachment 4.19-B, Methods and Standards for Establishing Payment Rates – Other Types of Care, Item 5.b. Medical and Surgical Services Furnished by a Dentist, are not subject to the \$1,500 limitation.

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.

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

10. Dental Services Pay for Performance Supplemental Payment

Effective October 1, 2014, qualifying dentist and dental hygiene providers will receive performance supplemental Medicaid payment upon providing two services to a new Medicaid dental client receiving Medicaid dental services for the first time.

New Medicaid dental client means any adult client who is enrolled in the Medicaid program and has not received benefits under the Medicaid dental program previously. Children clients will only be considered a new Medicaid dental client if they have not been seen by the dental provider in the past two years or since July 1, 2012.

New and existing dental providers will be eligible for the performance supplemental payment as follows:

1. Dentists taking a minimum of five (5) new Medicaid clients and who render services to those clients with dates of service between October 1, 2014 and December 31, 2015 will receive a supplemental payment of \$200 for the dental benefit rendered to each of the five clients for a total of \$1,000.
2. Dentists taking an additional fifty (50) new Medicaid clients (for a total of 55 new clients) and who render services to those clients with dates of service between October 1, 2014 and December 31, 2015 will receive a supplemental payment of \$20 for the dental benefit rendered to each of the additional fifty new clients for a total of \$1,000 additional.
3. Dentists taking an additional fifty (50) new Medicaid clients (for a total of 105 new clients) and who render services to those clients with dates of service between October 1, 2014 and December 31, 2015 will receive a supplemental payment of \$20 for the dental benefit rendered to each of the additional fifty new clients for a total of \$1,000 additional.
4. Dental hygienists taking a minimum of five (5) new Medicaid clients and who render services to those clients with dates of service between October 1, 2014 and December 31, 2015 will receive a supplemental payment of \$100 for the dental benefit rendered to each of the five clients for a total of \$500.
5. Dental hygienists taking an additional fifty (50) new Medicaid clients (for a total of 55 new clients) and who render services to those clients with dates of service

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between October 1, 2014 and December 31, 2015 will receive a supplemental payment of \$10 for the dental benefit rendered to each of the additional fifty new clients for a total of \$500 additional.

6. Dental hygienists taking an additional fifty (50) new Medicaid clients (for a total of 105 new clients) and who render services to those clients with dates of service between October 1, 2014 and December 31, 2015 will receive a supplemental payment of \$10 for the dental benefit rendered to each of the additional fifty new clients for a total of \$500 additional.

Providers qualifying for the supplemental performance payment will be identified through a monthly reporting process that will capture new clients by Medicaid ID with the dates of first and second service. Upon verification of report information, a supplemental performance payment will be authorized.

Qualifying services are those dental benefits identified in Supplement to Attachment 3.1-A Limitations to Care and Services Item 10. Dental Services, approved as CO 14-036. Claims data will be analyzed prior to June 30, 2016 and the performance supplemental payments will be made prior to June 30, 2016. The maximum potential performance supplemental payment that any single dentist could earn is \$3,000. The maximum potential performance supplemental payment that any single dental hygienist could earn is \$1,500.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
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11. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AND
AUDIOLOGY SERVICES

Services provided by licensed physical therapists, licensed physical therapist assistants, licensed occupational therapists, licensed occupational therapy assistants, certified speech-language pathologists, licensed audiologists, speech-language pathology assistants, and speech-language clinical fellows shall be reimbursed at the lower of the following:

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

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - CERTIFIED
FAMILY AND PEDIATRIC NURSE PRACTITIONER, CERTIFIED REGISTERED NURSE
ANESTHETIST, AUDIOLOGIST AND SPEECH PATHOLOGIST SERVICES.

Effective October 1, 1990, Certified Family and Pediatric Nurse Practitioner and Certified Registered Nurse Anesthetist services, and effective July 1, 1993, Audiologist and Speech Pathologist services, shall be reimbursed in accordance with the lower of the following:

- A. The rate determined by completing the calculation set out below using the HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS). This calculation consists of multiplying a unit value by a conversion factor.

1. Unit Values

The associated unit values shall be determined using, when available, information from three data sources:

- a. Input from a consultant who reviewed such specialty area;
- b. 90th percentile of charge data from basic Blue Shield;
- c. The current unit value for each code (1971 RVS).

When these data are obtained the unit value is determined as follows:

- a. When information from all three of the sources listed above is available, the middle unit value is used.
- b. When information from only two sources is available, the average unit value is used.
- c. When only one source of information is available, the unit value indicated by this information is used.
- d. Bilateral Surgery - The second surgery is paid at 80% of its normal payment rate.

TN No. 93-017 Approval Date 10/12/93 Effective Date 07/01/93
Supersedes
TN No. 90-15

Micro Surgery – Unit value is increased by 25%, except when micro surgery was the original basis for such unit weight selection.

The conversion factor represents an appropriate numerical value as selected for each type of service (i.e. medicine, medical consultation, surgery, assisting to surgery, anesthesia, laboratory, and x-ray) which will, when multiplied by the appropriate unit value assigned to each procedure, determine a unique dollar value for such procedures.

The conversion factors shall be selected utilizing the following criteria:

1. Analysis by geographic area and specifically using data establishing the percentage of charges being paid, current physician participation in each specialty, and the medical needs of recipients in order to ensure recipient freedom of choice and adequate physician participation in the program.
2. The percentage of billed charges for each type of service not to exceed a reimbursement rate of 80 percent of such charges; and
3. Available appropriations.

HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) conversion factors and associated unit values may be modified from time to time to meet Medicaid Program requirements to accommodate changes in medical practice, changes in medical terminology or the addition or deletion of procedure codes by medical specialties.

B. Provider's actual charge.

Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or rate of reimbursement equal to the rate paid by Medicare. Additional exceptions to the above reimbursement method are payments for services provided by audiologists, occupational, speech, and physical therapists, dentists, and opticians or providers of eyewear.

Audiologists or speech pathologist shall not receive direct reimbursement if they acting within the scope of their graduate education training program, or as contract agents or employees of a nursing home, hospital, FQHC, clinic, home health agency, a school, or a physician.

TRANSMITTAL NO. 02-009
Date of Issue 12/10/02
Effective Date 07/01/02
Supersedes Transmittal 93-017

Micro Surgery - Unit value is increased by 25%, except when micro surgery was the original basis for such unit weight selection.

Once the unit value is determined, it is multiplied by a conversion factor.

2. Conversion Factors

The conversion factor represents an appropriate numerical value as selected for each type of service (i.e. medicine, surgery, anesthesia, pathology, and radiology) which will, when multiplied by the appropriate unit value assigned to each procedure, determine a unique dollar value for each procedure. Details about conversion factors historically applied on specific dates are available at the Medical Assistance Program office.

B. Provider's Actual Charge.

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TN No. 90-15

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
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12.a. Pharmaceutical Services:

- A. Reimbursement for covered outpatient drugs dispensed by retail community pharmacies, rural pharmacies, mail order pharmacies, specialty pharmacies, government pharmacies, institutional and long-term care pharmacies, shall be based upon the lower of:
1. The usual and customary charge to the public; or
 2. The allowed ingredient cost as defined in B plus a professional dispensing fee.
- B. The allowed ingredient cost shall be the lesser of Colorado Actual Acquisition Cost (AAC) as defined in C, National Average Drug Acquisition Cost (NADAC) or submitted ingredient cost. If AAC and NADAC are not available, the allowed ingredient cost shall be the lesser of Maximum Allowable Cost (MAC) or submitted ingredient cost.
- C. AAC is the established maximum allowable reimbursement rate for covered drugs using the actual acquisition cost for like drugs grouped by Generic Code Number (GCN) or Generic Sequence Number (GSN).
- The Department shall update AAC on a regular basis based on changes in pharmacies' acquisition costs and national pricing benchmarks such as WAC. The AAC price list is available through the Department's website (colorado.gov/hcpf).
- D. Drugs acquired through the Federal Supply Schedule (FSS) shall be reimbursed at their actual acquisition cost, plus a professional dispensing fee.
- E. Drugs acquired at Nominal Price (as defined in 42 CFR §447.502) outside of FSS or the 340B Pricing Program shall be reimbursed at their actual acquisition cost plus a professional dispensing fee.
- F. Drugs dispensed by Indian Health Service/Tribal pharmacies shall be reimbursed at an encounter rate.

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- G. Drugs dispensed by 340B Covered Entities purchasing drugs through the 340B Pricing Program will be reimbursed at their actual acquisition cost, plus a professional dispensing fee.
- H. Drugs dispensed by Covered Entities (as defined in the Social Security Act, Section 1927(a)(5)(B)) not purchased through the 340B Pricing Program shall be reimbursed as defined in A
- I. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.
- J. Physician-administered drugs are reimbursed at the published Medicare Average Sales Price (ASP) Drug Pricing File minus 3.3 percent for drugs included in that file. Physician administered 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.
 - 1. Effective November 26, 2019, injectable opioid antagonists are reimbursed at the published Medicare ASP Drug Pricing File plus 2.2%.
- K. Clotting factor dispensed by specialty pharmacies or Hemophilia Treatment Centers shall be reimbursed the lesser of the provider's usual and customary charge to the general-public, or the submitted ingredient cost plus the professional dispensing fee, or the wholesale acquisition cost plus the professional dispensing fee.
- L. Experimental or investigational drugs will not be allowed for reimbursement.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
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- M. Any pharmacy, except a mail order pharmacy, that is the only pharmacy enrolled with the Medical Assistance Program within a twenty-mile radius, may submit a written request to the Department requesting the designation of a rural pharmacy.
- N. In the aggregate, the Medical Assistance Program expenditures for outpatient drugs shall be in compliance with the federal upper limits as set forth in 42 CFR §§447.512 and 447.514.

Professional dispensing fees shall be established based upon reported dispensing costs provided through the Medical Assistance Program's Cost of Dispensing (COD) survey. The professional dispensing fees for all pharmacies except government and rural pharmacies shall be tiered based upon annual total prescription volume. The professional dispensing fees shall be tiered at:

- Less than 60,000 total prescriptions filled per year = \$13.40
- Between 60,000 and 90,000 total prescriptions filled per year = \$11.49
- Between 90,000 and 110,000 total prescriptions filled per year = \$10.25
- Greater than 110,000 total prescriptions filled per year = \$9.31

The determination of total prescription volume shall be completed by surveying pharmacies on an annual basis. Pharmacies failing to respond to the survey shall be reimbursed the \$9.31 professional dispensing fee.

The tiered professional dispensing fee shall not apply to government pharmacies which shall instead be reimbursed a \$0.00 professional dispensing fee.

The tiered professional dispensing fee shall not apply to rural pharmacies, as defined in M, which shall instead be reimbursed a \$14.14 professional dispensing fee.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
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12.b. Dentures

- a. Dentures for adults age 21 and over shall be reimbursed at the lower of the following:
 - 1. Submitted charges or
 - 2. Dental services fee schedule as determined by the Department of Health Care Policy and Financing.

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.

TN No. 18-0023

Approval Date June 18, 2018

Supersedes TN No. 14-036

Effective Date April 1, 2018

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42 CFR 440.120

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12.c. PROSTHETICS

Prosthetics shall be reimbursed at the lower of the following:

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

Prosthetics that require manual pricing shall be reimbursed at the lower of the following:

1. Submitted charges;
2. Manufacturer's suggested retail price (MSRP) less 17.51 percent;
3. Actual invoiced acquisition cost plus 20.70 percent when no MSRP is available.

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.

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42 CFR 440.120

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12.d. EYEGLASSES AND CONTACT LENSES

Eyeglasses, contact lenses, and ocular prosthetics are reimbursed to opticians at the lower of the following:

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

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

13.b: SCREENING SERVICES

Attachment 4.19-B, 13.b. was superseded by TN 17-0050.

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13.c: PREVENTIVE SERVICES

Preventive services shall be reimbursed at the lower of the following:

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

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Reimbursable SBIRT services include the following:

1. Full Screening, using an evidence-based screening tool approved by the Department. Limited to 2 full screens per client per state fiscal year.
2. Brief Intervention and Referral to Treatment. Limited to 4 sessions per client per state fiscal year. Each session is limited to 2 units per session, at 15 minutes per unit.

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.

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13.d. REHABILITATIVE SERVICES: SUBSTANCE USE DISORDER TREATMENT
SERVICES

Outpatient substance abuse treatment services shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Market-based fee schedule as determined by the Department of Health Care Policy and Financing based on an analysis of private sector behavioral health care management corporation reimbursement rates and reimbursement rates of similar services covered by the Department.

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.

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13d. Rehabilitative Services: Behavioral Health Services

a. Reimbursement for Services Provided by a Community Mental Health Center

Reimbursement for covered behavioral health services shall be made on the basis of prospective rates set for each participating Community Mental Health Center. On the basis of audited unit cost worksheets submitted annually by the Community Mental Health Centers, prospective rates shall be calculated by the Division of Behavioral Health of the Colorado Department of Human Services and reviewed and approved by the Colorado Department of Health Care Policy and Financing.

Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.

The reimbursement rates for services shall be the lowest of the following:

1. Usual and customary charges submitted by the Community Mental Health Centers for services provided to the general public; or
2. The projected cost of such services as determined by the Department of Health Care Policy and Financing through review and audit of prior year's unit costs submitted annually by each Community Mental Health Center. The audited unit cost worksheets shall be trended by the Division of Behavioral Health. The trend factor is the most recently available Consumer Price Index. The Department shall use the following tests to determine the appropriateness of the rate costs:
 - i. The previous year's audited costs adjusted forward by the annual Consumer Price Index in effect at the beginning of the fiscal year; and
 - ii. Changes in the types and intensity of services to be provided.

b. Reimbursement for Services Provided by Qualified Mental Health Professionals

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Services provided by qualified mental health professionals shall be reimbursed at the lower of the following:

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

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. All rates can be found on the official web site of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf.

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13.d. REHABILITATIVE SERVICES: MENTAL HEALTH AND SUBSTANCE ABUSE
REHABILITATION SERVICES FOR CHILDREN

Mental Health and Substance Abuse Rehabilitation Services for Children are reimbursed on a fee-for-service basis per units of service per practitioner. Rates for services include only Medicaid allowable costs. These services are only available for children ages 0 to 21 for whom the services are found to be medically necessary. Rates do not include the cost of any room and board. Applicable practitioner provider salaries were considered in developing payment fee schedules. Rates for these services were compared with rates for similar services provided by Community Mental Health Centers under cost-based payment methodologies to ensure that rates for mental health rehabilitative services are not greater than the estimated costs of providing services.

Mental Health Services units of service are as follows:

- A. Psychiatric diagnostic examination unit of service shall be one hour .
- B. Individual psychotherapy (brief) unit of service shall be 16-37 minutes, face-to-face.
- C. Individual psychotherapy (long) unit of service shall be 38-60 minutes, face-to-face.
- D. Psychotherapy for Crisis unit of service shall be 30-74 minutes, face-to-face.
- E. Family psychotherapy unit of service shall be one hour.
- F. Group psychotherapy unit of service shall be 15 minutes.
- G. Psychological testing (professional) unit of service shall be one hour, face-to-face, interpreting or preparing report.
- H. Psychological testing (technician) unit of service shall be one hour, face-to-face.

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I. Interactive group psychotherapy unit of service shall be 15 minutes.

J. Pharmacologic management unit of service shall be one hour.

The mental health services fee schedule is reviewed annually and published in the provider billing manual accessed through the Department's fiscal agent's web site.

Reimbursement for services shall be the lower of:

1. Submitted charges;
2. Fee schedule as determined by the Department of Health Care Policy and Financing

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.

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18. HOSPICE SERVICES

1. The Department begins with the annual change in Medicaid hospice payment rates, applies the current hospice CMS wage index, and increases the final rate by a specified percentage.
2. Services that are included in the hospice reimbursement are:
 - a. Routine Home Care where most hospice care is provided-Days 1-60
 - b. Routine Home Care where most hospice care is provided-Days 61 and over.
 - c. Continuous Home Care
 - d. Hospice Inpatient Respite Care
 - e. Hospice General Inpatient Care
 - f. Service Intensity Add-On (SIA), effective for hospice services with dates of service on or after October 1, 2016, will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member's life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.
3. Hospice nursing facility room-and-board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income (PETI) amount, for Medicaid clients who are receiving hospice services. The hospice provider is responsible for passing the room-and-board payment through to the nursing facility.
4. Physician services are not included in Hospice reimbursement but are reimbursed directly to the provider of the service.

Except as otherwise noted in the State Plan, state-developed rates are the same for both governmental and private providers. As of October 1, 2019, the applied percentage increase will be 16.73% and the resulting rates are effective for services provided on or after that date.

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The provider rate is available on the Department of Health Care Policy and Financing's website at: <https://www.colorado.gov/hcpf/provider-rates-fee-schedule>. The rate table reflects one rate for full payment for providers that comply with quality data reporting requirements, as well as the rate for the two-percentage-point payment reduction specific for any Medicaid hospice provider that failed to comply with Section 3004 of the Affordable Care Act [Section 1814(i)(5)(A)(i)] and the Hospice Quality Reporting Program (HQRP).

Upon notice from CMS that a provider has failed to comply with HQRP the previous fiscal year, the State directs the provider to submit all hospice claims to the Colorado Department of Health Care Policy and Financing for the ensuing federal fiscal year using rates posted online for providers that failed to comply with quality reporting requirements. The two-percentage-point payment reduction is reflected in categories of hospice care, including routine home care, continuous home care, inpatient respite, and general inpatient care. The provider rate reflecting the two-percentage-point payment reduction specific for any Medicaid hospice provider that failed to comply with Section 3004 of the Affordable Care Act [Section 1814(i)(5)(A)(i)] and the Hospice Quality Reporting Program (HQRP) is available on the Department of Health Care Policy and Financing's website at: <https://www.colorado.gov/hcpf/provider-rates-fee-schedule>.

Aggregate payment to the Hospice provider is subject to an annual indexed aggregate cost cap. The method for determining and reporting the cost cap shall be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Sections 418.308 and 418.309 (2005). Total Medicaid payments made to the Hospice for services provided by physicians who are Hospice employees, along with total payments made at the various Hospice daily rates, will be counted in determining whether the cap amount has been exceeded. Payments made for the services of physicians who are not Hospice employees and for payments made for room and board will not be included in the cap calculation. A hospice will not be reimbursed for inpatient days (general and respite) beyond 20 percent of the total days of care it provides to Medicaid beneficiaries during the "cap year."

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19. Targeted Case Management Services: Persons with a Developmental Disability

Payment for targeted case management (TCM) services under the State Plan do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. The reimbursement methodology is based upon a market-based rate with a unit of service equal to 15 minutes according to the State's approved fee schedule.

TCM services for Persons with a Developmental Disability are reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule as determined by the Department of Health Care Policy and Financing.

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

The TCM fee-for-services rate is based on the estimated average number of hours a case manager and a case manager supervisor will spend on a case each month. The base for the rate is the estimated personnel related costs for these hours, and included consideration for non-direct cost allocations. The proposed rate is based on the following assumptions.

- Direct Personnel Costs: There are two sets of wages, case manager and supervisor, in the TCM model. Both wages were derived from the May 2005 BLS statewide wage data. These wages were adjusted for inflation by using the average SSI inflation rates for the past three years, which adjusted the salary by 9.7 percent.
- Caseload: This drives the average number of hours assumed for a given case in a month, based on a 40-hour work week. The proposed rate assumes a caseload of 40 cases per case manager, which translates to an average of 3.67 hours devoted to each client each month.
- Supervisor Span of Control: The supervisor span of control is the number of employees providing direct service supervised by a supervisor. This component of the rate model captures the costs associated with direct supervision; other levels of management are

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contained in the non-direct cost allocation, Program Support: Payroll Related. The TCM model allows for one supervisor for every ten case managers.

- Benefits Factor: The benefits factor represents taxes and benefits for the direct care employee and the direct care supervisor. The benefits factor is calculated using reported costs from the spring 2007 and the wage survey data. The same benefit factor of 24 percent was used for all of the proposed rates.
- Program Support, Payroll Related: This category of non-direct cost allocations captures salaries and benefits not captured in the direct care or supervisor of direct care components of the rate. As with all non-direct cost allocations, we calculate these costs as a percentage of the direct care salaries and benefits. The source of all of the non-direct cost allocations is the spring 2007 targeted cost survey. The percentage add-on for this category of costs is 13.2 percent. The salaries and benefits included are those of program managers, associate program managers, program directors and program secretaries.
- Program Support, Non-Payroll Related: This category of non-direct cost allocations includes program expenses, medical professional services, staff development, staff travel, and vehicles. The percentage add-on is 12.5 percent and is based on data reported in the spring 2007 targeted cost survey.
- Other Non-Direct Program Related Expenses: This category of non-direct cost allocations captures general program management costs. These costs include program administration expenses, other professional services, telephone, dues and subscriptions, insurance and other general management expenses. The percentage add-on is 18.4 percent and is based on data reported in the spring 2007 targeted cost survey.
- Facility Related Costs: This category of non-direct cost allocations captures costs associated with the office space for the case manager. The 2007 cost survey asked providers to report on costs by service – Day Habilitation, Residential Habilitation and Supported Employment. The business model for Supported Employment is the closest in nature to TCM, so we used the survey data associated with Supported Employment to develop this allocation percentage. The percentage is 4.0 percent and includes rent/leases, maintenance and utilities.
- Management and General: The spring 2007 cost survey may not have captured all administrative costs associated with providing Comprehensive Waiver services. To reflect costs like those of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and other non-program general administration, we included an additional overhead percentage of 5 percent.

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Item # 19 Methods for Establishing Payment Rates for Nurse Home Visitor Program
Targeted Case Management Services

Reimbursement for Targeted Case Management (TCM) provided through the Nurse Home Visitor Program is made on a per-unit basis, where one (1) unit is equal to fifteen (15) minutes. A maximum of fifteen (15) units of service may be reimbursed in any calendar month per mother/child couple. The 15 units per month may be divided between the mother and child if both are Medicaid-eligible in the same month.

Each Nurse Home Visitor Program provider agency has two rates for TCM: The TCM Office Rate and the TCM Home Rate:

1. TCM Office Rate

This is a market-based rate. This rate may be billed for TCM services occurring away from the client's home/off-site location.

- a. Using the United States Bureau of Labor Statistics' State Occupational Employment and Wage Estimates for Colorado for the most recent month available, the mean hourly wage for the Standard Occupational Classification of Registered Nurses (29-111) is determined.
- b. Using the United States Bureau of Labor Statistics' Employer Cost for Employee Compensation data for the most recent fiscal quarter available, the hourly cost for all fringe benefits for all occupations in the private industry is averaged with the hourly cost for all fringe benefits for all occupations in state and local government.
- c. The mean hourly wage for Registered Nurses from (a) is added to the hourly cost for fringe benefits from (b). The resulting figure is divided by four to arrive at a per-15-minute unit rate.

2. TCM Home Rate

This rate is based on the TCM Office Rate plus a reallocation of mileage costs. This rate may be billed for TCM services occurring in the client's home or off-site location.

- a. Documented mileage costs for a year (or half a year) are collected from the provider agency. These costs include travel to client visits only, excluding staff development/training travel costs.
- b. The number of minutes spent at home visits (visit-minutes) in a year (or half a year) is collected from the provider agency for all home visits to all program clients (Medicaid- and non-Medicaid-eligible) by all visiting nurses. Provider agencies are required to record this information in an electronic database.

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Item # 19 Methods for Establishing Payment Rates for Nurse Home Visitor
Program Targeted Case Management Services Continued

- c. Dividing the mileage costs by the total visit-minutes results in mileage costs per visit-minute. This figure is then multiplied by the provider agency-specific proportion of Medicaid clients to non-Medicaid clients in their caseload to account for only those mileage costs and visit-minutes associated with Medicaid clients.
- d. This figure is multiplied by 15, resulting in Medicaid mileage costs per 15 minutes of service.
- e. The resulting figure is added to the TCM Office Rate. The sum equals the TCM Home Rate.

All governmental and private Nurse Home Visitor Program providers will be reimbursed for Targeted Case Management services according to this same published methodology. The current Nurse Home Visitor Program provider reimbursement rates are effective for dates of service on or after July 16, 2008, and can be found on the official Web site of the Colorado Department of Health Care Policy and Financing at www.colorado.gov/hcpf. Medicaid will not reimburse Targeted Case Management services at a rate higher than Medicare payment rates, although this service is not currently a Medicare benefit.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
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19.a. TARGETED CASE MANAGEMENT: OUTPATIENT SUBSTANCE USE DISORDER TREATMENT

Targeted case management for Outpatient Substance Use Disorder Treatment services are reimbursed on a fee-for-service basis per each 15-minute unit of service per practitioner, not to exceed four (4) units per day. A unit of service consists of at least one documented contact with a client or person acting on behalf of a client, identified during the case planning process.

The cost includes only Medicaid allowable costs. The costs used to derive the targeted case management rate are derived from the average annual salary of the applicable providers expressed in 15-minute increments.

Targeted case management for Outpatient Substance Use Treatment services are reimbursed at the lower of the following:

1. Submitted charges or
2. Market-based fee schedule as determined by the Department of Health Care Policy and Financing based on an analysis of private sector behavioral health care management corporation reimbursement rates and reimbursement rates of similar services covered by the Department.

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.

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TARGETED CASE MANAGEMENT SERVICES FOR BEHAVIORAL HEALTH

- a. Item 19a: Payment for these services are made under a contractual arrangement in accordance with the requirements of 42 CFR § 438.

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19.b. Targeted Case Management: Transition Services shall be reimbursed at the lower of the following:

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

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.

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20. EXTENDED SERVICES FOR PREGNANT WOMEN

Extended services for pregnant women (Prenatal Plus Program) shall be reimbursed at the lower of the following:

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

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.

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24.a. TRANSPORTATION

Non-Brokered Transportation

Non-brokered emergent medical transportation shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Fee schedule for transportation services as determined by the Department of Health Care Policy and Financing.

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
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24a. TRANSPORTATION – SUPPLEMENTAL PAYMENT FOR AMBULANCE SERVICES

Effective January 1, 2015, Denver Health and Medical Center will receive supplemental Medicaid payments (Denver Health Ambulance Services Payment) to provide reimbursement for uncompensated costs incurred by Medicaid clients receiving ambulance services owned and operated by Denver Health and Hospital Authority. Denver Health will certify their uncompensated cost for providing ground emergency medical transportation (GEMT) ambulance services for Medicaid fee-for-service clients based on the Department's demonstration of the uncompensated Medicaid cost calculation.

Interim Payments for the Payment calendar year (January through December) will be made by June 30 of the following calendar year using as-filed cost reports to calculate uncompensated costs.

Uncompensated costs will be calculated for Final Payments using audited cost reports. Final Payments will be made by June 30 for Denver Health audited cost reports received by the Department between the previous November 2 and May 1. Final Payments will be made by December 31 for Denver Health audited cost reports received by the Department between the previous May 2 and November 1. Final payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to Denver Health shall equal the Payment amount calculated based on uncompensated costs calculated through audited cost reports.

Prior to making the Final Payment, the Department will present to Denver Health a demonstration of the uncompensated Medicaid costs calculations for purposes of authorizing certification. Denver Health shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Payment.

Uncompensated Ambulance Medicaid fee for service costs are calculated as follows:

1. Total Medicaid Ambulance Fee for Service Charges for Denver Health for the previous calendar year will be pulled from the Colorado Medicaid Management Information System (MMIS).
2. The Cost to Charge Ratio (CCR) for Denver Health will be calculated using their as-filed cost report for the Interim Payment and their audited cost report for the Final Payment. The CCR is found in CMS 2552-10, Worksheet C, Part I, column 8, line 95.

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3. The Total Medicaid Ambulance Fee for Service Charges will be multiplied by the CCR to calculate the Total Medicaid Ambulance Costs.
4. Total Medicaid Ambulance Fee for Service Payments for Denver Health for the previous calendar year will be pulled from the Colorado MMIS.
5. The Total Medicaid Ambulance Fee for Service Payments will be subtracted from the Total Medicaid Ambulance Fee for Service Costs to calculate the Total Uncompensated Medicaid Fee for Service Ambulance Costs.

The Interim Payment will be equal to the Total Uncompensated Medicaid Fee for Service Ambulance Costs. The Final Payment will be the difference between the Total Uncompensated Medicaid Fee for Service Ambulance Costs calculated using the as-filed cost report and the audited cost report. Any excess payments determined in the reconciliation processes are recouped and the Federal share is returned to CMS on the quarterly expenditure report in which the recoupment is made.

TRANSPORTATION – SUPPLEMENTAL PAYMENT FOR GOVERNMENT AMBULANCE SERVICE PROVIDERS

Effective January 1, 2018, governmental ambulance service providers that do not receive supplemental payments for Emergency Medical Services (EMS) services, meet the specified requirements outlined in section A below, and provide ground or air emergency medical transportation services to Medicaid beneficiaries will be eligible for this payment. This supplemental payment applies to EMS rendered to Medicaid beneficiaries by eligible governmental ambulance service providers on or after January 1, 2018. Denver Health and Medical Center is excluded from receiving the Supplemental Payment for Government Ambulance Service Providers, unless the above section 24a Transportation – Supplemental Payment for Ambulance Services is eliminated.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to other ambulance services providers in accordance with Attachment 4.19-B – Methods and Standards for Establishing Payment Rates- Other Types of Care – 24a. Transportation, Non-Brokered Transportation that eligible entities receive for emergency medical transportation services to Medicaid eligible recipients. The Department of Health Care Policy and Financing (The Department) will cap the total reimbursements from Medicaid (including supplemental payment) at one hundred percent of actual costs. The Department will recognize, on a voluntary basis, a supplemental payment equal to the total allowable Medicaid costs of approved governmental ambulance service providers for providing services as set forth below.

TN No. 18-0017
Supersedes TN No. 15-0007

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A. To qualify for supplemental payments, providers must meet all of the following:

1. Be enrolled as a Medicaid provider for the period being claimed on their annual cost report;
2. Provide ground or air emergency medical transport services to Medicaid enrollees; and
3. Be organizations owned or operated by the state, city, county, fire protection district, community services district, health care district, federally recognized Indian tribe or any unit of government as defined in 42 C.F.R. Sec. 433.50.

B. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning those expenses to the Medicaid program, except as expressly modified below.
2. The total uncompensated care costs of each eligible provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each eligible provider providing EMS to Colorado Medicaid beneficiaries, net of the amounts received and payable from the Colorado Medicaid program and all other sources of reimbursement for such services provided to Colorado Medicaid beneficiaries. If the eligible providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

C. Cost Determination Protocols

1. An eligible provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the state approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

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2. Direct costs for providing medical transport services include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.
3. The total percentage of time spent on medical calls throughout the cost reporting period will be calculated using Computer Aided Dispatch (CAD)/Trip statistics and used as an allocation methodology for those costs “shared” between Medical Transportation Services (MTS) vs. Non-MTS divisions. Providers will allocate shared Capital Related and Salaries & Benefits (CRSB) costs based on CAD/Trip Statistics.
4. Indirect costs are determined in accordance to one of the following options.
 - a. Eligible providers that receive more than \$35 million in direct federal awards must either have a Cost Allocation Plan (CAP) or a cognizant agency approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the Eligible provider does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.
 - b. Eligible providers that receive less than \$35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, Eligible providers may use methods originating from a CAP to identify its indirect cost. If the Eligible provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.
 - c. Eligible providers which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
 - i. A CAP with its local government
 - ii. An indirect rate negotiated with its local government
 - iii. Direct identification through use of a cost report
 - d. If the Eligible provider never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost.

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D. Cost Settlement Process

1. The payments and the number of transport data reported in the as-filed cost report will be reconciled to the Colorado MMIS reports generated for the cost reporting period within 10 months of the as-filed cost report deadline. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.
2. Each eligible provider will receive an annual lump sum payment in an amount equal to the total of the uncompensated care costs as defined in the above Supplemental Reimbursement Methodology – General Provisions Section B.2.
3. The Department will perform a final reconciliation where it will settle the provider's annual cost report as audited within the following calendar year. The Department will compute the net EMS allowable costs using audited per-medical transport cost, and the number of fee-for-service EMS transports data from the updated MMIS reports. Actual net allowable costs will be compared to the Medicaid reimbursement rates paid to other ambulance services providers in accordance with Attachment 4.19-B – Methods and Standards for Establishing Payment Rates-Other Types of Care – 24a. Transportation, Non-Brokered Transportation and settlement payments made, and any other source of reimbursement received by the provider for the period. If, at the end of the final reconciliation, it is determined that the eligible provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the eligible provider will receive an interim supplemental payment in the amount of the underpayment.

E. Eligible Provider Reporting Requirements

1. The cost report will be completed on a state fiscal year basis and will be due to the Department of Health Care Policy and Financing no later than 150 calendar days following the last day of the state fiscal year.
2. "Governmental ambulance services provider" means a provider of ambulance services that is a unit of government specified in 42 CFR 433.50.
3. Participating governmental ambulance services provider who meets the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with (a) through (d) for services provided on or after January 1, 2018.

TN No. 18-0017
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Approval Date October 15, 2018
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- a. The governmental ambulance services provider will be paid interim rates equal to the Medicaid reimbursement rates paid to other ambulance services providers in accordance with Attachment 4.19-B – Methods and Standards for Establishing Payment Rates-Other Types of Care – 24a. Transportation, Non-Brokered Transportation. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.
- b. The governmental ambulance services provider will submit a state approved cost report annually, on a form approved by the Department of Health Care Policy and Financing. The cost report will be completed on a state fiscal year basis and will be due to the Department of Health Care Policy and Financing no later than 150 calendar days following the last day of the state fiscal year.
- c. “Allowable costs” will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 CFR, part 200 as implemented by HHS at 45 CFR, part 75.
 - i. “Direct costs” are those costs that are identified by 45 CFR 75.413 that:
 - 1. Can be identified specifically with a particular final cost objective (to meet emergency medical transportation requirements), such as a federal award, or other internally or externally funded activity; or
 - 2. Can be directly assigned to such activities relatively easily with a high degree of accuracy.
 - ii. “Indirect costs” means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.
- d. The provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio, to Medicaid charges associated with paid claims for the dates of service covered by the submitted cost report.

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

28. FREE STANDING BIRTH CENTER SERVICES

Freestanding birth center facility services shall be reimbursed at the lower of the following:

1. Submitted charges or
2. 75 percent of the average payments to inpatient hospitals for uncomplicated vaginal deliveries.

Freestanding birth center transfer payments shall be reimbursed at the lower of the following:

1. Submitted charges or
2. 50 percent of the freestanding birthcenter's facility payment.

Professional services at freestanding birth centers are reimbursed separately under Physician Services at Attachment 4.19-B, Methods and Standards for Establishing Payment Rates – Other Types of Care, Item 5.a. Physician Services, and all eligible providers including certified nurse midwives, are reimbursed at 100 percent of the physician fee schedule rate for the service rendered. This may include but is not limited to labor and delivery, evaluation provided prior to transfer to a hospital and newborn care.

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. All rates can be found on the official Web site of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf.

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METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES
FOR THE COLORADO PRESCRIPTION DRUG INFORMATION
AND TECHNICAL ASSISTANCE PROGRAM

Consultations provided under the Prescription Drug Information and Technical Assistance Program are reimbursed on a fee-for-service basis per unit of service per practitioner. A unit of service consists of one documented meeting of any length with a client and documented follow-up with the client's physicians.

The cost includes only Medicaid allowable costs. The cost used to derive the rate is based on a regional market survey.

All governmental and private providers are reimbursed according to the same published fee schedule, which is published at <http://www.colorado.gov/cs/Satellite?c=Page&cid=1244207387794&pagename=HCPF%2FHCPFLayout>. The Department's rate was set as of May 1, 2008 and is effective for services on or after that date.

TN #: 12-006

APPROVAL DATE. 11/21/12

SUPERCEDES TN #: 08-002

EFFECTIVE DATE. 3/1/2012

Method and Standards for Establishing Payment Rates

Services Provided Under Section 1915(i) of the Social Security Act. This Section has been deleted effective February 12, 2019.

Revision: HCFA-PM-91-4
August 1991

(BPD)

Supplement 1 to Attachment 4.19-B
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OMB No.: 0938

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Payment of Medicare Part A and Part B Deductible /Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item _____ of this attachment (see 3 below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item A of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exception to the general methods used for a particular group or payment are specified on Page 3 in item _____ of this attachment (see 3 above).

TN. No. 00-011
Supersedes _____ Approval Date 09/08/00 Effective Date 04/01/00
TN. No. 92-028

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Payment of Medicare Part A and Part B Deductible /Coinsurance

QMBs:	Part A <u>NR</u> Deductibles	<u>NR</u> Coinsurance
	Part B <u>NR</u> Deductibles	<u>NR</u> Coinsurance

Other	Part A <u>NR</u> Deductibles	<u>NR</u> Coinsurance
Medicaid	Part B <u>NR</u> Deductibles	<u>NR</u> Coinsurance
Recipients		

Dual	Part A <u>NR</u> Deductibles	<u>NR</u> Coinsurance
Eligible	Part B <u>NR</u> Deductibles	<u>NR</u> Coinsurance
(QMB Plus)		

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August 1991

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

Payment of Medicare Part A and Part B Deductible/Coinsurance

A. For QMB Only, QMB Plus (QMBs with full Medicaid benefits), and Other Dual Eligibles (Medicare and Medicaid without QMB coverage), the reimbursement methodology for Medicare Part A and Part B services is as follows:

1. When Medicare and Medicaid services or items are comparable and paid under a comparable reimbursement methodology, the Medicaid payment is the lower of the following two values:
 - a. the Medicaid allowed amount minus the Medicare payment; or,
 - b. the sum of the Medicare coinsurance and deductible.
2. In the event Medicaid does not have an applicable fee related to the coding contained in a crossover claim or the payment methodologies are different, the Medicaid payment is the sum of the Medicare coinsurance and deductible. Circumstances of this include but are not limited to crossover claims where the service is not covered by Medicaid or the service is covered by Medicaid but pursuant to a payment methodology that is not compatible with the Medicare crossover claim.
3. If the crossover claim does not include adequate coding, such as HCPCS codes on each claim line, then Medicaid's payment is the sum of the Medicare coinsurance and deductible.

4. Following is specific information relating to certain providers:

Medicare UB 04 Part B claims. Nursing Facility Part B, freestanding Rural Health Clinics, freestanding Federally Qualified Health Clinics, Dialysis, and Independent Rehabilitation crossover claims are exempt from Lower Of Pricing and are reimbursed at the sum of the Medicare coinsurance and deductible.

5. Greater specificity regarding the circumstances under which Medicaid pays the sum of the Medicare coinsurance and deductible rather than utilizing Lower of Pricing methodology may be found in the Department's MMIS system documentation.

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**REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED PROVIDERS
FOR COSTS OF PROFESSIONAL SERVICES**

This segment of Attachment 4.19-B provides reimbursement to eligible government-operated hospitals or the government entities with which they are affiliated (including affiliated government-operated physician practice groups), for the uncompensated Medicaid costs of providing physician and specified non-physician practitioner professional services to Medicaid beneficiaries. Only the otherwise uncompensated costs of professional services not claimed by the hospital as Medicaid inpatient hospital services, outpatient hospital services or government operated clinic services set forth in other sections of Attachments 4.19A and 4.19-B, are eligible for reimbursement under this segment of Attachment 4.19B.

Eligible professional costs are reported on the designated hospitals' CMS-2552-10 cost report.

A. General Reimbursement Requirements

1. The government-operated hospitals identified in Section B of this attachment, and the government operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, are eligible providers that will receive supplemental payments for the un-reimbursed Medicaid costs specified in Section C of this attachment below.
2. Eligible providers will receive Medicaid fee-schedule payments for professional services. In addition, the eligible providers will receive supplemental payments up to cost as specified in Section C of this attachment. The reimbursement under this segment of Attachment 4.19-B is available only for Medicaid costs that are in excess of Medicaid fee schedule payments.
3. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid services described in this segment of Attachment 4.19B, that are provided to Medicaid patients by physicians and non-physician practitioners of government-operated hospitals or the government entities with which they are affiliated, will be governed by this segment of Attachment 4.19-B.
4. Professional costs incurred by freestanding clinics that are not recognized as hospital outpatient departments on the CMS-2552-10 and are reimbursable as clinic costs are not included in this protocol.
5. The supplemental payments determined under this segment of Attachment 4.19-B will be paid on an annual basis.

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B. Eligible Providers

1. The physician and non-physician practitioner professional costs being addressed in this protocol are limited to professional costs incurred by the governmental hospitals listed below and their affiliated government physician practice groups (i.e., practice group that is owned and operated by the same government entity that owns and operates the hospital). These professional costs are reported on the designated hospitals' CMS-2552-10 cost report.

Non-State Government-operated:

**Denver Health Medical Center
University of Colorado Health – Memorial Health System**

C. Reimbursement Methodology

This interim supplemental payment will approximate the difference between the fee-for-service (FFS) payment and the allowable Medicaid costs related to the professional component of physician or non-physician practitioner services eligible for Federal financial participation. This computation of establishing the interim Medicaid supplemental payments must be performed on an annual basis and in a manner consistent with the instructions below.

- a. The professional component of physician costs are identified from each hospital's most recently filed CMS-2552-10 cost report Worksheet A-8-2, Column 4. These professional costs are:
 1. limited to allowable and auditable physician compensations that have been incurred by the hospital;
 2. for the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service, including sites that are not owned or operated by an affiliated government entity;
 3. identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment;
 4. supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians
 5. removed from hospital costs on Worksheet A-8.

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- b. The professional costs on Worksheet A-8-2, Column 4 are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with the average rates paid to the provider by commercial payers. There will be revenue offsets to account for revenues received for services furnished by such professionals to non-patients (patients whom the hospital does not directly bill for) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.
- c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the CMS-2552-10 cost report. The practitioner types to be included are:

Certified Registered Nurse Anesthetists
Physician Assistants
RN Clinical Nurse Specialists
RN Nurse Midwives
Supervisor, Nurse Midwives
RN Nurse Practitioners
Psychologists
Licensed Clinical Social Workers
Optometrists

- d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the cost report, these costs may be recognized if they meet the following criteria:
1. the practitioners must engage in the direct provision of care in addition to being Medicaid qualified practitioners for whom the services are billable under Medicaid separate from hospital services;
 2. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
 3. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs;
 4. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with average rates paid to the provider by commercial payers and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

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The resulting net clinical non-physician practitioner compensation costs are allowable costs for this section of Attachment 4.19-B. The compensation costs for each non-physician practitioner type are identified separately.

- e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are separately reimbursable as clinic costs and therefore should not be included in this protocol.
- f. Hospitals may additionally include physician support staff compensation, data processing, office and patient accounting costs as physician-related costs to the extent that :
 - 1. these costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
 - 2. they are directly identified on Worksheet A-8 or Worksheet B, Part 1 as adjustments to hospital costs;
 - 3. they are otherwise allowable and auditable provider costs; and
 - 4. they are further adjusted for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed for the purposes of this section of 4.19-B.

- g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from hospital records.
- h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f by the total billed professional charges for each cost center as established in paragraph g. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f by the total billed professional charges for each practitioner type as established in paragraph g.

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- i. The total professional charges for each cost center related to covered Medicaid fee-for-service physician services, billed directly by the hospital, are identified using paid claims data from the State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and does not track claims on a cost center basis, the total professional charges related to Medicaid fee-for-service physician services must be allocated to the hospital cost centers using information from the hospital's billing system. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the covered Medicaid fee-for-service professional charges, billed directly by the hospital, are identified using paid claims data from State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and may not track claims by non-physician practitioner type, hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

- j. The total Medicaid costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid fee-for-service charges as established in paragraph i by the respective cost to charge ratio for the cost center as established in paragraph h.

For each non-physician practitioner type, the total Medicaid costs related to non-physician practitioner professional services are determined by multiplying total Medicaid fee-for-service charges as established in paragraph i by the respective cost to charge ratios as established in paragraph h.

- k. The total Medicaid costs eligible for Medicaid supplemental payment are determined by subtracting all Medicaid fee-for-service physician/practitioner payments received from the Medicaid fee-for-service costs as established in paragraph j. The amount of the Medicaid interim supplemental payment will be based on the Medicaid fee schedule payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS/claims system and auditable provider records. All revenues received (other than the Medicaid physician supplemental payments being computed here in this section) for the Medicaid professional services will be

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offset against the computed cost; these revenues include payments from the State, patient co-payments, and payments from other payers.

1. The Medicaid physician/practitioner amount computed in paragraph k above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The Medicaid amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:
 - (1). Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.
 - (2). Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the Medicaid physician/practitioner amount to be used for interim Medicaid supplemental payment purposes.

D. Interim Reconciliation

The physician and non-physician practitioner interim supplemental payments determined under Section C above which are paid for services furnished during the applicable calendar year are reconciled to the as-filed CMS-2552-10 cost report for the same year once the cost report has been filed with the State. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, the provider will receive an adjusted payment amount. For purposes of this reconciliation the same steps as outlined for the interim payment method are carried out except as noted below:

1. For the determinations made under paragraphs a through h of Section C, the costs and charges from the as-filed CMS-2552-10 cost report for the expenditure year are used.
2. For the determinations made under paragraph i of Section C, Medicaid fee-for-service professional charges for covered services furnished during the applicable fiscal year are

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used and are identified using paid claims data from the State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and does not track claims on a cost center basis, the total professional charges related to Medicaid fee-for-service physician services must be allocated to the hospital cost centers using information from the hospital's billing system. These charges must be associated with paid claims for services furnished during the applicable fiscal year covered by the as-filed cost report for the same fiscal year.

3. For the determinations made under paragraph k of Section C, Medicaid fee-for-service payments for professional services furnished during the applicable fiscal year from the State's MMIS/claims system are used. All revenues received (other than the Medicaid physician supplemental payments being computed here in this section) for the Medicaid professional services will be offset against the computed cost; these revenues include payments from the State, patient co-payments, and payments from other payers.

E. Final Reconciliation

Once the CMS-2552-10 cost report for the expenditure year has been finalized by the State, a reconciliation of the finalized costs to all Medicaid payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized CMS-2552-10 cost amounts and updated Medicaid data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. The final reconciliation adjustments will be made within one year of the date the cost report for the expenditure year is finalized.

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**SUPPLEMENTAL PAYMENTS FOR PHYSICIAN AND PROFESSIONAL SERVICES
AT QUALIFYING COLORADO STATE-OWNED OR OPERATED PROFESSIONAL
SERVICES PRACTICES**

1. Qualifying Criteria

Physicians and other eligible professional service practitioners as specified in 2. below who are employed by the University of Colorado School of Medicine, which is a state-owned school of medicine.

To qualify for the supplemental payment, the physician or professional service practitioner must be:

- a. licensed by the State of Colorado; and
- b. enrolled as a Colorado Medicaid provider; and
- c. members of an organization established by the University of Colorado School of Medicine pursuant to section 23-20-114, C.R.S.

2. Qualifying Providers Types

For purposes of qualifying for supplemental payments under this section, services provided by the following professional practitioners will be included:

- a. Physicians;
- b. Certified Registered Nurse Anesthetists (CRNA);
- c. Physician Assistants
- d. RN Clinical Nurse Specialists
- e. Nurse Midwives
- f. RN Nurse Practitioners
- g. Psychologists
- h. Licensed Clinical Social Workers
- i. Optometrists
- j. Dentists (For Medicare covered medical codes only)

3. Payment Methodology

The supplemental payment will be limited based on the available upper payment limit, which is the Medicare equivalent of the average commercial rate. The average commercial rate is defined as the rates paid by the five largest commercial payers for the same service. Under this methodology the terms "physician" and "physician services" includes services provided by all qualifying provider types as set forth in "2.", above.

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

- a. For services provided by physicians meeting the criteria as set forth in "1." above, the state will collect from the providers its current commercial physician fees by CPT code for the provider's top five commercial payers by volume.

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- b. The state will calculate the average commercial fee for each CPT code for qualifying provider types, as defined under "2." above, that are eligible in "1." above.
- c. The state will extract from its paid claims history file for the preceding fiscal year all paid claims for those qualifying provider types, as defined under "2." above, who will qualify for a supplemental payment. For each CPT code, the state will align the average commercial fee as determined in "b" above to Medicaid payments for qualifying provider types, as defined under "2." above and calculate the average commercial payments for the claims.
- d. The state will also align the same paid Medicaid claims with the Medicare fees for each CPT code for each qualifying provider type, as defined under "2." above and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.
- e. The state will then calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The current Medicare to commercial ratio is 255.46% and will be re-determined at least every three years.
- f. For each quarter the state will query its MMIS system for paid Medicaid claims for qualifying provider types, as defined under "2." above for that quarter.
- g. The state will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available Medicare Physician Fee Schedule for MAC Locality 0411201 - Colorado.
- h. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare equivalent of the average commercial rate and the amount Medicaid actually paid for those claims is subtracted to establish the total allowable supplemental payment amount for the physician or physician practice plan for that quarter.
- i. In order to allow for adequate claims runout, the payment for Medicaid services in any given quarter will be made one year after the quarter in which the dates of service occurred.

4. Effective Date of Payment

The supplemental payment will be made effective for services provided on or after July 1 2016.

5. Payment Amount

State Fiscal Year	Payment (Total Funds)
SFY 2017-18	\$123,529,218
SFY 2018-19	\$136,577,576
SFY 2019-20	\$155,996,320
SFY 2020-21	\$162,707,438

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PAYMENTS FOR RESERVED BEDS - NURSING HOMES

The Medical Assistance Program reimburses nursing home providers for costs incurred for reserved beds for recipients absent from the home up to a maximum of forty-two (42) days per calendar year. These absences must be provided for in the patient's plan of care, must be authorized by a physician's written order, and may not be due to the recipient's admittance to a hospital or other institution.

Reserved bed costs incurred for leave in excess of forty-two (42) days per calendar year will not be reimbursed by Medicaid.

Regardless of the source of payment, the specific bed occupied by the recipient prior to his absence must be reserved, and may not be utilized by any other person.

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Date Approved 3/9/88
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The State of Colorado Hereby finds and assures that the rates for long term care facilities are reasonable and adequate to meet the costs that efficiently and economically operated facilities but incur. A facility is considered to be operated efficiently and economically when it complies with the State and Federal licensing and certification requirements, applicable State reporting requirements at a patient per diem cost equal to or less than the maximum reasonable allowable cost ceilings, fair rental allowance payments and other payments standards specified in this Attachment 4.19.D.

NURSING FACILITY BENEFITS

Special definitions relating to nursing facility reimbursement.

1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any improvements thereto as determined in accordance with generally accepted accounting principles.
2. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on an independent nationally recognized valuation system as determined by the Department. The valuation system used by the Department can be found in 10 CCR 2505-10 8.443.9.A.1(b) (2019).
3. "Array of facility providers" means a listing in order from the lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state.
4. a. "Base value" means:
 - i) For the fiscal year 1986-87 and every fourth year thereafter, the appraised value of capital-related asset;
 - ii) For each year in which an appraisal is not done pursuant to subparagraph (i) of this paragraph (a), the most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index.

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- b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.
 - c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.
- 5. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.
 - 6. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.
 - 7. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to registered nurses, licensed practical nurses, and nurses' aides.
 - 8. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.
 - 9. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.
 - 10. "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's Medicaid residents as further specified in this section.
 - 11. "Class I nursing facility provider" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia.

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12. "Core Component per diem rate" means the per diem rate for direct and indirect health care services costs, administrative and general services costs, and fair rental allowance for capital-related assets for Class 1 nursing facility providers.
13. "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.
14. "Direct or indirect health care services costs" means the costs incurred for patient support services, including the following:
 - a. Salaries, payroll taxes, workers' compensation payments, training, and other employee benefits for registered nurses, licensed practical nurses, aides, medical records librarians, social workers, and activity personnel.
 - b. Nonprescription drugs ordered by a physician.
 - c. Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians, and therapies.
 - d. Purchases, rentals, and costs incurred to operate, maintain, or repair health care equipment.
 - e. Supplies for nurses, medical records personnel, social workers, activity personnel, and therapy personnel.
 - f. Medical director fees.
 - g. Therapies and other medically related services.
 - h. Other patient support services determined and defined by the state board pursuant to rule.
15. "Facility population distribution" means the number of Colorado nursing facility provider residents who are classified into each resource utilization group as of a specific point in time.
16. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.
17. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.
18. "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

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19. "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.
20. "Median per diem cost" means the average daily cost of care and services per patient for the nursing facility provider that represents the middle of all the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.
21. "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the federal Medicare and Medicaid programs.
22. "MMIS per diem reimbursement rate" means the per diem rate used for Medicaid Management Information Systems (MMIS) claims based reimbursement.
23. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.
24. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.
25. "Nursing facility provider" means a facility provider that meets the state nursing home licensing standards established pursuant to section 25-1.5-103(1)(a), C.R.S., and is maintained primarily for the care and treatment of inpatients under the direction of a physician.
26. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.
27. "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.
28. "Provider fee" means a licensing fee, assessment, or other mandatory payment that is related to health care items or services as specified under 42CFR 433.55.
29. "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent

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30. "Resource utilization groups" means the system for grouping a nursing facility provider's residents according to their clinical and functional statuses as identified from data supplied by the facility's minimum data set as published by the United States Department of Health and Human Services.
31. "Supplemental Medicaid payment" means a lump sum payment that is made in addition to a nursing facility provider's MMIS per diem reimbursement rate. A supplemental Medicaid payment is calculated on an annual basis using historical data and paid as affixed monthly amount with no retroactive adjustment.

SERVICES AND ITEMS INCLUDED IN REIMBURSEMENT

Reimbursement to skilled and intermediate nursing facility providers shall be all inclusive. This shall cover the necessary services to the resident, including room and board, as

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well as nursing and ordinary supplies and equipment related to the day-to-day care of the resident and the operation of the facility.

Each nursing facility shall furnish, within the per diem rate, equipment necessary to the operation of the facility and provide for necessary medical, nursing, respiratory and rehabilitation care.

SUBMISSION OF THE MED-13 COST REPORT AND MINIMUM DATA SET (MDS)

For purposes of completing the MED 13, each nursing facility shall:

1. Establish a 12-month period that is designated to the Department as the facility's fiscal year. The fiscal year shall remain the same as designated to the Department with two exceptions:
 - a. Providers seeking to coordinate their fiscal year with the fiscal year they have established with the Internal Revenue Service.
 - b. Subchapter "S" corporations required by law to have a fiscal year end of December 31.
2. Provide adequate cost data that:
 - a. Is based on their financial and statistical records. All financial and statistical records of the facility shall be maintained in accordance with generally accepted accounting principles as approved by the American Institute of Certified Public Accountants.
 - b. Is verifiable by reference to adequate supporting documentation by qualified auditors during the normal course of their audit.
 - c. Is based on the accrual basis of accounting.

Nursing facilities shall submit all Minimum Data Set (MDS) resident assessments and tracking documents to the Centers for Medicare and Medicaid Services (CMS) MDS database for Colorado maintained at the Colorado Department of Public Health and Environment (CDPHE). All assessment data submitted shall conform to federal and state specifications and meet minimum editing and validation requirements.

Failure to maintain adequate accounting and/or statistical records shall be cause for termination or suspension of the facility's provider agreement.

LEGAL FEES, EXPENSES AND COSTS

1. Legal fees, expenses and costs incurred by nursing facilities shall be allowable, in the period incurred, if said costs are reasonable, necessary and patient-related. Such costs shall be reimbursed only to the extent they

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affect the rates for those periods. These legal fees, expenses and costs shall be documented in the provider's files, and shall be clearly identifiable, including identification by case number and title, if possible. Failure to clearly identify these costs shall result in disallowance.

2. The following categories shall not be deemed reasonable, necessary and patient-related:
 - a. Legal fees, expenses and costs incurred in connection with the appeal of a Medicaid classification or reimbursement rate, rate adjustment, personal needs audit, or payment for any financial claim by or against the State of Colorado, or its agencies by a provider, in the event the State of Colorado or any of its agencies prevails in such a proceeding. In the event that each party prevails on one or more issues in litigation, allowable legal fees, expenses and costs in such cases shall be apportioned by percentage, for reimbursement purposes, by the administrative law judge rendering the final agency decision. In the event of the stipulated settlement of any such appeal, the parties shall, by agreement, determine the allowability for the provider's legal fees, expenses and costs. If a settlement agreement is silent concerning legal fees, expenses or costs, they shall not be allowable.
 - b. Legal fees, expenses and costs incurred in connection with a proceeding by the Department or the CDPHE to deny, suspend, revoke or fail to renew or terminate the license or provider contract of a long-term care facility, or to refuse to certify, decertify or refuse to recertify a long-term care facility as a provider under Medicaid and the Departments prevail in such a proceeding. Legal fees, expenses and costs incurred in connection with a proceeding by the United States Department of Health and Human Services to refuse to certify, decertify, or refuse to recertify a long-term care facility and the Department prevails in such a proceeding. For the purposes of this paragraph, the word "prevail" shall mean a result, whether by settlement, administrative final agency action or judicial judgment, which results in a change of the terms of a previously granted provider license, certification, or contract, including involuntary change of ownership or probation.
 - c. Legal fees, expenses and costs incurred in connection with a civil or criminal judicial proceeding against the provider by the State of Colorado and any of its agencies as the result of the provider's participation in the Medicaid program, resulting from fraud or other misconduct by the provider, and the State or its agencies prevail in such proceeding. For the purposes of this paragraph, the

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word "prevail" shall mean any result but dismissal or acquittal of a criminal action or dismissal, directed judgment, or judgment for the provider in a civil action.

- d. Legal fees, expenses and costs incurred in connection with an investigation by federal, state, or local governments and their agencies that might lead to a civil or criminal proceeding against the provider as a result of alleged fraud or other misconduct by the provider in the course of the provider's participation in the Medicaid program shall not be allowable where the provider makes any payment of funds to any federal, state, or local governments and their agencies as a result of the alleged fraud or misconduct which was the subject of the investigation.
- e. Legal fees, expenses and costs incurred for lobbying Congress, the Legislature of Colorado, or the State Boards of Medical Services, Health or Human Services.
- f. Legal fees, expenses and costs incurred by the seller in the sale of a nursing home.
- g. Nonrefundable retainers paid to Counsel.
- h. Legal fees, expenses and costs incurred for any reason after a change of ownership has occurred.
- i. Legal fees, expenses, or costs as a result of an attorney entering an appearance in person or in writing by counsel for the provider during the Informal Reconsideration. Legal fees, expenses and costs that are advisory in nature before and during the Informal Reconsideration process will be allowable.

DEPRECIATION

- 1. For purposes of this section concerning depreciation, the following definitions shall apply:

"MAI Appraiser" means the designation "Member, Appraisal Institute" awarded by the American Institute of Real Estate Appraisers.

"Straight Line Method of Depreciation" means the method of depreciation where the amount to be depreciated is first determined by subtracting the estimated salvage value of the asset from its cost or fair market value in the case of donated assets. The amount to be depreciated is then distributed equally over the estimated useful life of the asset.

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2. Depreciation on assets used to provide covered services to Medicaid recipients may be included as an allowable patient cost. Only the straight-line method of computing depreciation may be utilized for purposes of Medicaid reimbursement. Depreciation costs shall be identifiable as such, and shall be recorded in the provider's accounting records in accordance with "generally accepted accounting principles."
3. Depreciable items must be capitalized and written off over the estimated useful life of the item using the straight-line method of depreciation. With respect to expenditures during every facility fiscal year which begins on or after July 1, 1998, the following items must be depreciated:
 - a. Assets that, at the time of acquisition, had an estimated useful life of (2) two years or more; and a historical cost of \$5,000 or more.
 - b. Betterments or improvements that extend the original estimated useful life of an asset by (2) two years or more, or increase the productivity of an asset significantly; and cost \$5,000 or more.
 - c. For the purpose of applying the \$5,000 threshold in paragraphs A and B above, the costs of assets, betterments, and/or improvements shall be combined if the costs:
 - i) Are incurred within the same fiscal year of the nursing facility.
 - ii) Are of the same type or relate to the same project. For example, renovations or improvements to a facility's kitchen, done in three phases costing \$3,000 each, must be combined.
 - d. Major repairs are repairs which:
 - i) Occur infrequently, involve significant amounts of money, and increase the economic usefulness of the asset in the future, because of either increased efficiency, greater productivity, or longer life; or
 - ii) Restore the original estimated useful life of an asset where without such repairs, the useful life of the asset would be reduced or immediately ended; these repairs occur infrequently and have a significant cost in relation to the asset being repaired.
 - e. If the composite method of depreciation is used, the time period over which the major repair must be depreciated is not necessarily the remaining life of the composite asset. For example, a major

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repair to a roof of a facility that has a remaining useful life of thirty (30) years would not have to be depreciated over thirty (30) years if the normal life of the roof is only fifteen (15) to twenty (20) years; the shorter period could be used.

- f. The following are examples of major repairs and are not intended as a complete list: replacement or partial replacement of a roof, flooring, boiler, or electrical wiring.

EXPENSED ITEMS

1. Items which are to be entirely expensed in the year of purchase, rather than depreciated, are as follows:
 - a. All repair and maintenance costs, except major repairs.
 - b. Assets that, at the time of acquisition, had an estimated useful life of less than two (2) years; or cost less than \$5,000.
 - c. Betterments or improvements that do not extend the useful life of an asset by two (2) years or more, or do not increase the productivity of an asset significantly; or cost less than \$5,000.
 - d. For the purpose of applying the \$5,000 threshold in paragraphs "b" and "c" above, assets, betterments, and/or improvements that are purchased separately shall be combined if they meet the criteria described in section 8.441.5.D.

HISTORICAL COSTS

1. Historical costs shall be established in accordance with the Medicare and Medicaid Guide, 1981, published by Commerce Clearing House, paragraphs 4501- 4897P, except that any appraisals required or recommended shall be performed by an MAI Appraiser rather than an "appraisal expert" as defined in the Guide. No amendments or later editions are incorporated.
2. When the Internal Revenue Service requires a facility to change its allocation of costs of land, buildings or equipment for purposes of tax reporting, a copy of the IRS notice shall be submitted to the Department in order for the changes to be reflected in the cost report.
3. In regards to a determination of a bona fide sale, an initial presumption that the sale was not bona fide may be offset by a valuation report of an MAI appraiser of the reproduction cost depreciated to date on a straight-line basis. Cost determined in this manner shall be accepted for future depreciation purposes.

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4. An initial presumption that a sale was not bona fide shall be made when any of the following factors exist:
- a. The seller and purchaser are persons for whom a loss from the sale or exchange of property is not allowed under the Internal Revenue Services Code between:
 - i) Members of a family. The term "family" means a brother or sister (whole or half-blood relationship), spouse, ancestor, or lineal descendant, including in-laws and in-laws of ancestors of lineal descendants.
 - ii) An individual and a corporation if the individual owns (directly or indirectly) more than 50% in value of the outstanding stock.
 - iii) Two corporations if more than 50% in value of the outstanding stock in both is owned, directly or indirectly, by the same individual, but only if either one of the corporations was a personal holding company or a foreign personal holding company for the taxable year preceding the date of the sale or exchange.
 - iv) A grantor and a fiduciary of any trust.
 - v) A fiduciary of one trust and a fiduciary of another trust, if the same person is grantor of both trusts.
 - vi) A fiduciary of a trust and any beneficiary of such trust.
 - vii) A fiduciary of a trust and a beneficiary of another trust, if the same person is a grantor of both trusts.
 - viii) A fiduciary of a trust and a corporation more than 50% in value of the outstanding stock of which is directly or indirectly owned by or for the trust or a grantor of the trust. This would, for example, have the effect of denying a loss in a transaction between a corporation, more than 50% of the stock of which was owned by a father, and a trust established for his children. Under the constructive ownership rules (below), the children are treated as owning the stock owned by the father.
 - ix) A person and an exempt charitable or education organization controlled by the person or, if the person is an individual, by the individual or his family.

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- b. The transaction was effected without significant investment on the part of the purchaser; i.e., cash or property was not transferred from the purchaser to the seller and the sales price was met by assumption of existing debt and promises to pay additional amounts or issuance of life annuities to the seller.
- c. The sales price could be considered excessive when compared with other sales or costs of constructing, furnishing, and equipping other facilities of comparable size and quality during the preceding twelve months.

INTEREST

- 1. To be allowable, the interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower.
- 2. Interest on loans to providers by partners, stockholders or related organizations are allowable as costs at a rate not in excess of the prime rate.
- 3. Allowable interest expense on current indebtedness of a provider shall be adjusted to reflect the extent to which working capital needs which are attributable to covered services for beneficiaries have been met by payment to the provider designed to reimburse currently as services are furnished to beneficiaries.

MANAGEMENT SERVICES

- 1. The following requirements apply to all management companies:
 - a. Management company costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge of health care personnel from the management company or home office may be included in the health care cost center equal to the actual salaries and benefits of those health care personnel.
 - b. Management company costs allocated to facilities shall be based on actual services provided to the facility. The allocation shall be documented.
 - c. If the compensation to on-site management staff is separately reported on the cost report that compensation shall not also be included in the allowable management costs for the facility.

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OXYGEN

1. Only oxygen concentrator costs shall be allowable costs on the MED-13. Such costs include, but are not limited to, all supplies, equipment and servicing expenses.
2. Oxygen concentrators purchased by nursing facilities shall be capitalized over the useful life of the asset. All supplies and service costs are allowable.
3. The nursing facilities shall have documented the costs incurred with the oxygen concentrators. These costs shall be segregated by costs associated with Medicaid residents and non-Medicaid residents.
4. Oxygen concentrators provided by medical supply companies to Medicaid nursing facility residents shall not be allowable costs and shall not be included on the MED-13.

LIMITATION ON MEDICARE PART A AND PART B COSTS

1. Only those Medicare costs that are reasonable, necessary and patient-related shall be included in calculating the allowable Medicaid reimbursement for class I nursing facilities.
2. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for a class I facility shall be: The level of Part A costs allowed in the facility's latest Medicare cost report submitted by the facility to the Department prior to July 1, 1997.
3. Part B direct costs for Medicare shall be excluded from the allowable Medicaid reimbursement for class I nursing facilities.

SUBMISSION OF COST REPORTING INFORMATION

Each nursing facility shall complete a Financial and Statistical Report for Nursing Facilities (MED-13) and submit it to the Department's designee at 12-month intervals within ninety (90) days of the close of the facility's fiscal year.

Failure of a nursing facility to submit its MED-13 within the required ninety (90) day period shall result in the Department withholding all warrants not yet released to the provider as described below:

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1. When a nursing facility fails to submit a complete and auditable MED-13 (i.e., the information represented on the MED-13 can not be verified by reference to adequate documentation as required by generally accepted auditing standards) on time, the MED-13 shall be returned to the facility with written notification that it is unacceptable.
 - a. The facility shall have either 30 days from the postmark date of the notice or until the end of the original 90-day submission period, whichever is later, to submit a corrected MED-13.
 - b. If the corrected MED-13 is still determined to be incomplete or unauditable, the nursing facility shall be given written notification that it shall, at its own expense, submit a MED-13 that has been prepared by a certified public accountant (CPA). The CPA shall certify that the report is in compliance with all Department regulations and shall give an opinion of fairness of presentation of operating results or revenues and expenses.
 - c. The Department shall withhold all warrants not yet released to the provider once the original 90-day filing period and 30-day extension have expired and no acceptable MED-13 has been submitted.
2. If the audit of the MED-13 is delayed by the nursing facility's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure of the nursing facility to meet its responsibility to submit a timely MED-13 or failure to provide documents, personnel or other resources within its control and necessary for completion of the audit, within a reasonable time.
3. When the rate for the facility during a period of delay is found to have been higher than the new rate, the new rate shall be applied retroactively to this period and the Department shall make any adjustments and/or recoveries of overpayments.

**DELAYS OR CORRECTIONS IN MINIMUM DATA SET (MDS)
SUBMITTAL**

A nursing facility may request the Department accept late, completed and/or corrected MDS assessments for the purpose of recalculating quarterly resident case mix acuity calculations.

1. The Department shall only consider such a request if it pertains to MDS assessments which could affect the facility's per diem reimbursement for the rate year in which the request is made.

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2. In addition, such a request shall only be approved if:
 - a. The number of missing, incomplete, and/or inaccurate MDS assessments for one, or more, of the quarters is equal to, or greater than, 25% of the facility's total number of residents for that quarter.
 - b. The facility transmits corrected complete MDS assessments for at least 95% of the total number of missing, incomplete, and/or inaccurate MDS assessments for the respective quarter.
 - c. The request shall be made in writing and shall include such supporting information as is required by the Department.
 - d. If the request is approved, all late, completed, or corrected MDS assessments shall be transmitted to, and accepted by, the MDS database maintained by the Colorado Department of Public Health and Environment.

Where the Department withholds warrants not yet released to the provider, the following shall apply:

1. The Department shall withhold all warrants not yet released to the provider for services rendered in the prior three calendar months (four months if an extension was granted) and thereafter until an acceptable MED-13 is received.
2. Once the Department determines that the MED 13 submitted is complete and auditable, the provider's withheld payments shall be released.
3. If an acceptable MED-13 has not been submitted within 90 days after the Department began withholding payments, the provider's participation in the Medicaid program shall be terminated and the payments withheld shall be released to the provider.
4. Interest paid by the provider on loans for working capital while payments are being withheld shall not be allowable costs for purposes of reimbursement under Medicaid.
5. When the delayed submission of the MED-13 causes the effective date of a new lower rate to be delayed, the new rate shall be applied retroactively to this period and the Department shall make recoveries of overpayments.

NURSING FACILITY REIMBURSEMENT

Where no specific Medicaid authority exists, the sources listed below shall be considered in reaching a rate determination:

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1. Medicare statutes.
2. Medicare regulations.
3. Medicaid and Medicare guidelines.
4. Generally accepted accounting principles.

Effective July 1 of each year, a MMIS per diem reimbursement rate for Class 1 nursing facility providers shall be established for reimbursement of billed claims.

1. The MMIS per diem reimbursement rate shall equal a nursing facility provider's Core Component per diem rate multiplied by a percent factor. The percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by 3.00%.
2. For State Fiscal Year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement or the SFY 2019-20 Core Component per diem rate.
3. For State Fiscal Years (SFY) 2020-21 and 2021-22, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate of patient payment increased by 2.00%.
4. A nursing facility provider shall be notified, in writing or by electronic notification, at least ten business day before any change to their Core Component per diem rate, MMIS per diem reimbursement rate or percent factor.

The Core Component per diem rate shall be determined using information on the MED-13, the Minimum Data Set (MOS) resident assessment information and information obtained by the Department or its designee retained for cost auditing purposes.

The Core Component per diem rate includes the following components:

1. Health Care,
2. Administrative and General, and
3. Fair Rental Allowance for Capital-Related Assets.

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4. Facilities that have implemented a program meeting specified performance criteria beginning July 1, 2009.
5. Changes in acuity or case-mix of patients.
6. The amount by which the average statewide per diem rate exceeds the general fund share.

For class II intermediate care facilities for individuals with intellectual disabilities, a payment rate for each participating facility shall be determined on the basis of the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

The facility's prospective per diem rate includes the following components:

1. Health Care.

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2. Administrative and General.
3. Fair Rental Allowance for Capital-Related Assets.

For state-operated class IV intermediate care facilities for individuals with intellectual disabilities, a payment rate for each participating facility shall be determined on the basis of the MED- 13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

The facility's retrospective per diem rate includes the following components:

1. Health Care.
2. Administrative and General, which includes capital.

No nursing facility care shall receive reimbursement unless and until the nursing facility:

1. Has a license from the Colorado Department of Public Health and Environment (CDPHE).
2. Is a Medicaid participating provider of nursing care services.
3. Meets the requirements of the Department's regulations found at 10 CCR 2505-10, Medical Assistance, Health Care Policy and Financing Department Program Rules, Code of Colorado Regulations.

NURSING FACILITY CLASSIFICATIONS

1. Class I facilities are those facilities licensed and certified to provide general skilled nursing facility care.
2. Class II facilities are those facilities whose program of care is designed to treat individuals with intellectual disabilities who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.
 - a. Class II facilities shall be certified in accordance with 42 C.F.R. Part 442, Subpart C (2019), and 42 C.F.R. Part 483 (2019), and shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as a Class II facility. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.
 - b. Class II facilities shall offer full-time, twenty-four (24)hour interdisciplinary and professional treatment by staff employed at such facility. Staff must be sufficient to implement and carry out a comprehensive program to include, but not be limited to, care, treatment, training and education for each individual.

- c. Class II facilities shall provide care and services designed to maximize each resident's capacity for independent living and shall seek out and utilize other community programs and resources to the maximum extent possible according to the needs and abilities of each individual resident.
 - d. Class II facilities serve persons whose medical and psychosocial needs require services in an institutional setting and are expected to provide such services in an environment which approximates a home-like living arrangement to the maximum extent possible within the constraints and limitations inherent in an institutional setting.
3. Class IV facilities are those facilities whose program of care is designed to treat individuals with intellectual disabilities who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.
- a. Class IV facilities shall be certified in accordance with 42 C.F.R. Part 442, Subpart C (2019), and 42 C.F.R. Part 483 (2019), and shall be licensed by CDPHE as a Class IV Facility. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.
 - b. Class IV facilities shall offer full-time, 24-hour interdisciplinary and professional treatment by staff employed at such facility. Staff must be sufficient to implement and carry out a comprehensive program to include, but not be limited to, care treatment, training and education for each individual.
 - c. Class IV facilities serve persons whose medical and psychosocial needs require services in an institutional setting and are expected to provide such services in an environment which approximates a home-like living arrangement to the maximum extent possible within the constraints and limitations inherent in an institutional setting.
 - d. State-administered, tax-supported facilities are not subject to the maximum reimbursement provisions and do not earn an incentive allowance.
 - e. Private, non-profit or proprietary facilities that are not tax-supported or state-administered are subject to the maximum reimbursement provisions and may earn an incentive allowance.

IMPUTED OCCUPANCY FOR CLASS II FACILITIES

The Department or its designee shall determine what audited allowable costs per patient

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day are.

1. The Department shall utilize the total audited patient days on the MED-13 unless the audited patient days on the MED-13 constitute an occupancy rate of less than 85 percent of licensed bed day capacity when computing the audited allowable cost per patient day for all rates.
2. In such cases, the patient days shall be imputed to an 85 percent rate of licensed bed day capacity for the nursing facility and the per diem cost along with the resulting per diem rate shall be adjusted accordingly except that imputed occupancy shall not be applied in calculating the facility's health care services and food cost.

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that imputed occupancy shall not be applied in calculating the facility's health care services and food costs.

3. The licensed bed capacity shall remain in effect until the Department is advised that the licensed bed capacity has changed through the filing of a subsequent cost report.
4. The imputed patient day calculation shall remain in effect until a new rate from a subsequent cost report is calculated. Should the subsequent cost report indicate an occupancy rate of less than 85 percent of licensed bed day capacity, the resulting rate shall be imputed in accordance with the provisions of this section.

Nursing facilities located in rural communities with a census of less than 85 percent shall not be subject to imputed occupancy. A nursing facility in a rural community shall be defined as a nursing facility in:

1. A county of less than fifteen thousand population.
2. A municipality of less than fifteen thousand population which is located ten miles or more from a municipality of over fifteen thousand population.
3. The unincorporated part of a county ten miles or more from a municipality of fifteen thousand population or more.

Any nursing facility that has a reduction in census, causing it to be less than 85 percent, resulting from the relocation of mentally ill or developmentally disabled residents to alternative facilities pursuant to the provisions of the Omnibus Reconciliation Act of 1987 shall:

1. Be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department for two cost reporting periods.
2. The imputed occupancy calculation shall be applied when required at the end of this period.

Imputed occupancy shall be applied to a new nursing facility as follows:

1. A new nursing facility means a facility not in the Colorado Medicaid program within thirty days prior to the start date of the Medicaid provider agreement.
2. For the first cost report submitted by a new facility, the facility shall be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department.

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3. For the second cost report submitted by a new facility, imputed occupancy shall be applied but the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the monthly weighted average computation.
4. For the third cost report and cost reports thereafter, imputed occupancy shall be applied without exception.

Nursing facilities undergoing a state-ordered change in case mix or patient census that significantly reduces the level of occupancy in the facility shall:

1. Be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department for two cost reporting periods.
2. At the end of this period, the imputed occupancy calculation shall be applied when required.

INFLATION ADJUSTMENT

For class I nursing facilities, the per diem amount paid for direct and indirect health care services and administrative and general services costs shall include an allowance for inflation in the costs for each category using a nationally recognized service that includes the federal government's forecasts for the prospective Medicare reimbursement rates recommended to the United States Congress. Amounts contained in cost reports used to determine the per diem amount paid for each category shall be adjusted by the percentage change in this allowance measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

1. The percentage change shall be rounded at least to the fifth decimal point.
2. The index used for this allowance will be the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. The latest available publication prior to July 1 rate setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1, and June 30.

For class II intermediate care facilities for Individuals with intellectual disabilities, at the beginning of each facility's new rate period, the inflation adjustment shall be applied to all costs except interest and costs covered by fair rental allowance.

1. The inflation adjustment shall equal the annual percentage change in the National Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban consumers), from the preceding year, times actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for that class facility, whichever is less.

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2. The annual percentage change in the National Bureau of Labor Statistics Consumer Price Index shall be rounded at least to the fifth decimal point.
3. The price indexes listing in the latest available publication prior to the July 1 limitation setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1 and June 30.
4. The provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period.

ADMINISTRATIVE COST INCENTIVE ALLOWANCE FOR CLASS II

FACILITIES

If the nursing facility's combined audited administration, property, and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) cost per patient day is less than the maximum reasonable cost for administration, property and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) costs for the class, the provider will earn an incentive allowance.

The incentive allowance for class II facilities shall be calculated at 25 percent of the difference between the facility's audited inflation adjusted cost and the maximum reasonable cost for that class. The incentive allowance will not exceed twelve percent of the reasonable cost.

No incentive allowance shall be paid on health care services, raw food, fair rental value allowance and leasehold costs.

CASE MIX ADJUSTMENTS

The resource utilization group-III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), shall be used to adjust costs reported in the health care cost center in the determination of limits and in the rate calculation. No amendments or later editions are incorporated. The Department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

The Department shall distribute facility listings identifying current assessments for residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the Department's MDS assessment database.

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HEALTH CARE REIMBURSEMENT RATE CALCULATION

Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

If an employee has dual health care and administrative duties (i.e. Admissions and Marketing), contemporaneous time records must be kept or time studies performed to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.
3. Non-prescription drugs ordered by a physician which are included in the per diem rate.
4. Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.
5. Purchases, rental, and repair expenses of health care equipment and supplies used for health care services such as nursing care, medical records, social services, and activities.

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6. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.
2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.
3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:
 - a. Exclude part, or all, of a provider's MED-13.
 - b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.
4. The health care limit and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.
5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers; except

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that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

- a. In determining the median cost, the cost of direct health care shall be case-mix neutral.
 - b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.
 - c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.
 - i). The percentage change shall be rounded at least to the fifth decimal point.
 - ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.
6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.
7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent (8%) per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight-percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

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**CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND
MEDICAID CASE MIX INDEX (CMI):**

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups

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system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis.

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:
 - a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.
 - b. The facility's Medicaid resident acuity case mix index shall be a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.
 - c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.
 - d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.
 - e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.
 - f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.
2. The annual facility specific health care maximum reimbursement rate shall be determined as follows:
 - a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

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- b. The statewide health care maximum allowable reimbursement rate shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.
 - c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.
 3. The annual facility specific other health care maximum allowable reimbursement shall be determined as follows:
 - a. The percentage of the other health care per diem cost to total health care cost shall be determined by dividing the other health care per diem cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.
 - b. The facility specific other health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.
 4. The case mix reimbursement rate component shall be determined as follows:
 - a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.
 - b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall be the case mix reimbursement rate component.
 5. The other health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

**DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM
ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV FACILITIES**

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1. For class II facilities, one hundred twenty-five percent (125%) of the weighted actual costs of all class II facilities;
 2. State-administered class IV facilities shall not be subject to the health care limit.
 3. The determination of the reasonable cost of services shall be made every 12 months.
 4. Determination of the rates beginning on July 1 each year shall utilize the Medicaid population in each nursing facility class on May 1 and the most current MED-13 cost report submitted, in accordance with these regulations, by each facility on or before May 2.
 5. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2.
 6. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:
 - a. Exclude part, or all, of a provider's MED-13 or
 - b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report to May 2.
 7. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling.
 8. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.
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10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

Administration Costs means the following categories of reasonable, necessary and patient-related costs:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, hall monitors, security guards, janitorial and plant staff and food service staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records or perform a time study in order to properly allocate their salaries between cost centers. Time studies used must meet the criteria described under Health Care Reimbursement Rate Calculation.
2. Any portion of other staff costs directly attributable to administration.
3. Advertising.
4. Recruitment costs and staff want ads for all personnel.
5. Public relations.
6. Office supplies.
7. Telephone costs.
8. Purchased services: accounting fees, legal fees; computer services. Computer services refer to any costs associated with the information technology system such as repair, maintenance and upgrades.
9. Computers and related software used in administrative departments.
10. Payroll taxes.
11. Licenses and permits (except health care licenses and permits), non resident transportation, training for administrative personnel, dues for professional associations and organizations.
12. All travel of facility staff, except that required for transporting residents to activities or for medical purposes.

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13. Insurance, including insurance on vehicles used for resident transport, is an administrative cost. The only exception is professional liability insurance that is a health care cost.
14. Facility membership fees in trade groups or professional organizations.
15. Miscellaneous general and administrative costs.
16. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.
17. Purchases, rentals, repairs, betterments and improvements of equipment utilized in administration.
18. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.
19. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food or capital-related assets.
20. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.
21. Management fees and home office costs except as described under Health Care Reimbursement Rate Calculation.

Property costs include:

1. Depreciation costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).
2. Rental costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).
3. Property taxes.
4. Property insurance.
5. Interest on loans associated with property costs covered in this section.

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6. Repairs, betterments and improvements to property not covered by the fair rental allowance.
7. Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations regarding expensing of items.

Room and board includes:

1. Dietary, other than raw, food and salaries related to dietary personnel including tray help, except registered dieticians which are health care.
2. Laundry and linen.
3. Housekeeping.
4. Plant operation and maintenance (except removal of infectious material or medical waste which is health care).
5. Repairs, betterments and improvements to equipment related to room and board services.

The maximum allowable reimbursement of administration, property and room and board costs, excluding raw food, land, buildings and fixed equipment, shall not exceed:

1. For class II facilities, one hundred twenty percent (120%) of the weighted average actual costs of all class II facilities.
2. For class IV facilities, one hundred twenty percent (120%) of the weighted average actual costs of all class IV facilities.
3. The determination of the reasonable cost of services shall be made every 12 months.
4. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling.
5. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

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6. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

Class I Administrative and General Per Diem Reimbursement Rate

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the Department shall establish an annually readjusted schedule to pay each facility a reasonable price for the costs.

1. The reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers.
2. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one or more licensed beds, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.
3. In computing per diem cost, each nursing facility provider shall annually submit cost reports to the Department.
4. Actual days of care shall be counted rather than occupancy-imputed days of care.
5. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation.
6. Amounts contained in cost reports used to establish this median shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.
 - a. The percentage change shall be rounded at least to the fifth decimal point.
 - b. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.
7. The reasonable price determined at July 1, 2008 will be adjusted annually at July 1st for three subsequent years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global

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Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8. For each succeeding fourth year, the Department shall re-determine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.
9. The reasonable price established by the median per diem costs determined each succeeding fourth year will be adjusted annually at July 1st for the three intervening years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.
10. For fiscal years commencing on and after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general per diem rate to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.
11. For fiscal years commencing on or after July 1, 2009, through the fiscal year commencing July 1, 2014, if a reallocation of management costs between the administrative and general costs and the direct and indirect health care costs causing a nursing facility provider's administrative and general costs to exceed the reasonable price established by the state department, a nursing facility provider may receive a higher per diem payment for administrative and general services than provided for in number 2 above.

For the purpose of reimbursing class II intermediate care facilities for individuals with intellectual disabilities a per diem rate for the cost of administrative and general services, the Department shall establish an annually readjusted schedule to reimburse each facility, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care services costs and a fair rental allowance for capital-related assets.

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1. In computing per diem cost, each intermediate care facility for individuals with intellectual disabilities provider shall annually submit cost reports to the Department.
2. The per diem reimbursement rate will be total allowable costs for administrative and general and health care services (actual or the limit) divided by the higher of actual resident days or occupancy imputed days.
3. An inflation adjustment will be applied to the per diem administrative and general and health care reimbursement rates.
4. An incentive allowance for administrative and general costs may be included.
5. Each facility will be paid a per diem for capital-related assets.

FAIR RENTAL ALLOWANCE FOR CAPITAL-RELATED ASSETS

1. For purposes of this section concerning fair rental allowance, the following definitions shall apply:

Appraised Value means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent, the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the most recent edition of the Boeckh™ Commercial Building Valuation System available on December 31st of the year preceding the year in which the appraisals are to be performed.

Base Value means the value of the capital related assets as determined by the most current appraisal report completed by the Department or its designee and any additional information considered relevant by the Department. For each year in which an appraisal is not done, base value means the most recent appraisal value increased or decreased by fifty percent (50%) of the change in the Index. Under no circumstances shall the base value exceed \$25,000 per bed plus the percentage rate of change referred to as the per bed limit.

Capital-Related Asset means the land, buildings and fixed equipment of a participating facility.

Fair Rental Allowance means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

Fair Rental Allowance Per Diem Rate means the fair rental allowance described above, divided by the greater of the audited patient days on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

Fiscal Year means the State fiscal year from July 1 through June 30.

Fixed equipment means building equipment as defined under the Medicare principle of reimbursement as specified in the Medicare provider reimbursement manual, part 1, section 104.3. Specifically, building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

- a. Affixed to the building and not subject to transfer; and
- b. A fairly long life but shorter than the life of the building to which it is affixed.

Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company,

Inc. that is updated annually (section M.450, "Nursing Home"), hereafter referred to as the Means Index.

Rental Rate means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

FAIR RENTAL ALLOWANCE PER DIEM REIMBURSEMENT RATES

In addition to the reimbursement components paid under Health Care Services and Administrative and General Costs, a per diem rate constituting a fair rental allowance for capital-related assets shall be paid to each nursing facility provider as a rental rate based upon the nursing facility's appraised value.

1. For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for capital-related assets, the state department shall establish an annual per bed limit.
2. The annual per bed limit established July 1, 1985 is \$25,000 per bed plus the percentage rate of change in the Means Index.
3. The Means Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is updated annually (section M.450, "Nursing Home").
4. The per bed limit shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.
5. The fair rental allowance will be calculated for each facility using the lesser of the Base Value plus non-appraisal year modifications to the physical structure due to improvements or a change in the condition and/or use of the facility subsequent to the appraisal increased or decreased by fifty percent (50%) of the change in the Means Index or the annual per bed limit.
6. In computing the fair rental allowance per diem rate, the fair rental allowance is multiplied by the rental rate to obtain the annual allowable fair rental payment.
7. The rental rate is the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.
8. The resulting fair rental payment amount is divided by the greater of the audited patient days based on the provider's annual cost report or ninety

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percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

SUPPLEMENTAL MEDICAID PAYMENTS FOR CLASS 1 NURSING FACILITY PROVIDERS

Cognitive Performance Scale Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers who have residents with moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury based upon the resident's score on the Cognitive Performance Scale (CPS).

*(Medicaid CPS Resident Count * Days in Prior Calendar Year)
* CPS Per Diem Rate*

1. Annually, the Department shall calculate the payment by multiplying a CPS per diem rate by CPS Medicaid days.
2. The CPS per diem rate shall be calculated based on the number of standard deviations a nursing facility provider's CPS percentage is above the statewide average CPS percentage. The CPS per diem rate shall be determined in accordance with the following table:

Standard Deviation Above Statewide Average	CPS Per Diem
Greater Than or Equal to Statewide Average + 1 Standard Deviation	1x
Greater Than or Equal to Statewide Average + 2 Standard Deviation	2x
Greater Than or Equal to Statewide Average + 3 Standard Deviation	3x

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental Medicaid payment divided by total statewide CPS Medicaid days equal 1.00% of the statewide average MMIS per diem reimbursement rate as of July 1 of the state fiscal year.

3. The CPS percentage shall be the sum of Medicaid residents with a CPS score of 4, 5, or 6 divided by the sum of Medicaid residents.
4. CPS Medicaid patient days shall be the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent multiplied by the days in the calendar year ending prior to the state fiscal year.

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5. A CPS score of 4, 5, or 6 shall be determined based on a Medicaid resident's score on the CPS used in the RUG-III classification system reported on the MDS assessment.
6. A Medicaid resident shall be included if they have an active MDS assessment on a nursing facility provider's most recent April roster.
 - a. Effective April 1, 2020 and ending June 30, 2020, a one-time revision will be exercised for State Fiscal Year 2020-2021 to pull MDS data that is most recent and unaffected by Coronavirus Disease 2019 (COVID-19) emergency procedures.
7. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via Automated Clearing House (ACH) transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Preadmission Screening and Resident Review II Resident Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers who serve residents with severe mental health conditions that are classified at Level II by the Medicaid program's Preadmission Screening and Resident Review (PASRR) tool.

(Medicaid PASRR II Resident Count Days in Prior Calendar Year) *
(2.00% * Statewide Average MMIS Per Diem Reimbursement Rate)*

1. Annually, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.
2. The PASRR II per diem rate shall equal 2.00% of the statewide MMIS per diem reimbursement rate as of July 1 of the state fiscal year.
3. Medicaid PASRR II days shall be the count of Medicaid PASRR II residents multiplied by the days in the calendar year ending prior to the state fiscal year.
4. A Medicaid PASRR II resident shall be determined based on the most recently completed MDS assessment occurring during the previous 365 days ending May 1 of the prior state fiscal year.
 - a. Effective April 1, 2020 and ending June 30, 2020, a one-time revision will be exercised for State Fiscal Year 2020-2021 to pull data from the previous 365 calendar days ending March 1, 2020 to account for COVID-19 delays for MDS submissions.
5. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Preadmission Screening and Resident Review II Facility Supplemental Medicaid Payment

The Department shall pay a supplemental Medicaid payment to facilities that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegration.

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*If specialized behavioral services nursing facility provider then:
(Medicaid PASRR II Resident Count * Days in Prior Calendar Year) *
(2.00% * Statewide Average MMIS Per Diem Reimbursement Rate)*

1. Annually, the Department shall determine those nursing facility providers with a specialized behavioral services program. A nursing facility provider has a specialized behavioral services program if they can demonstrate annually that they provide additional staff training/credentialing, therapeutic groups and work programs, life skills training, community reintegration efforts, and a Memorandum of Understanding with local mental health providers in March of the prior state fiscal year.
2. For those nursing facility providers with a specialized behavioral services program, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.
3. The PASRR II per diem rate shall equal 2.00% of the statewide MMIS per diem reimbursement rate as of July 1 of the state fiscal year.
4. Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the calendar year ending prior to the state fiscal year.
5. A Medicaid PASRR II resident shall be determined based on the most recently completed MDS assessment occurring during the previous 365 days ending May 1 of the prior state fiscal year.
 - a. Effective April 1, 2020 and ending June 30, 2020, a one-time revision will be exercised for State Fiscal Year 2020-2021 to pull data from the previous 365 calendar days ending March 1, 2020 to account for COVID-19 delays for MDS submissions.
6. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Medicaid Utilization Supplemental Medicaid Payment

The Department shall pay a nursing facility provider a supplemental Medicaid payment for care and services rendered to Medicaid residents.

1. Annually, the Department shall calculate the percentage of Medicaid patient days to total patient days.
2. The percentage of Medicaid patient days shall then be multiplied by the Provider Fee.
3. Percentage of Medicaid patient days shall be Medicaid patient days divided by total patient days.
4. Medicaid patient days shall be from the MMIS for the calendar year prior the state fiscal year. Total patient days shall be from the nursing facility provider for the calendar year.

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ending prior to the state fiscal year.

5. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Core Component Supplemental Medicaid Payment

The Department shall pay a nursing facility provider a supplemental Medicaid payment for the difference between their MMIS per diem reimbursement rate and Core Component per diem rate.

1. Annually, the Department shall calculate the difference between the MMIS per diem reimbursement rate and the Core Component per diem rate. The difference shall then be multiplied by applicable Medicaid patient days.
2. Applicable Medicaid patient days shall be Medicaid patient days divided by days in the calendar year ending prior to the state fiscal year, multiplied by the days the Core Component per diem rate was effective.
3. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year the Core Component per diem rate was effective.
4. For SFY 2019-20, the Department shall include the difference between the SFY 2018-19 MMIS per diem reimbursement rate and the SFY 2018-19 Core Component per diem rate, multiplied by applicable Medicaid patient days.
5. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Pay-For-Performance Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers that provide services resulting in better care and higher quality of life for their residents.

1. Annually, the Department shall calculate the payment by multiplying a Pay-for-Performance (P4P) per diem rate by Medicaid patient days.

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2. The P4P per diem rate shall be calculated according to the following table:

P4P Points	Per Diem Rate
0 – 20 points	No add on
21 – 45 points	\$1.00
46 – 60 points	\$2.00
61 – 79 points	\$3.00
80 – 100 points	\$4.00

3. The P4P points shall be based on a completed and verified/audited application including performance measures in each of the domains: quality of life, quality of care and facility management. The application includes the following:

- a. The number of points associated with each performance measure;
- b. The criteria the facility must meet or exceed to qualify for the points associated with each performance measure.

4. The prerequisites for participating in the program are as follows:

- a. No facility with substandard deficiencies on a regular annual, complaint, or any other Colorado Department of Public Health and Environment survey will be considered for pay for performance. Substandard quality of care means one or more deficiencies related to participation requirements under Freedom from Abuse, Neglect, and Exploitation, Quality of Life quality of life, or quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.
- b. The facility must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the facility; and, (b) be administered on an annual basis with results tabulated by an agency external to the facility. The facility must report their response rate, and a summary report must be made publicly available along with the facility's State's survey results.

5. To apply the facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The facility must maintain documentation supporting its representations for each performance measure the facility represents it meets or exceeds the specified criteria. The required documentation for each performance measure is identified on the matrix and must be submitted with its application. In addition, the facility must include a written narrative for each sub- category to be considered that describes the process used to achieve and sustain each measure.

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6. The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. Applications and supporting documentation as received will be considered complete. No post receipt or additional information will be accepted for that application. Facilities will be selected for onsite verification of performance measures representations based on risk.
7. A nursing facility provider will accumulate a maximum of 100 points by meeting or exceeding all performance measures indicated on the application.
8. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year.
9. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Acuity Adjusted Core Component Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers for changes in resident acuity or case-mix.

1. Annually, the Department shall calculate the difference between the prior year Core Component per diem rate and the prior year Core Component per diem rate adjusted for changes in resident acuity or case-mix. The difference shall then be multiplied by applicable Medicaid patient days.
2. Applicable Medicaid patient days shall be Medicaid patient days divided by days in the calendar year ending prior to the state fiscal year, multiplied by the days the acuity adjusted Core Component per diem rate was effective.
3. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year the acuity adjusted Core Component rate was effective.
4. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

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Nursing Facility Rate Reduction

Effective for the State Fiscal Year beginning July 1, 2010, the aggregate state-wide nursing facility per diem rate will be reduced by two and three-tenths percent (2.3%).

Effective for the State Fiscal Year beginning July 1, 2011, the aggregate state-wide nursing facility per diem rate will be reduced by one and four-tenths percent (1.4%).

Effective for the State Fiscal Year beginning July 1, 2012, the aggregate state-wide nursing facility per diem rate will be reduced by one and fort-five-hundredths percent (1.45%).

Effective for the State Fiscal Year beginning July 1, 2013, and for each State Fiscal Year thereafter, each nursing facility's calculated MMIS per diem reimbursement rate will be reduced 1.5%.

RATE EFFECTIVE DATE

For cost reports filed by all facilities except the State-administered class IV facilities, the rate shall be effective on the first day of the eleventh (11th) month following the end of the nursing facility's cost reporting period.

For the 12-month cost reports filed by the State-administered class IV facilities, the rate shall be effective on the first day covered by the cost report.

The permanent rate shall be established, issued and shall pay Medicaid claims billed on and after the later of the following dates:

1. The beginning of the provider's new rate period, as set forth under Rate Effective Date.

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Effective December 1, 2010, nursing facilities that provided care to Program of All Inclusive Care for the Elderly (PACE) residents in SFY 2009 will receive a one-time supplemental Medicaid payment for nursing facility services provided to Medicaid clients, such that the total of all payments will not exceed the Upper Payment Limit for nursing facility services. Each qualifying nursing facility's lump sum payment is calculated as the difference between the nursing facility's Interim and Final SFY 2009 per diem rate, multiplied by their individual PACE resident days that occurred during SFY 2009. This payment will be distributed to providers in the third quarter of SFY 2011.

Supplemental Provisions:

1. For the fiscal year beginning July 1, 2009 and each succeeding year, if the provider fee is insufficient to fully fund the supplemental Medicaid payments for pay for performance, CPS, PASRR II and the provider fee offset, the state department may suspend or reduce the supplemental Medicaid payments.
2. Provider fee revenue will first be used to pay the provider fee offset payment, then acuity, then the state share of the base rate exceeding the statutory limitation on annual growth in the general fund, then pay for performance, then PASRR II and CPS. Any difference between the amount of provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share above.

SFY 2009-10	\$53,616,414
SFY 2010-11	\$72,699,123
SFY 2011-12	\$84,511,966
SFY 2012-13	\$84,166,164
SFY 2013-14	\$88,514,898

Nursing Facility Rate Reduction

Effective for the State Fiscal Year beginning July 1, 2010, the aggregate state-wide nursing facility per diem rate will be reduced by two and three-tenths percent (2.3%).

Effective for the State Fiscal Year beginning July 1, 2011, the aggregate state-wide nursing facility per diem rate will be reduced by one and four-tenths percent (1.4%).

Effective for the State Fiscal Year beginning July 1, 2012, the aggregate state-wide nursing facility per diem rate will be reduced by one and forty-five-hundredths percent (1.45%).

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Effective for the State Fiscal Year beginning July 1, 2013, and for each State Fiscal Year thereafter, each nursing facility's calculated MMIS per diem reimbursement rate will be reduced 1.5%.

RATE EFFECTIVE DATE

For cost reports filed by all facilities except the State-administered class IV facilities, the rate shall be effective on the first day of the eleventh (11th) month following the end of the nursing facility's cost reporting period.

For 12-month cost reports filed by the State-administered class IV facilities, the rate shall be effective on the first day covered by the cost report.

The permanent rate shall be established, issued and shall pay Medicaid claims billed on and after the later of the following dates:

1. The beginning of the provider's new rate period, as set forth under Rate Effective Date.

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2. One hundred (100) days after the date the MED-13 is filed by the provider.

In the event a permanent rate cannot be established, issued and paid as set forth under Rate Effective Date:

1. The Department shall establish and issue a temporary rate calculated on the provider's filed cost report without adjustments.
2. All temporary rates shall, at the time the permanent rate is established, issued and paid, be subject to adjustment and recovery of any over or under payments.

Any delay in completion of the audit of the MED-13 that occurs within 90 days from the filing of the MED-13, and that is attributable to the provider, shall operate, on a time equivalent basis, to extend the time in which the Department shall establish, issue and pay a temporary rate under the provisions set forth above.

RATES FOR NEW FACILITIES

A new nursing facility means a facility:

1. That has not previously been certified for participation in Title XIX; or
2. That has not participated in Title XIX for a period in excess of 30 days prior to the effective date of the current Title XIX certification; or
3. That has changed from one class designation to another.

Nursing facilities that have undergone a transfer of ownership are not new nursing facilities provided the previous owner had participated in Title XIX in the last 30 days prior to ownership change.

A new nursing facility shall receive a per diem rate equal to the most recent average weighted rate for the appropriate nursing facilities class at the time the new facility begins business as a Medicaid provider.

1. This per diem rate shall remain in effect until a new rate is established based on the first cost report submitted as specified below.
2. The average weighted rate shall be calculated by the Department on the 30th of each month and shall not be revised when new rates are established which would retroactively affect the calculation.
3. The average weighted rate paid a new facility shall be adjusted on July 1 each year by the average weighted rate in effect on July 1.

New nursing facilities shall submit MED-I 3s during their initial year of operation as follows:

1. The first cost report shall be for a period covering the first day of operation through the facility's fiscal year end.
 - a. If the first cost report for the period covers a period of 90 days or more, imputed occupancy shall be applied as described under Imputed Occupancy for class II Facilities.
 - b. If the first cost report for the period covers a period of 90 days or more, the first cost report shall set the base for limitations on growth of allowable costs as described under Limitation on Medicare Part A and Part B Costs.
2. If the first cost report for the period specified above covers a period of 89 days or less, the facility's first cost report shall not be submitted until the next fiscal year end.
3. The next cost report shall be submitted for the twelve month period following the period of the first cost report.
4. A new nursing facility shall advise the Department of the date its fiscal year will end and of the reporting option selected.

RATES FOR RECEIVERSHIP

The following rate provisions apply for a facility where a receiver has been appointed by the Court, pursuant to Section 25-3-108, C.R.S., at the request of the CDPHE:

1. During the Receivership
 - a. During the term of the receivership, the facility shall be reimbursed the rate payable to the previous operator.
 - i) The Department may increase the rate if it finds that the patient-related, necessary and reasonable costs of the facility operation are not covered by the rate payable to the previous operator.
 - ii) The Department's analysis of necessary, patient related and reasonable costs incurred by the receiver shall not include any previous unpaid expenses of the prior owner or the mortgage costs of the facility.

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- b. The receiver shall submit a cost report for the time beginning when the receiver is appointed until the time the receiver is no longer operationally in control of the nursing facility operation.
 - i) This cost report shall set a rate payable to the receiver for the date the receiver took operational control of the facility.
 - ii) This retrospective rate may set a rate higher or lower than the initial rate established and paid to the receiver in which case the under or over payment shall be either paid to or collected from the receiver.
 - iii) The retrospectively set rate shall not exceed the established maximum allowable rates for that period.
- 2. New providers after the receivership period
 - a. The new operator shall receive the rate paid to the prior owner until the new provider submits a cost report unless the new operator chooses the retrospective option described below where a new operator takes control and ownership of a nursing facility from the receiver.
 - b. The new operator may elect to have a retrospective rate set for the initial three months of operation.
 - i) In order to exercise this option, the new operator shall file a cost report for the first three months of operation.
 - ii) The first day of operation shall mean the first day of licensure of the new operator. The last day of the initial three months of operation shall be the last day of the month in which the 90th day occurs.
 - iii) The cost report shall be filed within 90 days of the end of the initial three months of operation.
 - c. The retrospective rate established from the three month cost report shall be in effect from the first date of licensure of the new owner until the last day of the month in which the 90th day occurs. This rate shall be a prospectively paid rate to the new operator beginning with the first day of the month after the three month cost reporting period.
 - d. The initial rate paid to the new operator shall be the prior owner's rate.
 - i) The retrospective rate established by the three month cost report shall replace the initial rate paid to the operator.

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- ii) The retrospective rate may be higher or lower than the initial rate established and paid to the new operator in which case the under or over payment shall be either paid to or collected from the new operator.
- iii) The retrospectively established rate shall not exceed the maximum reasonable cost rates for that period.
- e. The three month cost report shall establish the prospective rate for the period established by the regulations at Section 8.443.13.
- f. The provider shall file the first cost report after the three month cost report. If the first cost report filed for the period immediately following the three month cost report demonstrates a reduction in per diem costs more than five percent which is caused by a reduction in per diem costs and not an increase in census, the following special provision shall apply:
 - i) The provider's prospective per diem rate driven by the three month cost report shall be retroactively reduced to the per diem rate as determined by the actual costs of the provider.
 - ii) The Department shall recover the difference between the provider's actual costs and the prospective rate paid to the provider. This recovery shall not apply to the three month retrospective rate as established by the initial three month cost report.

These special provisions do not apply when the receiver is appointed at the request of any other party such as the previous operator, landlord or other interested party.

PAYMENT FOR OUT OF STATE NURSING FACILITY CARE

Payments for out-of-state nursing facility care shall be made to providers when:

1. The nursing facility services are needed because of a medical emergency.
2. The nursing facility services are needed because the resident's health would be endangered if he/she were required to travel to Colorado and the attending physician has certified to such in the resident's medical records.
3. The Department determines, on the notification from the client's primary care physician, the needed medical services or necessary supplementary resources, are not available in Colorado but are available in another state;
 - a. The Department's State Utilization Review Contractor may review the appropriateness of care plan and documentation that the resident will demonstrate significant improvement.

The out-of-state nursing facility shall:

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1. Enroll as a provider in the Colorado Medicaid Program;
2. Submit a copy of the re-certification survey yearly upon completion done by the survey and certification and/or licensure agency in their state;
3. Submit a copy of the following documentation with the claims:
 - a. The current Medicaid provider agreement with the state where it is located;
 - b. The provider number in the state where it is located; and
 - c. Their Medicaid rate, at the time services were rendered, in the state where it is located.

Payment shall not exceed 100 percent of audited Medicaid costs as determined by the Department or its designee. Audited costs shall be based on Medicaid costs in the state where the facility is located.

If the facility is not a Medicaid participant in the state where it is located, it shall submit to the Department an audited Medicare cost report. The payment shall not exceed 100 percent of audited Medicare costs.

**STATE-OPERATED INTERMEDIATE CARE FACILITIES FOR
INDIVIDUALS WITH INTELLECTUAL DISABILITIES (CLASS IV)**

State-operated intermediate care facilities for Individuals with Intellectual Disabilities (class IV) shall be reimbursed based on the actual costs of administration, property; including capital-related assets, and room and board, and the actual costs of providing health care services. Actual costs will be determined on the basis of information on the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

1. These costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period.
2. Reimbursement to state-operated intermediate care facilities for the mentally retarded shall be adjusted retrospectively at the close of each twelve-month period.
3. The retrospective per diem rate will be calculated as total allowable costs divided by total resident days.

PROVIDER FEES

The state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal

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financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

1. Each class I nursing facility that is licensed in this State shall pay a fee assessed by the state department.
2. The following nursing facility providers are excluded from the provider fee:
 - a. A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102, C.R.S., or that provides assisted living services on-site, twenty-four hours per day, seven days per week
 - b. A skilled nursing facility owned and operated by the state;
 - c. A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and
 - d. A facility that has forty-five or fewer licensed beds.
3. To determine the amount of the fee to assess pursuant to this section, the state department shall establish a rate per non-Medicare patient day that is equivalent to accrual basis gross revenue (net of contractual allowances) for services provided to patients of all class I nursing facilities licensed in this State. The percentage used to establish the rate must not exceed that allowed by federal law. For the purposes of this section, total annual accrual basis gross revenue does not include charitable contributions received by a nursing facility.
4. The state department shall calculate the fee to collect from each nursing facility during the July 1 rate-setting process.
 - a. Each July 1, the state department will determine the aggregate dollar amount of provider fee funds necessary to pay for the following:
 - (i) State department's administrative cost
 - (ii) Provider Fee Offset Payment
 - (iii) Changes in acuity or case-mix of residents
 - (iv) Pay for Performance
 - (v) CPS
 - (vi) PASRR Resident and Facility
 - (viii) Excess of statutory limitation on growth in the general fund
 - b. This calculation will be based on the most current information available at the time of the July 1 rate-setting process.

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- c. The aggregate dollar amount of provider fee funds necessary will be divided by non-Medicare patient days for all class I nursing facilities to obtain a per day provider fee assessment amount for each of the two following categories:
- (i) Nursing facilities with 55,000 non-Medicare patient days or more;
 - (ii) Nursing facilities with less than 55,000 non-Medicare patient days.

The state department will lower the amount of the provider fee charged to nursing facility providers with 55,000 non-Medicare patient days or more to meet the requirements of 42 CFR 433.68 (e).

- d. Each facility's annual provider fee amount will be determined by taking the per day provider fee calculated above times the facility's reported annual non-Medicare patient days.
- e. Each nursing facility will report annually its total number of days of care provided to non-Medicare residents to the state department. Non-Medicare patient days reported in the year prior to the July 1 rate-setting process will be used as the facility's annual non-Medicare patient days for the provider fee calculation. New Facilities, facilities that will close during the rate year, and facilities with a change in certification or licensure will have their non-Medicare days estimated in order to determine the provider's fee payment.
- f. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.
- g. The state department shall assess the provider fee on a monthly basis.
- h. The fee assessed pursuant to this section is due 30 days after the end of the month for which the fee was assessed.

All provider fees collected pursuant to this section by the state department shall be transmitted to the state treasurer, who shall credit the same to the Medicaid nursing facility cash fund, which fund is hereby created and referred to in this section as the 'fund'.

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1. All monies in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the administrative cost of implementing section 25.5-6-202 and this section and to pay a portion of the per diem rates established pursuant to section 25.5-6-202 (1) to (4).
2. Following payment of the amounts described above, the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the rates established under section 25.5-6-202 (5) to (7).
3. Any monies in the fund not expended for these purposes may be invested by the state treasurer as provided by law.
 - a. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.
 - b. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but may be appropriated by the general assembly to pay nursing facility providers in future fiscal years.

The state department shall establish administrative penalties for the late payment by a nursing facility of a fee assessed pursuant to this section.

The state department may recoup any payments made to nursing facilities providing services pursuant to the Medicaid program up to the amount of the fees owed as determined pursuant to this section and any administrative penalties owed if a nursing facility fails to remit the fees and administrative penalties owed within 30 days after the date they are due. Before recoupment of payments pursuant to this section, the state department may allow a nursing facility that fails to remit fees and administrative penalties owed an opportunity to negotiate a repayment plan with the state department. The terms of the repayment plan may be established at the discretion of the state department.

HOSPITAL BACK UP LEVEL OF CARE

This program provides extra reimbursement to nursing facilities for costly, heavy care patients admitted directly from the hospital. The program is limited to patients whose hospitalization is being paid by Medicaid. In addition, the Statewide Utilization Review

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Contractor (SURC) must make a finding that the patient would continue to need hospital level of care.

Rate-setting under the Hospital Level Nursing Facility Clients Program is prospective and is based on an itemization of patient costs submitted by the nursing facility before the patient's admission to the facility. These costs must be based on a plan of care approved by the URC that adequately addresses each of the patient's care needs. The rate is approved by the Department prior to the client's admission to the facility. This reimbursement rate is subject to revision after the client's admission to the nursing facility based on the SURC's periodic assessment of the client's current care needs. The ceiling for payment under this program shall not exceed ninety percent (90%) of the Medicaid payment to the discharging hospital.

HOSPITAL SWING BEDS

When a hospital offers swing bed services, payment will be made at the average rate per client day paid to class I nursing facilities for services furnished during the previous calendar year. Payment for nursing facility services may not exceed the rates charged for the same services to private residents or residents with other sources of income.

Oxygen provided to swing bed patients is being paid at the same rate currently paid for residents in nursing care facilities in addition to payments made for routine services.

Recipients shall be required to contribute all patient income minus the personal needs amount to the cost of their skilled or intermediate nursing care. Collection as well as determination of the patient income amount shall be in accordance with the 10 C.C.R. 2505-10, §8.482 entitled "Resident Income and Possession".

RECOVERIES

In the event that an audit or other competent evidence reveals that a provider is indebted to the Medicaid program, the State shall recover this amount either through a repayment agreement by offsetting against current and future claims of the provider, through litigation, or by any other appropriate legal resource. Recovered amounts shall be reported to the Federal government through the HCFA 64.

APPEALS AND HEARING

The State provides an appeals or exception procedure that allows an individual nursing facility to submit additional evidence during and subsequent to the field audit of the nursing facility's annual cost report. Following completion of the rate audit process and the Department's issuance of a "rate letter" (stating the nursing facility's rate), the nursing facility is entitled to prompt administrative review through (1) informal reconsideration by the Department, and (2) a de novo hearing before an administrative law judge. Any issue relevant to the Department's

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calculation of the nursing facility's reimbursement rate may be considered during administrative review. However, the only evidence which may be admitted and considered is the evidence submitted by the nursing facility during the audit process prior to the issuance of the rate letter being appealed.

PUBLIC NURSING FACILITIES ADJUSTMENT

Effective October 25, 2001, expenditures for Medicaid services made by publicly owned nursing facilities shall be reflected in computation of an adjustment to quarterly expenditure reports. Application of this adjustment shall result in federal reimbursement, at the applicable matching rate, of total Medicaid expenditures that are up to but which do not exceed the allowable percentage of the Medicare Upper Payment Limit for nursing facility services established under federal regulations.

To complete this calculation, medicaid recipients within the publish nursing facilities shall be categorized into the forty-four (44) resource utilization groups ("RUGs") established by the Centers for Medicare & Medicaid Services for purpose of determining Medicare reimbursement. Once the RUGs categorization of Medicaid recipients is complete, a weighted average Medicare rate (which reflects the applicable rural wage index adjustment for the Prospective Payment System ("PPS")) will be calculated for each public facility. The weighted average Medicare rate will then be adjusted to remove ancillary services that are not included in the applicable Colorado Medicaid reimbursement rate for each public facility.

The weighted average per diem Medicare rate and the applicable per diem rate of Medicaid reimbursement shall then be compared. The difference between the Medicare reimbursement rate and the Medicaid reimbursement rate will be multiplied by Medicaid utilization for each public facility to determine the amount of public expenditures reflected in the quarterly payment adjustment.

IMPLEMENTATION OF A PASS-THROUGH PAYMENT SYSTEM FOR THE COSTS ASSOCIATED WITH THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA '87)

Pursuant to Senate Bill 90-18, the Department shall make pass-through payments to nursing facility providers to cover the costs associated with provisions of P.L. 101-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87)

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METHODS AND STANDARDS FOR ESTABLISHING PROSPECTIVE PAYMENT RATES
- NURSING FACILITY CARE

7. Public Nursing Facilities Adjustment

- A. Effective October 25, 2001, expenditures for Medicaid services made by publicly owned nursing facilities shall be reflected in computation of an adjustment to quarterly expenditure reports. Application of this adjustment shall result in federal reimbursement, at the applicable matching rate, of total Medicaid expenditures that are up to buy which do not exceed the allowable percentage of the Medicare Upper Payment Limit for nursing facility services established under federal regulations.

To complete this calculation, Medicaid recipients within the public nursing facilities shall be categorized into the forty-four (44) resource utilization groups ("RUGs") established by the Centers for Medicare & Medicaid Services for the purpose of determining Medicare reimbursement. Once the RUGs categorization of Medicaid recipients is complete, a weighted average Medicare rate (which reflects the applicable rural wage index adjustment for the Prospective Payment System ("PPS")) will be calculated for each public facility. The weighted average Medicare rate will then be adjusted to remove ancillary services that are not included in the applicable Colorado Medicaid reimbursement rate for each public facility.

The weighted average per diem Medicare rate and the applicable per diem rate of Medicaid reimbursement shall then be compared. The difference between the Medicare reimbursement rate and the Medicaid reimbursement rate will be multiplied by Medicaid utilization for each public facility to determine the amount of public expenditures reflected in the quarterly payment adjustment.

- B. Effective July 1, 2008, public nursing facilities will receive supplemental Medicaid payments to provide reimbursement to public providers for uncompensated care related to nursing facility services for Medicaid clients, such that total payments will not exceed the Medicare Upper Payment Limit for nursing facility services by provider class (state-owned and non-state owned Government nursing facilities). The nursing facilities Medicare Upper Payment Limit will be equal to a reasonable estimate of the amount that would be paid for nursing facility services using Medicare cost principles.

Public nursing facilities will certify their uncompensated costs for providing nursing facility services for Medicaid clients based on the Department's demonstration of the uncompensated Medicaid costs calculations performed for each provider. The Public Nursing Facility Supplemental Payment (Payment) will be distributed to providers based

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on each provider's uncompensated Medicaid care costs relative to the sum of uncompensated Medicaid care costs for all providers in the class, multiplied by the available Medicare Upper Payment Limit for the class. No public facility shall receive aggregate Medicaid payments that exceed the uncompensated costs it certifies for providing nursing facility services to Medicaid clients.

Interim Payments for the Payment calendar year (January through December) will be made by December 31 of the following calendar year using as-filed cost reports to calculate uncompensated costs. Uncompensated costs will be calculated for Final Payments using audited cost reports. Final Payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to each provider shall equal the Payment amount calculated based on uncompensated costs calculated through audited cost reports. Final Payments will be made by June 30 of the calendar year following the year of the Interim Payment. In the event that data entry errors are detected after the Final Payment has been made, or other unforeseen payment calculation errors are detected after the Final Payment has been made, reconciliations and adjustments to impacted provider payments will be made retroactively. Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed to each provider for purposes of authorizing certification. Each provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Payment.

Uncompensated costs for nursing facilities with State fiscal year reporting periods (i.e. July 1 through June 30) must be calculated and approximated for the calendar year Payment using cost reports from two adjacent years following the methodology in 7.B.2 and 7.B.4.

1. Calculating uncompensated Medicaid costs for Interim Payments made to nursing facilities with financial reporting periods of January 1 through December 31.
 - a. Adjusted costs are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63.
 - b. Total resident days are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D.4.
 - c. The average per-diem cost is calculated by dividing adjusted costs by total resident days.
 - d. Total Medicaid patient days are as recorded in the Colorado Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report

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- b Medicaid costs are calculated by multiplying the average per-diem cost by total Medicaid patient days
 - c Total Medicaid costs are the sum of Medicaid costs and the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report
 - d Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report
 - e Medicaid patient payments are as recorded in the Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report
 - f Total Medicaid payments are the sum of Medicaid reimbursements and Medicaid patient payments
 - g Uncompensated Medicaid costs are the difference between total Medicaid costs and total Medicaid payments
 - h Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs
- 2 Calculating uncompensated Medicaid costs for Interim Payments made to nursing facilities with financial reporting periods corresponding to the State fiscal year of July 1 through June 30
- a Adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63
 - b Total resident days for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D 4
 - c The average per-diem cost for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are computed by dividing the adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) by the total resident days for the fiscal year reporting period that includes the first six months of the Payment calendar year (January through June)
 - d Adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63
 - e Total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D 4
 - f The average per-diem cost for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) is

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computed by dividing the adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) by the total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December)

- g Total Medicaid patient days for the first six months of the calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS)
- h. Medicaid costs for the first six months of the Payment calendar year (January through June) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the first six months of the calendar year (January through June) by total Medicaid patient days for the first six months of the Payment calendar year (January through June) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report
- i Total Medicaid patient days for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS)
- j Medicaid costs for the last six months of the Payment calendar year (July through December) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the last six months of the calendar year (July through December) by total Medicaid patient days for the last six months of the Payment calendar year (July through December)
- k Medicaid costs for the Payment calendar year (January through December) are computed by adding Medicaid costs for the first six months of the Payment calendar year (January through June) plus Medicaid costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.
- l Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the first six months of the Payment calendar year (January through June)
- m Medicaid patient payments for the first six months of the Payment calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS)

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- n. Total Medicaid payments for the first six months of the Payment calendar year (January through June) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) and Medicaid patient payments for the first six months of the Payment calendar year (January through June)
 - o. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES" for the last six months of the Payment calendar year (July through December)
 - p. Medicaid patient payments for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).
 - q. Total Medicaid payments for the last six months of the Payment calendar year (July through December) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and Medicaid patient payments for the last six months of the Payment calendar year (July through December)
 - r. Total Medicaid payments for the Payment calendar year (January through December) are computed by adding total Medicaid payments for the first six months of the Payment calendar year (January through June) plus total Medicaid payments for the last six months of the Payment calendar year (July through December)
 - s. Uncompensated Medicaid costs for the Payment calendar year (January through December) are the difference between total Medicaid costs for the Payment calendar year (January through December) and total Medicaid payments for the Payment calendar year (January through December)
 - t. Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs
3. Calculating uncompensated Medicaid costs for Final Payments made to nursing facilities with financial reporting periods of January 1 through December 31
- a. Adjusted costs are as reported on the audited Colorado "Med-13" cost report, Schedule C, column 11, line 63
 - b. Total resident days are as reported on the audited Colorado "Med-13" cost report, Schedule of Adjustments, "Adjusted Balance" column
 - c. The average per-diem cost is calculated by dividing adjusted costs by total resident days.

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- d Total Medicaid patient days are as recorded in the Colorado Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the Colorado audited "Med-13" cost report
 - e Medicaid costs are calculated by multiplying the average per-diem cost by total Medicaid patient days
 - f Total Medicaid costs are the sum of Medicaid costs and the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report
 - g Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4 19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report
 - h Medicaid patient payments are as recorded in the Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the audited Colorado "Med-13" cost report
 - i Total Medicaid payments are the sum of Medicaid reimbursements and Medicaid patient payments
 - j Uncompensated Medicaid costs are the difference between total Medicaid costs and total Medicaid payments
 - k Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs
- 4 Calculating uncompensated Medicaid costs for Final Payments made to nursing facilities with financial reporting periods corresponding to the State fiscal year of July 1 through June 30

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- a Adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the audited Colorado "Med-13" cost report, Schedule C, column 11, line 63
- b Total resident days for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the audited Colorado "Med-13" cost report, Schedule of Adjustments, "Adjusted Balance" column
- c The average per-diem cost for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are computed by dividing the adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) by the total resident days for the fiscal year reporting period that includes the first six months of the Payment calendar year (January through June)
- d Adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the audited Colorado "Med 13" cost report, Schedule C, column 11, line 63
- e Total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the audited Colorado "Med-13" cost report, Schedule of Adjustments, "Adjusted Balance" column
- f The average per-diem cost for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) is computed by dividing the adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) by the total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December)
- g Total Medicaid patient days for the first six months of the calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS)
- 1 Medicaid costs for the first six months of the Payment calendar year (January through June) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the first six months of the calendar year (January through June) by total Medicaid patient days for the first six months of the Payment calendar year (January through June)) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado ' Med-13 ' cost report

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- h. Total Medicaid patient days for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS)
- i. Medicaid costs for the last six months of the Payment calendar year (July through December) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the last six months of the calendar year (July through December) by total Medicaid patient days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December)
- j. Medicaid costs for the Payment calendar year (January through December) are computed by adding Medicaid costs for the first six months of the Payment calendar year (January through June) plus Medicaid costs for the last six months of the Payment calendar year (July through December)
- k. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4 19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the first six months of the Payment calendar year (January through June)
- l. Medicaid patient payments for the first six months of the Payment calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS)
- m. Total Medicaid payments for the first six months of the Payment calendar year (January through June) are the sum of Medicaid reimbursements for the first six months of the Payment calendar year (January through June) and Medicaid patient payments for the first six months of the Payment calendar year (January through June)
- n. Medicaid reimbursements for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS). Medicaid reimbursements shall include any supplemental payments paid in accordance under this Attachment 4 19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the last six months of the Payment calendar year (July through December)
- o. Medicaid patient payments for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS)

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- p. Total Medicaid payments for the last six months of the Payment calendar year (July through December) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and Medicaid patient payments for the last six months of the Payment calendar year (July through December)
- q. Total Medicaid payments for the Payment calendar year (January through December) are computed by adding total Medicaid payments for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) plus total Medicaid payments for the last six months of the Payment calendar year (July through December)
- r. Uncompensated Medicaid costs for the Payment calendar year (January through December) are the difference between total Medicaid costs for the Payment calendar year (January through December) and total Medicaid payments for the Payment calendar year (January through December)
- s. Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs

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**FACILITY EVACUATION PAYMENTS AND MEDICAID ADMINISTRATIVE
PROCESSES**

Medicare and Medicaid nursing facilities must take measures to adhere to all applicable federal and state processes and/or rules when affected by natural disasters and critical incidents. If situations imposed by the disaster or critical incident impedes the ability of the facility to adhere to applicable federal and/or state rules and processes, the facility will report the rule or process that cannot be followed due to the disaster to Colorado Department of Health Care and Policy and Financing (the state agency). The facility may request modification or waiver of the process and/or rule from the state agency and the request will be modified or waived at the state agency's discretion. This is applied when facilities:

- (a) Due to the disaster or critical incident, must evacuate residents from Medicare and/or Medicaid participating facilities into non-participating facilities and/or other locations, including but not limited to shelters, state licensed private nursing facilities, hospitals, community, or other;
- (b) Due to the disaster or critical incident, cannot follow federal and/or state processes and/or rules, including but not limited to, Pre-Admission Screening and Resident Review (PASRR), Institution for Mental Disease (IMD) restrictions, and/or Minimum Data Set (MDS) rules and processes;
- (c) Due to the disaster or critical incident, cannot comply with licensure and certification requirements;
- (d) Due to the disaster or critical incident, nursing facilities receive home and community based (HCBS waiver) or home health clients in order to preserve their health, safety, and welfare;
- (e) Due to the disaster or critical incident, the evacuated facility is evacuated beyond the 30-day MDS/Prospective Payment System (PPS) "emergency transfer" limit and continues to retain staff (or share staff with the receiving facility), have operational expenses, and requests payment in order to preserve client access to this Medicaid service; and
- (f) Due to the disaster or critical incident, the affected facilities (evacuated or receiving) cannot adhere to any other federal and/or state process and/or rules.

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Payments made under this provision will not exceed, in the aggregate, the upper payment limit defined under 42 CFR 447.272. For the purposes of the upper payment limit calculation, a resident day shall only be counted once for any day that an evacuated resident is not in the evacuating facility but is in another location.

Evacuation Payment Methodology

The Department will use the methodology detailed in Colorado SPA 4.19-D, TN 09-013, entitled "Nursing Facility Benefits", which establishes a prospective reimbursement system for nursing facilities. To address how the methodology is applied during a disaster and resulting nursing facility evacuation, the process allows the evacuated resident to "transfer" to a receiving facility, a mutual payment agreement between the facilities to form, and a "pass-through" payment to occur.

Here is the process:

1. When a resident is transferred to a second facility with an anticipated return to the originating facility, the originating facility may bill for the services using the originating facility's provider number. The originating facility will be responsible for payment to the second facility for the services the second facility provides. This occurs when the transfer is for no more than 30 days.
 - a. A mutual agreement between the facilities is formed which addresses how to disburse reimbursement differentials, disparities, patient payment issues, shared staff, etc.
 - b. The evacuated facility will bill under its provider number and "pass through" payment to the receiving facility, and
 - c. The evacuated facility will record the census.
2. The evacuating facility should determine by day 15 whether or not residents will be able to return to the facility within 30 days. (If the residents are able to return to the originating facility, the MDS cycle will continue as though the residents were never transferred.) The intermediary will process these claims using the originating facility's provider number as if the resident had not been transferred.

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3. If the originating facility determines that the resident will not return to their facility within the previously mentioned time frame of 30 days, the originating facility will discharge the resident as appropriate. The receiving facility will then admit the resident and complete an admission MDS (and/or a 5-day MDS) as per the OBRA/ PPS requirements. The MDS cycle will begin as of the admission date.
 - a. Prior to day 30 or on day 30, the receiving facility should discharge or admit the evacuated residents, which terminates the pass through payment process.
 - b. The evacuated facility may not bill for day 30, if the resident is admitted into the receiving facility on day 30.
 - c. If the receiving facility admits residents on day 30, it must initiate a new PAR.
4. Until the return or not date is determined, the OBRA/PPS MDSs are to continue to be done as per their respective schedules.
5. If the transfer period with the pass through payment must occur beyond the thirty days, both facilities must notify the Department that transfer cannot occur and provide supporting evidence explaining why the transfer cannot occur.
6. The Department will make a determination of whether it should grant an extended transfer period.
7. If the Department grants the extended transfer period, the "pass-through" payment system will continue until discharge or a permanent placement is possible.

TN No. 13-054

Supersedes TN No. NEW

Approval Date MAY 21 2014

Effective Date: September 11, 2013

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METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES - OTHER
TYPES OF CARE

16. Psychiatric Residential Treatment Facilities

METHODOLOGY

The Psychiatric Residential Treatment Facility (PRTF) reimbursement rate is an all-inclusive per diem rate based on a prospective payment model for the 24-hour treatment of Medicaid clients residing within a PRTF.

The sources used to develop the all-inclusive per diem rate include:

- a. Historical cost reports and utilization data from numerous PRTFs within Colorado
- b. Various nurse compensation benchmarking data sources including: Pay Scale, Allied Physicians, Economic Research Institute, and the Health Resources and Services Administration of the U.S. Department of Health and Human Services
- c. State of Colorado Medicaid Fee-For-Service (FFS) reimbursement rates for mental health services comparable to mental health services provided within a PRTF
- d. Subject matter expertise with broad managed care experience
- e. Subject matter expertise with developing mental health payment models, and
- f. Historical Medicaid cost and utilization claims data.

The PRTF per diem rate is determined to reimburse for the following three categories:

- I. Child maintenance services including 24-hour care, room and board, and administrative services.

Costs for child maintenance services are determined using PRTF submitted facility, personnel, food, and occupancy expenses, janitorial, maintenance, rent, property taxes, etc.

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METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

16. Psychiatric Residential Treatment Facilities

2. Medical services including behavioral health therapies, medication management, psychiatrist care and supervision, case management, and rehabilitative type therapies.

Costs for medical services are determined using 660 expected minutes of care per week divided as follows:

- a. Individual Therapy (120 minutes/week),
 - b. Group Therapy (240 minutes/week),
 - c. Family Therapy (90 minutes/week),
 - d. Treatment Team Care (60 minutes/week),
 - e. Psychiatrist Care, including treatment team care, medication management, and post-intervention debriefs (90 minutes/week, services), and
 - f. Occupational Therapy (60 minutes/week).
3. Registered Nurse (RN) staffing on-site 24 hours per day, 7 days per week.
- Costs for RN staffing are determined using three full-time equivalent (FTE) salaries with benefits, training and ongoing education, and an additional amount to accommodate coverage during vacation time..

PROVIDER REIMBURSEMENT

The per diem rate is all-inclusive, covering all costs associated with daily care, administrative services, and room and board. No services are to be billed by the PRTF in addition to the PRTF per diem rate on the same date of service for a Medicaid client.

Payments are made to providers as they are billed with Medicaid Management Information System (MMIS) on a weekly, bi-weekly, or monthly basis.

Services shall be provided in an out-of-state setting if medically necessary and no suitable treatment option is found in Colorado. Out-of-state providers must enroll as a Colorado Medicaid Provider pursuant to 10 C.C.R. 2505-10, Section 8.013.1, and shall meet the requirements pursuant to 10 C.C.R. 2505-10, Section 8.765.5.N.1.d and Section 8.765.5.N.1.e prior to receiving payment. Payment for services provided in an out-of-state setting shall be individually negotiated by the Department. Payment is not to exceed 100% of billed charges.

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METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

16. Psychiatric Residential Treatment Facilities

UPPER PAYMENT LIMIT (UPL) CALCULATION

The Department conducts an analysis of the prevailing private-pay and commercial-insurance rates for PRTF-like services for the purposes of setting the Upper Payment Limit (UPL) for PRTF services according to 42 CFR 447.325.

PAYMENT RATES

The PRTF rate is set according to the methodology outlined in this document and is adjusted according to Colorado General Assembly appropriation.

PRTF services shall be reimbursed at the lower of the following:

1. Submitted charges, or
2. Fee schedule for PRTF services as determined by the Department of Health Care Policy and Financing.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. The reimbursement rates were set as of July 1, 2020 and are effective for services provided on or after that date. All rates can be found on the official website of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf.

TN No. 20-0023
Supersedes TN No. 19-0007

Approval Date_ 12/21/20
Effective Date July 1, 2020

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ATTACHMENT 4.19-D

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**NURSING FACILITY SUPPLEMENTAL PAYMENT FOR PHYSICALLY,
BEHAVIORALLY, AND/OR SOCIALLY COMPLEX PATIENTS**

Effective Date of Payment

Effective July 1, 2017, eligible privately-owned nursing facilities shall receive supplemental Medicaid reimbursement for costs incurred treating complex clients, such that the sum of all Medicaid reimbursement remains below the Upper Payment Limit (UPL) for privately-owned nursing facilities. This supplemental payment will be referred to as the "Nursing Facility Supplemental Payment for Physically, Behaviorally, and/or Socially Complex Patients" (the Payment).

The Nursing Facility Supplemental Payment for Physically, Behaviorally, and/or Socially Complex Patients will only be made if there is available federal financial participation under the aggregate Upper Payment Limit (UPL) for privately-owned nursing facilities after all Medicaid reimbursement – as defined in Colorado State Plan 4.19-D – is completed.

Qualifying Criteria

To be eligible for the Payment, a nursing facility must meet the following criteria:

1. Be privately-owned;
2. Have a client census that is at least ninety (90) percent Medicaid days based on its most recently audited Med-13 cost report;
3. Demonstrate that for at least eighty (80) percent of the most recent cost report year it served at least two (2) uninsured clients lacking the resources to pay for care (not including clients that have a pending Medicaid eligibility);
4. Be located within the city and county of Denver; and,
5. Certify to the state its commitment to provide long term care services and supports in the least restrictive manner for such complex patients discharged from a hospital operated by the Denver Health and Hospital Authority created pursuant to Colorado Revised Statutes § 25-29-101, et seq.

Certification Process

Prior to issuing the supplemental Payment, the state will notify, by electronic mail, each privately-owned nursing facility located within the city and county of Denver with a client census count of at least ninety (90) percent Medicaid days based on its most recently audited Med-13 cost report that it may be eligible to receive a "Nursing Facility Supplemental Payment

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for Physically, Behaviorally, and/or Socially Complex Patients". In order to receive this payment, the nursing facility must comply with the instructions and deadlines contained in the electronic mail notification and:

- Provide documentation to the state that demonstrates that for at least eighty (80) percent of the most recent cost report year it served at least two (2) uninsured clients lacking the resources to pay for care (not including clients that have a pending Medicaid eligibility); and
- Provide a signed statement from its administrator, chief financial officer, or chief executive officer that certifies to the state its commitment to provide long term care services and supports in the least restrictive manner for complex patients discharged from Denver Health Medical Center and report annually to the state on the number of patients accepted and patient outcomes.

Payment Methodology

For state fiscal year (SFY) 2017-2018, the payment pool will equal total funds of \$1,000,000. For SFY 2018-2019 and onwards, the payment pool will have total funds of \$1,400,000, subject to the UPL described above. The pool payments will be distributed to eligible nursing facilities based on their relative share of Medicaid fee for service (FFS) days to Medicaid FFS days of all eligible nursing facilities based on the most recently audited Med-13 of each eligible facility. Payment will occur as an annual lump-sum payment in the third quarter of the SFY, and will not exceed 75 percent of the available UPL. If the payment pool is not paid in its entirety due to its exceeding the 75 percent UPL availability, then the remainder not paid during the third quarter will be paid in the following quarter, up to the available UPL room left for the state fiscal year.

TN No. 19-0011

Supersedes TN No. 15-0040

Approval Date: JUN 27 2019

Effective Date 4/1/2019

ATTACHMENT A

OBRA'87 Topic: Requirements Relating to Provision of Services

Summary Impact on: Nursing Facility

OBRA'87 Requirement

State Requirement

Fiscal Impact

Quality of Life

- Promote the maintenance/enhancement of patient quality of life.

Previous State regulations did require social work and activity programming to meet needs of residents. State regulations also required same qualification at these regulations.

The interpretative guidelines seem to indicate a higher level of effort that required in the past. The State assumes NFs will need to increase their social work and/or activity staff personnel by approximately 25 percent of an FTE. Average costs per activity/social worker personnel is assumed to be \$10.48 per hour. Assuming a full time person works 2,080 hours, a quarter person is 520 hours. There are 183 NFs = \$997,276 x 65 percent Medicaid patients x 75 percent of the year (10/1/90 - 6/30/91) = \$486,172.

The State has a special program of providing mental health services to nursing facility residents which is not reimbursed through the nursing home rate structure and not a part of Section 4.190. Further information on this special program is in Attachment D.

Document No. 95-007
File Approved 8/2/96
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Transmittal 90-010

ATTACHMENT A

OBRA'87 Topic: Requirements Relating to Provision of Services

Summary Impact on: Nursing Facility

OBRA'87 Requirement

State Requirement

Fiscal Impact

Quality of Life

NF must:

- Maintain quality assessment and assurance committee - composed of nursing director, physician, and three other staff members; committee must meet quarterly to identify quality assurance activities and implement plans to correct deficiencies.

Previous State requirement.

Since NFs required to meet this requirement no increase due to OBRA'87.

Sec. 1919(b) (1)

Transmittal No. 95-007
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Fiscal Year 10/1/95
Transmittal 90-010

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

<u>OBRA '87 Requirement</u>	<u>State Requirement</u>	<u>Fiscal Impact</u>
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Plan of Care

Services must be provided according to a plan of care.

Plan to be developed by:

- attending physician
- RN
- Resident or representative

Plan must describe patients medical, nursing and psychosocial needs, and how needs will be met.

Plan must be reviewed/revised periodically following resident assessment.

[Sec. 1919(b)(2)]

Previous State requirement.

No new cost increase due to OBRA '87. The State has previously required comprehensive plans of care, developed by the attending physician, RN, resident or representative. OBRA '87 does introduce the new MDS form which will be the principle plan of care document. Pre-existing level of effort and cost experience will be used to meet the preparation requirements of the MDS. The State also estimates additional nursing time will be needed in the preparation than previously experience. This new level of effort is provided for in the fiscal impact found on page 3.

95-007
 Approved 8/2/96
 Effective Date 10/1/95
 Transmittal 90-010

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

<u>OBRA '87 Requirement</u>	<u>State Requirement</u>	<u>Fiscal Impact</u>
Resident assessment must be conducted by RN no later than 4 days following admission.	Not previous State requirement, however, a general assessment of resident's conditions were required.	The resident assessment requirements of OBRA 87 are more extensive than State requirements. Please see Detailed Analysis, Attachment B.
Assessment must:		
• describe resident capabilities and significant impairments in performing ADLs	Same	The PASARR assessments were conducted by agencies independent of the NFs, therefore, NFs incurred no, or very little, cost for this review.
• be based on uniform minimum data set prescribed by HHS	Same	
• identify medical problems of Medicare-eligible residents	Same	
• use State-specified instrument for Medicaid-eligible residents	Previous State requirement	
• be performed at least once every 12 months, or after significant change in condition	Not previous State requirement, however, a general assessment of resident's conditions were required.	
• be coordinated with PAS to avoid duplication	Not previous State requirement.	
Preadmission screening (PAS) - MR/MI residents must not be admitted to NF without State MR/MI authority concurrence.		

[Sec. 1919(b)(3)]

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ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

<u>OBRA '87 Requirement</u>	<u>State Requirement</u>	<u>Fiscal Impact</u>
<u>Required Training of Nurse Aides</u>		
Within first 4 months of employment, nurse aide must:	No previous State requirement.	Significant fiscal impact (See detailed worksheet, Attachment C)
<ul style="list-style-type: none"> • complete a state-approved training and competency evaluation program • be determined competent 		Portion of aide training expenses covered under Section 4.19D of the State Plan which is considered to be medical assistance.
Nurse aides employed as of July 1, 1989, must complete training and competency evaluation by January 1, 1990.		Continuing education total: \$558,196 (see Attachment C for calculations and estimates).
Training required for aides who have not performed nursing-related services for a 24-month period.		
NF to provide regular in-service education.		
NF must query state nurse aide registry to determine competency prior to employing aides.		
[Sec 1919(b)(5)(B)]		

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ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Residents' Rights

Primary Impact on: Nursing Facility

OBRA '87 Requirement

State Requirement

Fiscal Impact

Equal Access to Quality Care

NF must maintain identical policies and practices regarding transfer, discharge and covered Medicaid services for all individuals regardless of payment source.

This requirement must be detailed in the Medicaid State plan.

Not a previous State requirement.

While not a previous State requirement, the State does not believe this will incur a significant impact beyond the level of effort currently incurred by NFs or if there is a fiscal impact, it is confined to documenting a transfer or a discharge has been completed in accordance with the new standards. The State believes these document requirements will be satisfied when the NF completes the resident assessment on residents upon transfer or discharge the resident assessment task has been found to cost more and has been included in the "add-on" payment calculation.

Based upon State surveyor knowledge of provision of care in Colorado, NFs equal access to quality of care has been provided to non-Medicaid residents.

INITIAL NO. 95-007
 Date Approved 8/2/96
 Effective Date 10/1/95
 Encloses Transmittal 90-010

x65

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Residents' Rights

Primary Impact on: Nursing Facility

OBRA '87 Requirement

State Requirement

Fiscal Impact

Protection of Resident Funds

NF may not require residents to deposit personal funds with the facility.

NF must, if it accepts the written authorization to manage and account for personal funds:

- Deposit all amounts \$50 and over in an interest-bearing account separate from the facility's operating account.
- Credit interest to the separate account. Maintain other personal funds in a non-interest bearing account or petty cash fund.
- Keep separate accounting for each resident's personal funds and make the written records accessible to residents.
- Upon death of resident, promptly convey personal funds and final accounting to administrator of resident's estate.

Previous State requirement.

Generally speaking, State requirements covered these OBRA '87 requirements in most areas. However, the requirement that all amounts of \$50.00 or more be deposited in an interest bearing account and credit the interest to the individual's account may require additional bookkeeping, as most homes currently place all personal needs money into one personal needs account. Generally speaking, no provisions are made to keep accounts with less than \$50.00 segregated from the other personal needs accounts.

There will be a slight fiscal impact to the bookkeeping operation due to the \$50.00 rule. Amount of fiscal impact should be less than \$50,000 per year.

\$50,000 X 65% Medicaid residents = \$32,500.

As stated, the State has had very extensive regulations governing the administration of personnel needs funds. The only difference in the OBRA '87 regulations is the \$50.00 interest bearing provision. The State does not foresee NFs having extra staff or incurring additional time to meet this requirement. However, the State does foresee a small new level of effort for the start up activities to meet the new requirement. Start up would involve changing existing accounting procedures. Some NFs may expend small amounts of money in this training, reformatting activities. While it is very difficult to estimate a cost for this item, it seems reasonable to assume no more than 15 hours per NF at a cost of \$20 per professional accounting time would be sufficient for this task.

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Total Attachment A Costs in Period July 1990 to June 1991

Quality of Life	\$ 486,172
Resident Assessments	795,000
24 Hour Nursing	183,660
Aides Training	2,025,242
Specified Rights	260,000
Resident Funds	32,500
TOTAL	\$3,782,574

Patient days October 1, 1990 - June 30, 1991 = 2,790,688

Add-on Rate = \$1.35

Total Attachment A Costs Which is Medical Assistance

Quality of Life	\$ 486,172
Resident Assessments	795,600
24 Hour Nursing	183,660
Aides Training	558,196
Specified Rights	260,000
Resident Funds	32,500
TOTAL	\$2,316,128

Patient days October 1, 1990 - June 31, 1991 = 2,790,688

Medical Assistance costs per day = .83 cents per day

95-007
8/2/95
Effective Date 10/1/95
Summary of Transmittal 90-010

ATTACHMENT B

Detailed Analysis on Resident Assessment

Assumption #1

Effective October 1, 1990, OBRA 87 requires all residents be assessed each quarter.

Assumption #2

Nursing facilities assess residents under current practice and regulations. Much of the costs have been incurred by nursing facilities. However, the Department estimates that each assessment will require an additional 1.5 hours of nursing time to complete the assessment.

Assumption #3

There are currently 10,000 Medicaid residents. This 10,000 person enrollment is generally steady throughout the year. During any year, it is reasonable to expect nursing facilities to complete 10,000 Medicaid assessments, including admissions, transfers, quarterly reviews, etc.

Assumption #4

The average hourly costs of an RN with fringe benefits is 17.68.

Calculation

10,000 Medicaid residents
X 4 Assessments per year
= 40,000 Assessments
X 1.5 hours per assessment
= 60,000 hours
X 17.68 costs per hour
= \$1,060,800
X .75% Nine months of assessments in the July 1990 to June 1991 year
= \$795,600

Transmittal No. 95-007
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Supplemental Transmittal 90-010

ATTACHMENT Ctailed worksheet for required training of nurses aides.

Federal law and instruction allows aide training expenses associated with continuing education of nurse aides to be claimed by the states as medical assistance and as such is covered by State Plan TN 90-10. The training and certification of new aides is considered to be Medicaid administration. These figures provide detail on these two categories of costs. The costs in State Fiscal Year 1990 have already been "passed-through" to the nursing facilities in June 1990, the actual amount paid is presented in this report. The costs in State Fiscal Year 1991 are an estimate of the portion of the rate add-on the providers have received in State Fiscal Year 1991 beginning with dates of service after October 1, 1990.

Assumption #1:

The most recent figures from the Colorado Department of Regulatory Agencies (which administers the aide training certification responsibility in Colorado) show there are 7,000 nursing home aides.

Assumption #2:

There is a 50% turnover in aides per year. Each newly hired aide would need to receive 75 hours of training. Since some new aides recently received 75 hours of aide training, they would not be subject to the continuing education requirements until they are at least in their second quarter of employment. We assume that only 65% of total 3,000 aides would need continuing education a year due to the 50% turnover rate.

Assumption #3:

Aides in nursing facilities would need to complete their continuing education during the period when they are not working in the nursing facilities. Such overtime activity would cause many aides to be paid time and one-half. According to Department statistics, time and one-half would be approximately \$6.48 in the July 1989 to June 1990 period and \$7.01 in the July 1990 to June 1991 period.

Assumption #4:

Nursing facilities began the continuing education process in January 1990 as originally required by HCFA.

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Approved 8/2/96
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Sponsor's Transmittal 90-010

ATTACHMENT C

- I. Aide training certification and continuing education costs for the July 1, 1989 to June 30, 1990 period.

Total Medicaid "pass-through" expenditures to date: \$2,419,299

These pass-through payments were based on the requests submitted by providers during this period. The Department is in the process of auditing these requests to actual costs. When the providers submitted their requests, a break down between aide training and continuing education costs was not established. The audits will provide this break down. The Department estimates the following amounts were expended in the following categories:

Aide Training and certification:	2,148,421.00 (i.e., Medicaid administration)
Continuing Education:	<u>270,878.00</u> (i.e., Medicaid assistance)
Total:	2,419,299.00

The basis for the Department's estimates for continuing education are as follows:

1. Salary Costs

7,000 Total aides
 X 65% Aides needing continuing education
 4,550 Aides needing 24 hours continuing education a year
 4,550 aides X 12 hours training* X \$6.84/hour = \$373,646

2. Training Time

150 classes (with 30 aides per class) X 31 hours X \$12/hour = \$43,272

3. Total

	373,646
+	<u>43,272</u>
	416,736
X	65% Medicaid residents
	<u>\$270,878</u>

*Twelve hours of training time is specified here instead of 24 hours because the continuing education would have only been provided from January 1, 1990 through June 30, 1990

- II. Aide training certification and continuing education costs for the July 1, 1990 to June 30, 1991 period.

The State is providing a rate "add-on" payment of \$1.20 beginning with dates of service beginning October 1, 1990. This rate "add-on" payment covers many new cost categories besides aide training. The Department provides a breakdown of the aide training expenses as follows:

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ATTACHMENT C

Aide Training and Certification

1. Initial Training Total: 1,467,046 (i.e., Medicaid administration)

3,500 new aides X 75 hours X \$4.21/hour = \$1,105,125

Training the Trainer

Two RNs per nursing facility X 183 homes X 445 per RN = \$162,870

Supplies and Materials

3,500 new aides X \$25/aide = \$87,500

Training Time

1,000 classes X 75 hours X \$12.00/training hour = \$901,500

TOTAL:

\$1,105,125

162,870

87,500

901,500

\$2,256,995

X 65% Medicaid share of residents

\$1,467,046

2. Continuing Education Total: \$558,196 (i.e., Medical assistance)

Salary Costs

7,000 total aides

X 65% Aides will need continuing education

4,550 aides needing 24 hours continuing education a year

4,550 aides X 24 hours training X \$7.01/hour = \$765,492

Training Costs

150 classes (with 30 aides per class) X 24 hours X \$12.00/hour = \$93,282

TOTAL:

\$765,492

+93,282

\$858,774

X 65% Medicaid share of residents

\$558,196

1,209
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3. Total amount of the \$1.20 rate add-on associated with aide training:

\$1,467,046 Training and certification

+ 558,196 Continuing education

\$2,025,242

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Effective Date 8/2/96
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TOTAL P.11

ORIGINAL NO. 95-007
 Date Received 8/2/96
 Expiration Date 10/1/95
 Date of Transmittal 90-010

Amount of the 17 cents in revenue established
to be Medicaid Administration and Medical Assistance.

The 17 cents is expected to be paid during the
October 1, 1990 to June 30, 1991 period.

Estimate 7/1/88 - 6/30/90

Total Aide Training and Certification costs:
 Aide Training and Certification
 Continuing Education

2,419,299.00
 2,148,921.00 = Medicaid Administration
 270,868.00 = Medical Assistance

The 17 cents in revenue for the 10/1/90 to 6/30/91 period is based on the OBRA'87 costs described above.

The portion of the 17 cent which relates to Medicaid Administration is 15.1 cents ($2,148,421.00 \div 89\%$. 89% of 17 cents is 15.1 cents).

The portion of the 17 cents which relates to Medical Assistance is 1.9 cents ($270,878 \div 11\%$. 11% of 17 cents is 1.9 cents).

ATTACHMENT D

Costs of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for benefits.

The rate add-on analysis provided in Attachments A, B and C indicates an expectation that nursing facilities will need to increase their staffing levels to meet the OBRA '87 requirements. Specifically all nursing facilities are expected to increase their social work staff on average by 25 percent of a Full Time Employee. Facilities are also expected to increase their nursing staff to complete the MDS/resident assessment and related requirements.

An additional program to promote care and treatment of the psychosocial needs of the Medicaid residents in Colorado nursing facilities includes a mental health initiative which was expected to cost \$2.8 million for the period of July 1, 1990, through June 30, 1991. This program is based on the results of the PASARR examination of the residents in Colorado facilities exhibiting evidence of mental illness. Over 2,300 PASARR reviews were completed in the last year. The PASARR exam, in addition to indicating the need for nursing facility placement, also identified the mental health needs of the residents. These exams indicated that 800 residents were in need of various forms of mental health treatments to meet their psychosocial needs.

On the basis of the needs identified in the PASARR process, a special mental health treatment program provided by the mental health professionals in the employ of local mental health clinics will be delivered to these residents. This program will provide therapies, treatments and in-house training to nursing facility staff to meet the psychosocial needs of these residents.

This program will be reimbursed by Medicaid through the rehabilitation option. Medicaid payments will go directly to the mental health clinics who will be directly treating the nursing facility residents. Since this payment methodology is not included in the rate add-on it is not included in State Plan TN 90-10. However, this \$2.8 million initiative which is in direct response to the OBRA '87 reforms should, when combined with the provision of State Plan TN 90-10 which includes a interim rate add on payment of \$1.37 (see page 4 of CDSS 2/21/91 letter) as well as retrospective adjustment to actual cost, meet the psychosocial needs of nursing facility residents.

Transmittal No. 95-007
Date Approved 8/2/96
Effective Date 10/1/95
Supersedes Transmittal 90-010

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

OFFICIAL

State of Colorado

79-29

DEFINITION OF A CLAIM - BY TYPE OF SERVICE

The following definitions of a claim shall apply for purposes of meeting the requirements of Section 4.19 of this Plan.

1. For all services except prescription drugs, a claim shall mean a bill for services.
2. For prescription drugs, a claim shall mean a line item of service.

TN 79-29

Colo. 11/13/79 Incorp. 12/28/79 10/1/79

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for
Physicians' or Dentists' Services

Direct payments are made to certain recipients
as specified by, and in accordance with, the
requirements of 42 CFR 447.25.

- ☐ Yes, for ☐ physicians' services
☐ dentists' services

ATTACHMENT 4.20-A specifies the
conditions under which such payments are
made.

- ☒ Not applicable. No direct payments are
made to recipients.

TN # 79-13
Supersedes
TN # _____

Approval Date 12/19/79 Effective Date 4/1/79

OFFICE

Revision: HCFA-AT-81-34 (BPP)

10-81

State _____

Citation42 CFR 447.10(c)
AT-78-90
46 FR 426994.21 Prohibition Against Reassignment of
Provider ClaimsPayment for Medicaid services
furnished by any provider under this
plan is made only in accordance with
the requirements of 42 CFR 447.10.

Administrative

DEC 31 12 47 PM '91

RECEIVED

TN # 81-31

Supersedes

TN # _____

Approval Date 1/26/82Effective Date 10/1/81

Revision: HCFA-PM-94-1 (MB)
September 1994

State/Territory: Colorado

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

- (1) 42 CFR 433.138 and 433.139.
- (2) 42 CFR 433.145 through 433.148.
- (3) 42 CFR 433.151 through 433.154.
- (4) Sections 1902(a)(25)(H) and (I) of the

1902(a)(25)(H) and (I)
Act.
of the Act

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii)
and (2)(ii)

- (2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i)
and (iii)

- (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i)
through (iii)

- (4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

TN No. 94-027

Supersedes

TN No. 90-08

Approval Date

10/27/94

Effective Date

10-1-94

Revision: HCFA-PM-94-1 (MB)
September 1994

State/Territory: Colorado

Citation

- 42 CFR 433.139(b)(3) (ii)(A) (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
- (d) ATTACHMENT 4.22-B specifies the following:
- 42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
- 42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
- 42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
- 42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

TN No. 94-027
Supersedes Approval Date 10/27/94 Effective Date 10-1-94
TN No. 90-08

Revision: HCFA-PM-94-1 (MB)
September 1994

State/Territory: Colorado

Citation

4.22 (continued)

42 CFR 433.151(a)

- (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

☐ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

☐ Other appropriate State agency(s)--

☐ Other appropriate agency(s) of another State--

☐ Courts and law enforcement officials.

1902(a)(60) of the Act

- (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

- (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

☒ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

TN No. 94-027

Supersedes

TN No. 92-9

Approval Date 10/27/94

Effective Date 10-1-94

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

Requirements for Third Party Liability -
Identifying Liable Resources

Identifying Liable Resources

I. Frequency of Data Exchanges

Data exchanges with the state wage information collection agency (SWICA) and the SSA wage and earnings files are conducted quarterly.

Monthly medical support enforcement extract is collected through the IV-D child support enforcement file. Third party resources identify those absent parents who have primary health coverage on their Medicaid eligible dependents.

State IV-A information is available through the automated eligibility system and no separate request is necessary.

Data exchange with the State Workers Compensation file is conducted quarterly.

The state has demonstrated attempts to data match with the State Motor Vehicle Accident Report Files. The State Motor Vehicle Accident Report is not automated. No automated data exchange is possible.

The diagnosis file contains an accident indicator for diagnosis codes 800-999. During weekly claims processing, an edit is set regardless of the amount of Medicaid payment on all claims with these diagnosis for which there is no record of other resources.

TN No. 00-007
Supersedes
TN No. 90-08

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HCFA ID: 1076P/0019P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

Requirements for Third Party Liability -
Identifying Liable Resources

2. Follow-up Procedures

Follow-up is conducted within 30 days on the SWICA and SSA wage and earnings file exchanges. Upon receipt, the exchanges are screened according to the following requirements:

- Eliminate employers known not to offer insurance.
- Eliminate employers known to offer HMO coverage only;
- Eliminate employees who have not worked enough quarters to qualify for insurance benefits.

After screening, the employers are contacted within 30 days by phone or writing to obtain insurance coverage information. Upon receipt of verification, the insurance data is updated into the third party database, case file, and recovery unit.

Claims with trauma diagnosis codes for which there is no record of other resources are reviewed monthly and follow-up conducted by prioritization. Trauma codes yielding the highest recoveries are given priority. Upon final determination of liability the case file is updated within 30 days, if appropriate.

Follow-up is conducted within 30 days by the County IV-D child support enforcement worker, on those absent parents, not covering their Medicaid eligible dependents. The IV-D child support enforcement extract is screened according to the following:

- Eliminate absent parents whose dependents are not Medicaid eligible.
- Eliminate absent parents who do not have a medical support order in force.
- Eliminate absent parents who have not had a medical support notice sent to employer/third party administrator.
- Eliminate absent parents who do not have a primary health plan listed in Automated Child Support Enforcement System (ACSES).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

Requirements for Third Party Liability -
Identifying Liable Resources

After chronological messages are sent to County IV-D child support enforcement worker, absent parents are contacted within 30 days by phone or writing to obtain insurance coverage information. Upon receipt of verification, the health plan coverage data is updated into ACSES case information, for potential cost avoidance or recoveries.

Claims with trauma diagnosis codes for which there is no record of other resources are reviewed monthly and follow-up is conducted by prioritization. Trauma codes yielding the highest recoveries are given priority. Upon final determination of liability the case file is updated within 30 days, if appropriate.

Health Insurance and State Workers' Compensation

Health insurance information is obtained by the County department of Social Services of all recipients of medical assistance during initial application and redetermination. Under a written 1634 agreement, health insurance information is obtained by the Social Security Administration during initial application and redetermination for Supplemental Security Income (SSI). Within 60 days, the insurance is verified and if appropriate, incorporated in the third party database, case file, and recovery unit.

Within 60 days of the run date of the State Workers Compensation data match, the third party database, case and recovery unit files are updated, if appropriate.

TN No. 00-007
Supersedes
TN No. 90-08

Approval Date 09/08/00 Effective Date 04/01/00

HCFA ID: 1076P/0019P

SUPPLEMENT 1 TO ATTACHMENT 4.22-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN No. 08-005
Supersedes TN No. NEW

Approval Date 7/16/08
Effective Date: July 1, 2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

Requirements for Third Party Liability -
Payment of Claims

(d) (2) (3) Third Party Liability Thresholds and Guidelines

The state of Colorado has determined the most cost-effective method for seeking reimbursement from liable third parties is a combination of automated cost avoidance, intent to retract and manual benefit recovery.

A threshold amount of \$50.00 for health insurance and \$250.00 for casualty claims is used in determining whether to seek reimbursement from a liable third party.

Health insurance claims are accumulated by recipient, by liable third party by calendar year or until the threshold is achieved. Billings are initiated within 60 days of threshold achievement.

When a third party resource is identified, and retroactively loaded to third party files, an Intent To Retract Letter (ITR) is produced. The Medicaid provider has 60 days to respond.

Carrier billings for third party recoveries performed by the Fiscal Agent occur automatically through the MMIS. Resource types identified for billing: pregnant women, absent parents, and EPSDT.

Casualty claims are accumulated by recipient for 12 months or until the threshold is achieved. Recovery actions are initiated within 60 days of threshold achievement.

TN No. 00-007
Supersedes
TN No. 92-11

Approval Date 09/08/00

Effective Date 04/01/00

HCFA ID: 1076P/0019P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

An individual's enrollment in a commercial (group or individual) health insurance plan is cost - effective when the amount paid for premiums and other cost sharing obligation plus the State's administrative costs are less than Medicaid's expenditure for an equivalent set of services for the average person in the same category of service.

Colorado's Cost-Effectiveness Formula

1. Determine the scope of benefits available to the Medicaid recipient under the commercial (group or individual) health insurance plan by gathering information about the effective date of the policy, exclusions to enrollment, the covered services under the policy, service limits, and premium, deductible and coinsurance charges. Then identify the areas of overlap between the commercial policy and Medicaid benefits. Estimate the maximum annual cost of the coinsurance and deductible (the maximum out-of-pocket cost sharing under the commercial health plan). Health plan cost sharing amounts in excess of the Medicaid allowed amounts will only be paid if the provider is not enrolled as a Medicaid provider (and, as such, has no mechanism to bill Medicaid through MMIS) AND it would still be cost-effective to Medicaid to pay the higher amount. Medicaid-enrolled providers are bound by Medicaid rules and, as such, will be paid up to the Medicaid allowed amount.

TN No. 00-008
Supersedes

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TN No. 94-027

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

2. Calculate the total insurance costs by adding together the commercial health plan's annual premium, deductible, and maximum out-of-pocket costs. Add to this figure the State's administrative cost for processing the health insurance information. (The administrative cost is periodically readjusted.) The resulting sum is the "total insurance costs."
3. Obtain the estimated average annual cost to Medicaid of persons like the recipient (profiled by factors of age, sex, and category of service data) for services covered by the commercial health insurance plan. Add the estimated Medicaid costs for the overlapping services together. This is the amount Medicaid would pay for those services if the commercial health insurance plan were not in place.
4. Calculate the cost-effectiveness by comparing the total insurance costs (premiums, deductibles, coinsurance, and administration) obtained in Step 2 to the average annual Medicaid costs (obtained from MMIS) for similar coverage for clients with similar profiles obtained in Step 3.

A commercial policy is determined to be cost-effective if the costs to the State under the commercial health plan are lower than the costs to the State for these services under Medicaid.

TN No. 00-008
Supersedes

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TN No. 94-027

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

5. If the health insurance plan is determined not to be cost-effective using average Medicaid costs in the above process, the specific recipient's known historical medical costs may be substituted for the average Medicaid costs in the above formula.

The State will pay premium, deductible, and coinsurance charges when it is cost-effective to do so.

TN No. 00-008
Supersedes

Approval Date 09/08/00

Effective Date 04/01/00

TN No. 94-027

HCFA ID: 7983E

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: Colorado

Citation4.23 Use of Contracts

42 CFR 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

☐ Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

☒ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2

☒ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

☐ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

☐ Not applicable.

TN # 03-033
Supersedes TN # 84-8

Effective Date 07/01/03
Approval Date 12/16/03

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: COLORADO

<p><u>Citation</u> 42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826</p>	<p>4.24 <u>Standards for Payments for Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities</u></p> <p>With respect to nursing facilities and intermediate care facilities for individuals with intellectual disabilities all applicable requirements of 42 CFR Part 442, Subparts B and C are met.</p> <p>Not applicable to intermediate care facilities for individuals with intellectual disabilities; such services are not provided under this plan.</p>
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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing
Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN # 74-9
Supersedes
TN # _____

Approval Date 12/13/74 Effective Date 12/1/73

Revision: HCFA-PM-93-3 (MB)

State/Territory: ColoradoCitation1927(g)
42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b) and
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d)and(f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

TN No. 94-003

Supersedes

TN No. New

Approval Date

1-5-94

Effective Date

10-1-93

State/Territory: ColoradoCitation1927(g)(1)(D)
42 CFR 456.703(b)

- D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

☒ Prospective DUR
☒ Retrospective DUR.

1927(g)(2)(A)
42 CFR 456.705(b)

- E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b),
(1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705 (c)
and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

- F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

TN No. 94-003
Supersedes
TN No. New

Approval Date

1-5-94

Effective Date

10-1-93

State/Territory: ColoradoCitation927(g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)

G.1. The DUR program has established a State DUR Board either:

- ☒ Directly, or
- ☐ Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

TN No. 94-003

Supersedes

TN No. New

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1-5-94

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10-1-93

Revision: HCFA-PM-93-3 (MB)

OMB No.

State/Territory: ColoradoCitation

- 1927 (g) (3) (C)
42 CFR 456.711
(a) - (d)
- G.4 The interventions include in appropriate instances:
- Information dissemination
 - Written, oral, and electronic reminders
 - Face-to-Face discussions
 - Intensified monitoring/review of prescribers/dispensers
- 1927 (g) (3) (D)
42 CFR 456.712
(A) and (B)
- H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
- 1927 (h) (1)
42 CFR 456.722
- X I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:
- realtime eligibility verification
 - claims data capture
 - adjudication of claims
 - assistance to pharmacists, etc. applying for and receiving payment.
- 1927 (g) (2) (A) (i)
42 CFR 456.70S (b)
- X 2. Prospective DUR is performed using an electronic point of sale drug claims processing system.
- 1927 (j) (2)
42 CFR 456.703 (c)
- J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.
- SUPPORT ACT §1004
Social Security Act §1902(a)(85)
42 U.S.C. 1396a(a)(85)
- K. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) assurances.
- The State Medicaid agency gives the following assurances:

*U.S. G.P.O.: 1993-342-239:B0043

State/Territory: Colorado42 U.S.C.
1396a(oo)(1)(A)

CLAIMS REVIEW LIMITATIONS

X Assures that the State Medicaid agency complies with the opioid related prospective place of service safety edits and retrospective reviews to address duplicate fill and early fill alerts, quantity limits, dosage limits, and maximum daily morphine milligram equivalents limitations under sections 1902(oo)(1)(A)(i)(I-II) of the Social Security Act. The State Medicaid agency also assures that it conducts concurrent utilization review for opioids and benzodiazepines or opioids and antipsychotics under section 1902(oo)(1)(A)(i)(III) of the Social Security Act.

Prospective Safety Edits:

- The Department has a limitation on the maximum daily allowable morphine milligram equivalents (MME) for long and short acting opioid prescriptions;
- The Department has day supply, quantity and duplicate fill limitations for long and short acting opioid agents; and
- The Department limits early refills on opioid prescriptions.

Retrospective Reviews:

- The Department's Drug Utilization Review (DUR) program conducts retrospective analysis and monitoring of opioid utilization, including: days' supply, early refills, duplicate fills, quantity, and maximum daily morphine milligram equivalents (MME) on an ongoing basis, and provider education materials are provided; and
- The Department's DUR program reviews concurrent utilization of opioids and benzodiazepines and opioids and antipsychotics on an ongoing basis.

42 U.S.C. 1396a(oo) (1) (B)	<p>PROGRAM TO MONITOR ANTIPSYCHOTIC MEDICATIONS BY CHILDREN</p> <p><u> X </u> Assures that the State Medicaid agency complies with the requirement to have a program to monitor and manage the appropriate use of antipsychotic medications by children enrolled under the State plan (or under a waiver of the State plan) under section 1902(oo) (1) (B) of the Social Security Act.</p> <ul style="list-style-type: none">• The DUR program conducts retrospective analysis and monitoring of antipsychotic medication utilization for pediatric members, including those in foster care, and provider education materials are provided.
42 U.S.C. 1396a(oo) (1) (C)	<p>FRAUD AND ABUSE IDENTIFICATION</p> <p><u> X </u> Assures that the State Medicaid agency complies with the requirement to have a program in place to identify and address fraud and abuse under section 1902(oo) (1) (C) of the Social Security Act.</p> <ul style="list-style-type: none">• The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

Revision: HCFA-AT-80-38 (RPP)
May 22, 1980

OFFICIAL81-8
RECEIVED

State _____

Citation

42 CFR 431.115 (c)

AT-78-90

AT-79-74

4.27 Disclosure of Survey Information and Provider
or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

TN #

81-8

Supersedes

Approval Date 4/30/81

Effective Date 11/1/81

TN #

Revision: HCFA-PM-93-1
January 1993

(BPD)

State/Territory: COLORADO

Citation

4.28 Appeals Process

42 CFR 431.152;
AT-79-18
52 FR 22444;
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act; P.L.
100-203 (Sec. 4211(c)).

- (a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
- (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

TN No. 93-012

Supersedes

TN No. 89-006

Approval Date 07/14/98

Effective Date 7-1-93

New: HCFA-PM-99-3
JUNE 1999

State: Colorado

Citation

1902(a)(4)(C) of the
Social Security Act
P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the
Social Security Act
P.L. 105-33
1932(d)(3)
42 CFR 438.58

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

TN # 03-027
Supersedes TN # 00-015

Effective Date 07/01/03
Approval Date 12/16/03

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Colorado

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of
Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are
met.

☒ The agency, under the authority of State law,
imposes broader sanctions.

TN No. 88-13
Supersedes
TN No. 87-12

Approval Date 3/3/89

Effective Date 4/1/88

HCFA ID: 1010P/0012P

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Colorado

Citation

(b) The Medicaid agency meets the requirements of –

1902(p) of the Act

(1) Section 1902(p) of the Act by excluding from participation—

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

42 CFR 438.808

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

1932(d)(1)
42 CFR 438.610

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance, the State will comply with the requirements of 42 CFR 438.610(c)

TN # 03-030
Supersedes TN # 88-13

Effective Date 07/01/03
Approval Date 12/16/03

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: Colorado

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec. 9(f))

(2) Section 1902(a)(39) of the Act by--

- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
- (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

- (1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

- (2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

TN No. 88-13
Supersedes
TN No. NEW

Approval Date 3/3/89

Effective Date 4/1/88

HCFA ID: 1010P/0012P

State/Territory: _____

Citation

Sanctions for Psychiatric Hospitals

1902(y)(1),
1902(y)(2)(A),
and Section
1902(y)(3)
of the Act
(P.L. 101-508,
Section 4755(a)(2))

(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

1902(y)(1)(A)
of the Act

(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.

1902(y)(1)(B)
of the Act

(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:

1. terminate the hospital's participation under the State plan; or
2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.

1902(y)(2)(A)
of the Act

(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

TN No. 93-011
Supersedes
TN No. New

Approval Date 6/7/93

Effective Date 5/15/93

State: Colorado

Citation

Sanctions for MCOs and PCCMs

1932(e)
42 CFR 428.726

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:
- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

TN # 03-034
Supersedes TN # new

Effective Date 07/01/03
Approval Date 12/16/03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADOCitation

455.103

44 FR 41644

1902(a)(38)

of the Act

P.L. 100-93

(sec. 8(f))

435.940

through 435.960

52 FR 5967

- 4.31 Disclosure of Information by Providers and Fiscal Agents
The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act

4.32 Income and Eligibility Verification System

- (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.
- (b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment and the agencies and the State(s) from which that information will be requested.
- (c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS) or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PH-86-9 (BERC)
MAY 1986

ATTACHMENT 4.32-A
Page 1
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Colorado

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

TN No. 86-15
Supersedes
TN No. N/A

Approval Date 11/7/86

Effective Date 7/1/86

HCFA ID: 0123P/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

4.46 Provider Screening and Enrollment (Page 3 of 3)

42 CFR 455.440	<p>NATIONAL PROVIDER IDENTIFIER</p> <p><u>X</u> Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.</p>
42 CFR455.450	<p>SCREENING LEVELS FOR MEDICAID PROVIDERS</p> <p><u>X</u> Assures that the State Medicaid agency complies 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.</p>
42 CFR455.460	<p>APPLICATION FEE</p> <p><u>X</u> Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.</p>
42 CFR455.470	<p>TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS</p> <p><u>X</u> Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.</p>

TN **18-0040**

SUPERSEDES: **New**

APPROVAL DATE: October 18, 2018 __

EFFECTIVE DATE: **July 1, 2018**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

Citation: 4.47 21st Century Cures Act
Section 5006 of P-L 114- *Requiring Publication of Fee-for-Service*
255 *Provider Directory*

- ☒ State is in compliance with the requirements of Section 5006 of the 21st Century Cures Act.
- ☐ State will be in compliance with Section 5006 of the 21st Century Cures Act by_____.
- ☐ State Plan's managed care coverage exempts this state from the requirements of Section 5006 of the 21st Century Cures Act.
- ☐ State would potentially need to enact legislation to comply with Section 5006 of the 21st Century Cures Act and will discuss compliance with CMS.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: COLORADO

Citation

1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L. 100-93
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TN No. 88-13
Supersedes
TN No. None

Approval Date 3/3/89

Effective Date 4/1/89

HCFA ID: 1010P/0012P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

The agency assures the issuance of Medicaid eligibility cards by:

- (1) holding them at the Human Service office to be picked up by the recipient, or
- (2) hand delivering them to the shelters for the recipients, or
- (3) mailing them to a post office box.

County Departments use any of these three methods dependent on the needs of the recipient.

TN No. 00-023
Supersedes
TN No. 88-13

Approval Date 10/11/00

Effective Date 07/01/00

HCFA ID: 1080P/0020P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: COLORADO

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

☒ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☒ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

☐ Total waiver

☐ Alternative system

☐ Partial implementation

TN No. 99-06
Supersedes
TN No. —

Approval Date 3/1/89

Effective Date 10/1/88

HCFA ID: 1010P/0012P

Revision: HCFA-PM-91-9
November 1991

(MB)

State/Territory: COLORADO

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

Colorado statutes provide information on the following subjects:

1. Living Wills (statute provides a sample living will)
2. Medical Durable Powers of Attorney
3. Surrogates and Guardians

PROVISION FOR HEALTH CARE PROVIDERS OBJECTING TO IMPLEMENTATION OF ADVANCE DIRECTIVES ON THE BASIS OF CONSCIENCE.

An attending physician who refused to comply with the terms of a medical treatment declaration, valid on its face, shall transfer the care of the declarant to another physician who is willing to comply with the declaration and failure to transfer the care of the declarant to another physician shall constitute unprofessional conduct.

TN No. 92-5Supersedes NEWApproval Date 12/30/91Effective Date 12-1-91

TN No. _____

HCFA ID: 7982E

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: COLORADO

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR
\$488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

- (1) nature of noncompliance,
- (2) which remedy is imposed,
- (3) effective date of the remedy, and
- (4) right to appeal the determination leading to the remedy.

42 CFR
\$488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR
\$488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR
\$488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR
\$488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

— The State considers additional factors. Attachment 4.35-A describes the State's other factors.

TN No. 95-021
Supersedes
TN No. 92-32

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: COLORADO

Citation

c) Application of Remedies

- 42 CFR
\$488.410
- (i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
- 42 CFR
\$488.417(b)
\$1919(h)(2)(C)
of the Act.
- (ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
- 42 CFR
\$488.414
\$1919(h)(2)(D)
of the Act.
- (iii) The State imposes the denial of payment for new admissions remedy as specified in \$488.417 (or its approved alternative) and a State monitor as specified at \$488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
- 42 CFR
\$488.408
\$1919(h)(2)(A)
of the Act.
- (iv) The State follows the criteria specified at 42 CFR \$488.408(c)(2), \$488.408(d)(2), and \$488.408(e)(2), when it imposes remedies in place of or in addition to termination.
- 42 CFR
\$488.412(a)
- (v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

- 42 CFR
\$488.406(b)
\$1919(h)(2)(A)
of the Act.
- (i) The State has established the remedies defined in 42 CFR 488.406(b).
- X (1) Termination
 - X (2) Temporary Management
 - X (3) Denial of Payment for New Admissions
 - X (4) Civil Money Penalties
 - X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
 - X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

This statute (Colorado Revised Statutes (CRS) 26-2-122) gives Colorado the authority to impose these remedies.

TN No. 95-021
Supersedes
TN No. new

Approval Date: 11/27/95

Effective Date: 7-1-95

79c.3

Revision: HCEA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: COLORADO

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) The State uses alternative remedies.
The State has established alternative
remedies that the State will impose in
place of a remedy specified in 42 CFR
488.406(b).

- (1) Temporary Management
- (2) Denial of Payment for New Admissions
- (3) Civil Money Penalties
- (4) Transfer of Residents; Transfer of
Residents with Closure of Facility
- (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the
alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
§1910(h)(2)(F)
of the Act.

(e) State Incentive Programs

- (1) Public Recognition
- (2) Incentive Payments

(f) Optional Remedies

- (1) Directed Inservice Training
- (2) Directed Plan of Correction

TN No. 75-021

Supersedes

TN No. new

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A

TN No. 95-021
Supersedes
TN No. 92-32

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

x Specified Remedy

(Will use the criteria and
notice requirements specified
in the regulation.)

TN No. 95-021
Supersedes
TN No. 92-32

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-021
Supersedes
TN No. new

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-021
Supersedes
TN No. new

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-021
Supersedes
TN No. new

Approval Date: 11/27/95

Effective Date: 7-1-95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-021
Supersedes
TN No. new

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-G

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

x Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

 Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-021
Supersedes
TN No. New

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-H

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: COLORADO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

N/A

TN No. 95-021
Supersedes
TN No. new

Approval Date: 11/27/95

Effective Date: 7-1-95

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Colorado

<u>Citation</u> 1902(a)(11)(C) and 1902(a)(53) of the Act	4.36 <u>Required Coordination Between the Medicaid and WIC Programs</u> The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.
--	--

TN No. <u>92-1</u>	Approval Date <u>4/9/92</u>	Effective Date <u>10/1/91</u>
<u>Supersedes</u> <u>New</u>		

HCFA ID: 7982E11

79n

Revision: HCFA-PM-91- 10
DECEMBER 1991

(BPD)

State/Territory: Colorado

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

4.38 Nurse Aide Training and Competency
Evaluation for Nursing Facilities

- (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
- (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
- (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
- (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
- X (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
- X (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN No. 92-21
Supersedes
TN No. New

Approval Date

4/24/92

Effective Date

12/1/91

Revision: HCFA-PM-91- 10
DECEMBER 1991

790
(BPD)

State/Territory: Colorado

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program.
- (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

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State/Territory: Colorado

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
- (n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
- (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
- (p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
- X (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
- (r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

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42 CFR 483.75; 42
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Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
- (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
- (u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
- (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
- (w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
- X (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
- (y) The State has a standard for successful completion of competency evaluation programs.

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Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
- (aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
- (bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
- X (cc) The State includes home health aides on the registry.
- (dd) The State contracts the operation of the registry to a non State entity.
- X (ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
- X (ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

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12/1/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

Pursuant to 42 CFR 483.156(c)(1)(iii) and (iv), CRS 24-72-203, and CRS 12-38.1-114(9), all information contained in registry records is a public record and can be disclosed except for the following:

- any medical, psychological or sociological data from which the individual can be identified;
- test scores on a competency evaluation;
- information about a complaint filed against a nurse aide prior to the agency preparing charges against the individual.

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ATTACHMENT 4.38A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

Certification Number and Status

TN No. 92-21
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January 1993

State/Territory: Colorado

Citation
Secs.

1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Pre-admission Screening and Annual
Resident Review in Nursing Facilities

- (a) The Medicaid agency has in effect a written agreement with the State mental health and individuals with intellectual disabilities authorities that meet the requirements of 42 (CFR) 431.621(c).
- (b) The state operates a pre-admission and annual resident review program that meets the requirements of 42 CFR 483.100-138.
- (c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive pre-admission screening or annual resident review until such individuals are screened or reviewed.
- (d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.
- (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

X

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Colorado

4.39 (Continued)

- | | |
|------------|---|
| <u>N/A</u> | (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or individuals with intellectual disabilities authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized. |
| <u>X</u> | (g) The State describes any categorical determinations it applies in <u>ATTACHMENT 4.39-A</u> . |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: _____

DEFINITION OF SPECIALIZED SERVICES

- A. Specialized Mental Health Services for the Mentally Ill are defined as the continuous and aggressive implementation of an individual Plan of Care that is developed under and supervised by a physician in conjunction with an interdisciplinary team of qualified mental health professionals. The Plan of Care specifies therapists and activities for the treatment of persons with major mental illness. The Plan is directed toward diagnosing and reducing the resident's behavioral symptoms that would otherwise necessitate institutionalization.

Two levels of service for the mentally ill are;

1. Enhanced mental health program:

- a. A continuous program designed for the specific needs of each mentally ill person who requires those services.
- b. The implementation of specialized and generic training, specific therapies, treatments and mental health interventions and activities, health services and other related services to meet the individual needs.
- c. Specialized services and treatment plans are developed and supervised by an interdisciplinary team which includes a physician, a qualified mental health professional and other, as appropriate, professionals trained and experienced in treatment of the mentally ill.
- d. Individuals who do not need in-patient psychiatric care, but require mental health interventions at a level more intense than can be provided at a general mental health services level.
- e. Services must be provided by trained mental health professionals.
- f. Services are provided less than 24 hours per day on-site but the contingency for more intense services are available.

2. General mental health services:

- a. Services would be provided to mentally ill individuals who do not require the specialized mental health program level of care.
- b. Intervention would be provided by mental health professionals.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: _____

Replacement of Attachment 4.39 A, page 1

CATEGORICAL DETERMINATIONS

The criteria for categorical admissions include the following:

1. Convalescent Care

Admission is from an acute care hospital.
Admission is for a prescribed, limited nursing facility stay for rehabilitation or convalescent care.
Admission is for a medical or surgical condition that requires hospitalization.

2. Terminal Illness

The individual must be certified by a physician as having a terminal illness, under the definition in Section 1861 (d) (3) (A) of the Social Security Act.

3. Severity of Illness

CFMC must conduct a review to determine if a person, with one or more of the following conditions, may be admitted to a nursing facility:

- (1) Comatose,
- (2) Ventilator dependent,
- (3) Vegetative state.

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State/Territory: Colorado

Citation

4.40 Survey & Certification Process

Sections

1919(g)(1)
thru (2) and
1919(g)(4)
thru (5) of
the Act P.L.
100-203
(Sec.
4212(a))

1919(g)(1)
(B) of the
Act

1919(g)(1)
(C) of the
Act

1919(g)(1)
(C) of the
Act

1919(g)(1)
(C) of the
Act

1919(g)(1)
(C) of the
Act

- (a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
- (b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
- (c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.
- (d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?
- (e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
- (f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

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OMB No:

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- 1919(g)(2)
(A)(i) of
the Act
- (g) The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
- 1919(g)(2)
(A)(ii) of
the Act
- (h) The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
- 1919(g)(2)
(A)(iii)(I)
of the Act
- (i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
- 1919(g)(2)
(A)(iii)(II)
of the Act
- (j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
- 1919(g)(2)
(B) of the
Act
- (k) The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
- 1919(g)(2)
(C) of the
Act
- (l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

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OMB No:

State/Territory: Colorado

- 1919(g)(2)
(D) of the
Act
- (m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
- 1919(g)(2)
(E)(i) of
the Act
- (n) The State uses a multidisciplinary team of professionals including a registered professional nurse.
- 1919(g)(2)
(E)(ii) of
the Act
- (o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
- 1919(g)(2)
(E)(iii) of
the Act
- (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
- 1919(g)(4)
of the Act
- (q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.
- 1919(g)(5)
(A) of the
Act
- (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
- 1919(g)(5)
(B) of the
Act
- (s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
- 1919(g)(5)
(C) of the
Act
- (t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
- 1919(g)(5)
(D) of the
Act
- (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

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Attachment 4.40-A
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

SURVEY AND CERTIFICATION EDUCATION PROGRAM

The state has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The Department of Health, Health Facilities Division's training section provides instruction to administrators and staff, residents of nursing homes, and family members of residents in conjunction with the two nursing home associations and the State Long Term Care Ombudsman's office. Changes in regulations, procedures and policies are presented at conferences and seminars throughout the state.

In addition, the Department of Social Services mails information directly to residents of nursing facilities regarding changes in laws and policies that effect them.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

If an allegation of neglect is present it is investigated as a complaint, which are prioritized as to whether they are life threatening, serious, but not life threatening or routine. Life threatening complaints are investigated within 24 hours of receipt.

Allegations of abuse are referred to the Medicaid Fraud Control Unit and a joint investigation may be conducted or they may choose to do their own separate investigation. The Local Law Enforcement Agency is usually involved, Adult Protection may be involved. The Board of Nursing may be notified.

Misappropriation of property is referred to the Local Law Enforcement and/or the Medicaid Fraud Unit of the Attorney General's Office.

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Attachment 4.40-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The Department of Health, Health Facilities Division has the responsibility for scheduling surveys on an unannounced basis. The section is divided into survey teams with a team supervisor. These survey schedules are kept confidential and not distributed outside the division.

The names of the facilities to be surveyed in any given quarter are given to the team supervisors. The team supervisors schedule each facility survey and assign the surveyors that will actually conduct the survey. These survey schedules are kept confidential and are not distributed outside the Health Facilities Division.

All surveyors are aware of the monetary and disciplinary penalties that can be imposed for disclosing to a facility or outside entity the impending survey date. Local Ombudsman are notified of a survey only after the team has arrived at the facility.

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Attachment 4.40-D
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The following systems are in place which assist the Department of Health, Health Facilities Division in identifying and minimizing inconsistency in survey applications:

1. The quality assurance process developed by Program Development section of Health Facilities Division uses On-Line Survey Certification and Reporting (OSCAR) data system to apply consistency to all regulations and programs. The survey input from surveyors is input into the OSCAR system, a multidisciplinary analysis is used, resulting in feedback which directly affects survey procedures.
2. An Omnibus Budget Reconciliation Action (OBRA) Long Term Care workgroup, which consists of surveyors who represent all of the LTC teams meet on a regular basis. The committee receives concerns and questions directly from surveyors, which result in policy decisions for the Health Facilities Division. Feedback is taken to all staff and improves consistency in survey.
3. The training section has preceptor and check list criteria established to standardized the survey process for new employees. Updates in training are held as mandated by Health Care Financing Administration, ie., new procedures and regulations, to keep the survey process current for all surveyors.
4. There are team supervisors who interact directly with the surveyors on specific issues, such as review of deficiency lists, Plan of Correction review and approval, and related survey processes. There are program administrators who supervise surveyors by program and deal directly with specific regulations and consistency issues.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaint of violations of requirements by nursing facilities and monitors on-site on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c) and (d) for the following reasons:

- (i) The facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance.
- (ii) the facility was previously found not be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

If a complaint is received on a facility, it is prioritized and investigated accordingly:

- 1. Life-threatening requires an immediate response, a site visit within 48 hours.
- 2. Serious (but not Life-threatening) Severe & Urgent requires an investigation within 7 working days.
- 3. Routine requires an investigation within 45 working days.

Complaint investigations are unannounced and can take place any time of the day or night, including weekends. An on-site visit is conducted and a survey is done to try to validate the allegations. If violations of the State and/or Federal Regulations occur, a Deficiency List is issued to the facility and they must submit and acceptable plan of correction within 10 days.

If it is warranted, a revisit is made to the facility to determine if their plan of correction has been implemented and the deficiencies corrected.

Monitoring occurs when a facility continues to have complaints lodged against them which can be validated. They show a pattern or history of poor care and we have a concern for the welfare of the patients and feel that the facility needs to be watched closely to insure that conditions do not deteriorate to the detriment of the residents. The Department Health, Health Facilities Division monitors, daily, weekly, monthly, or as needed, depending on the nature of the violations or problems.

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(HSQB)

COLORADO

State/Territory: _____

Citation4.41 Resident Assessment for Nursing Facilities

Sections
1919(b)(3)
and 1919
(e)(5) of
the Act

- (a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.

1919(e)(5)
(A) of the
Act

- (b) The State is using:

_____ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or

1919(e)(5)
(B) of the
Act

X a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

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Approval Date 1-5-94 Effective Date 10-1-93

HOPA-ID# _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

Citation

1902(a)(68)
of the Act,
P.L. 109-
171
(section
6032)

4.42 Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

- (A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

- (B) An "employee" includes any officer or employee of the entity.
 - (C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.
- (2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but

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STATE OF COLORADO

must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
 - (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
 - (5) The State will implement this State Plan amendment on January 1, 2007.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

TN# 07-001

SUPERCEDES: New

APPROVAL DATE 6/27/07

EFFECTIVE DATE: January 1, 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

Citation

1902(a)(69) of
the Act,
P.L. 109-171
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.

The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

TN # 08-004

APPROVAL DATE: 6/26/08

SUPERCEDES: New

EFFECTIVE DATE: June 1, 2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

For 2007 calendar year compliance, the Department of Health Care Policy and Financing sent letters to identified "entities" dated March 26, 2007 making entity declarations due April 25, 2007.

By the 31st day of January each calendar year the Department of Healthcare Policy and Financing, Program Integrity Section will identify "entities" that are required to comply and notify them by letter which states:

- 1 That they are designated as an entity for the following calendar year.
- 2 That they must establish and disseminate written policies for all employees including management and employees of any contractor or agent of the entity. The employees including management and employees of any contractor or agent must abide by the written policies, to the extent the policies apply.
- 3 The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse.
- 4 That the written policies, which may be on paper or in electronic form, must be readily available to employees, contractors, or agents.
- 5 That the policies be included in the employee handbook, if one exists.
- 6 That the entity need not create an employee handbook if none already exists.
- 7 That the entity provide the Department with written assurance:
 - a That they have a policy
 - b that the entity has incorporated language required by the statute into the employee handbook, if one exists.
 - c that it has been disseminated
 - d that they understand failure to comply within thirty (30) calendar days from the date of the Department's notification letter will result in suspension of claims until such assurances are provided to the Department. If after sixty (60) days from the date of the

TN# 07-001

APPROVAL DATE 6/27/07

SUPERCEDES: New

EFFECTIVE DATE: January 1, 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF COLORADO

notification letter, the Department has not received the above referenced declaration, participation in the Medical Assistance Program will be terminated.

- 8 The Department's Program Integrity Section will maintain the annual listing of entities, copies of letters sent, and each entity's returned written assurance of compliance along with any attachments.
- 9 Beginning September 2007, the Quality Improvement Section at the Department will review managed care entities' (MCO) policies and procedures for detecting and preventing waste, fraud, and abuse during Managed Care compliance reviews, which are conducted no less than every three years. Any identified deficiencies shall either be corrected or investigated to determine if termination from participation in the Medical Assistance Program is warranted.
- 10 Beginning January 2008 and every even numbered year thereafter, Program Integrity Section at the Department will review non-MCO entities' policies and procedures for detecting and preventing waste, fraud, and abuse by requesting that a copy of the policies and procedures, and a copy of the employee handbook, if one exists, be attached to the entity's declaration of compliance, as indicated in Attachment 4.42-A.7. Any deficiencies shall be investigated to determine if termination from participation in the Medical Assistance Program is warranted.

TN# 07-001

SUPERCEDES: New

APPROVAL DATE 6/27/07

EFFECTIVE DATE: January 1, 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF COLORADO

Citation

1902(a)(69) of
the Act,
P.L. 109-171
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.

The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

TN # 08-004

APPROVAL DATE: 6/26/08

SUPERCEDES: New

EFFECTIVE DATE: June 1, 2008

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

State/ Territory: Colorado

4.44: Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation:

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

x The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

TN No. 11-034

Supersedes TN No NEW

Approval Date: 6/14/11

Effective Date: June 1, 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

4.46 Provider Screening and Enrollment (Page 1 of 3)

<u>Citation</u> 1902(a)(77) 1902(a)(39) 1902(kk) P.L. 111-148 and P.L. 111-152	The State Medicaid agency gives the following assurances:
42 CFR 455 Subpart E	PROVIDER SCREENING <u> X </u> Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS <u> X </u> Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. <u> X </u> Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State Plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES <u> X </u> Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT <u> X </u> Assures that providers will be revalidated regardless of provider type at least every 5 years.

TN 18-0040

SUPERSEDES: New

APPROVAL DATE: October 18, 2018

EFFECTIVE DATE: July 1, 2018

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Colorado

4.46 Provider Screening and Enrollment (Page 2 of 3)

42 CFR 455.416	<p>TERMINATION OR DENIAL OF ENROLLMENT</p> <p><u>X</u> Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.</p>
42 CFR 455.420	<p>REACTIVATION OF PROVIDER ENROLLMENT</p> <p><u>X</u> Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.</p>
42 CFR 455.422	<p>APPEAL RIGHTS</p> <p><u>X</u> Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.</p>
42 CFR 455.432	<p>SITE VISITS</p> <p><u>X</u> Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.</p>
42 CFR 455.434	<p>CRIMINAL BACKGROUND CHECKS</p> <p><u>X</u> Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.</p>
42 CFR 455.436	<p>FEDERAL DATABASE CHECKS</p> <p><u>X</u> Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.</p>

TN **18-0040**

SUPERSEDES: **New**

APPROVAL DATE: October 18, 2018 __

EFFECTIVE DATE: **July 1, 2018**

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

- (a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☒ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

TN # 78-11
Supersedes
TN # _____

Approval Date 5/9/78

Effective Date 4/1/78

Revision: ~~HCFA~~-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado _____

5.2 [Reserved]

OFFICIAL

TN # _____
Supersedes _____
TN # _____

Approval Date _____

Effective Date _____

CONFIDENTIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR Part 432,
Subpart B
AT-78-90

5.3 Training Programs; Subprofessional and
Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

TN # 79-8
Supersedes
TN # _____

Approval Date 6/12/79 Effective Date 7/1/79

Revision: HCFA-AT-30-38 (BPP)
May 22, 1980

State _____ of Colorado

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

IN 81-7
series

Approval Date 4/24/81 Effective Date 1/1/81

OFFICIAL

Revision: HCFA-AT-81- (BPP)

State COLORADO

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 83-1
Supersedes
TN # _____

Approval Date 3/16/83 Effective Date 1/1/83

OFFICIAL

85

Revision: ~~HCTA~~-AT-80-38 (BPP)
May 22, 1980

State _____ of Colorado

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

- (a) State funds are used in both assistance and administration.

☐ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☒ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

- (b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

TN # 81-7
Supersedes
TN # _____

Approval Date 4/24/81 Effective Date 1/1/81

Revision: HCFA-PM-91-
1991

(BPD)

OMB No. 0938-

State/Territory: Colorado

SECTION 7 - GENERAL PROVISIONS

Citation

7.1

Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN No. 92-1

Revised

Approval Date

4/9/92

Effective Date 10/1/91

74-9

HCFA ID: 7982E11

Revision: HCFA-PM-91-
1991

(BPD)

OMB No. 0938-

State/Territory: ColoradoCitation 7.2 Nondiscrimination45 CFR Parts
80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

TN No. 92-1~~Supersedes~~J. 79-9

Approval Date

4/9/92

Effective Date

10/1/91

HCFA ID: 7982EII

74-9

OFFICIAL

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

Attachment 7.2-A

State of Colorado

METHODS OF ADMINISTRATION - CIVIL RIGHTS

TN 74-9

St. Colo Tr. 3/19/74 Incorp. 12/13/74 Effective 12/1/73

74-9 OFFICIAL

1. Current Colorado Statutes Concerning Civil Rights:

CRS; 25-3-1 through 25-3-6 - Antidiscrimination Civil Rights Commission
 CRS; 69-7-1 through 69-7-7 - Fair Housing
 CRS; 60-21-1 through 60-21-8 - Equal Employment Opportunities

The Colorado State Board of Public Welfare at its meeting on February 5, 1965 authorized and directed the staff of the Colorado State Department of Public Welfare to prepare the following material concerned with Prohibition of Discrimination under requirements of the Federal Act.

2. Assurance of Compliance by other Agencies, Institutions, Etc.

The State Department has secured, or is in the process of securing, statements of compliance with the provisions of the Act from children's agencies, institutions, day care facilities, organizations, and other facilities from which services are purchased. Medical vendor organizations have been notified of the provisions of the Federal Act and they, in turn have notified their membership. Further, the Colorado State Department of Public Welfare has secured assurance of compliance, using Form HEW 441-A, from the Colorado Medical Service, Inc. and the Colorado Hospital Service, Inc. (Blue Cross - Blue Shield) concerning services purchased through such organizations. Copies of this form are submitted herewith. Statements of compliance are to be obtained from all other vendors or a statement will be included on all State and County vouchers for vendor services in which there is Federal financial participation, notifying vendors of State policy and that services can not be purchased if there is discrimination in regard to race, color, or national origin. Individual nursing homes are being required to assure compliance as part of a signed quarterly report of staffing pattern and services. Such assurance is that each nursing home does not discriminate in regard to race, color or national origin.

Other participants in public welfare programs, agencies, organizations, etc., providing any aid, care, services, or other benefits, are being notified of the provisions of the Act. The form of this latter notification is Form PA-40A, "Notice to the Public Concerning Prohibition of Discrimination." Particulars concerning this distribution are spelled out in appropriate manual material.

In the course of its auditing, quality control review, and other administrative contacts with children's agencies, institutions, day care facilities, organizations, and individual medical care facilities, the staff of the State Department will be alert to any indications of discrimination. When any discriminatory activities are found and the agency or organization persists in such activities after a warning, the State Department will terminate payment for services or otherwise discontinue use of the agency, organization or individual as a resource for public welfare applicants or recipients.

Members of the staff of county welfare departments are also directed to be alert to any instances of discrimination by agencies, individuals or organizations with which it is associated in the provision of aid, care, services, or other benefits to public welfare applicants or recipients.

Under direction of the State Department, county departments will secure such information as may be necessary concerning discriminatory practices or allegations and will promptly act as directed in assuring compliance with provisions of the Act. County departments will, as directed by the State Department,

SE. Colo. Tr. 3/19/74 Incorp. 12/13/74 Effective 12/1/73

terminate payment and other services or otherwise discontinue use of the agency organization as a resource for public welfare applicants or recipients where discriminatory practices are found to exist.

Our procedural material also provides for annual notification (on the same basis as above) to those Agencies, institutions, etc., concerning provisions of the Act. In addition, the Colorado State Department of Public Welfare and/or the county departments will make annual reviews of the practices of these agencies to determine and assure that the agency or institution, etc., continues in compliance with provisions of the Act.

3. Dissemination of Information:

All applicants and recipients of public welfare, as provided in the various Staff Manuals cited below, are to be notified of the provisions of the Civil Rights Act. This is to be carried out by use of Form PA-40, "Notification to Individuals Concerning Prohibition of Discrimination." Particulars concerning dissemination of information by county departments are inserted in the Colorado State Department of Public Welfare Staff Manuals: Vol. IV; 4721, Vol. VII; 7021, and Vol. IX; 9101.

On the State level, all employees have been informed and instructed as to their obligations under the Act as well as State advisory boards, committees and other State consultative groups. Copies of all pertinent documents are available to the staff groups. Staff has been instructed as to the meaning and intent of the Act and their obligations in the continuing nature of compliance. All practices and policies are to be regularly reviewed to assure that no individual is being discriminated against because of race, color, or national origin.

Such interpretation and further discussion as may be necessary concerning both State and county staff will be carried out in district meetings of county staffs, by supervisory staff of the State Department, and by other administrative contacts between county and State personnel. All new staff members are to be informed of the Act's provisions in orientation sessions and there will be periodic discussion with all staff members. The county departments of public welfare have been directed to post this notification form in a prominent place in the county welfare department waiting rooms.

4. Complaints:

The procedure for reception and consideration of complaints is set forth in the Staff Manuals: Vol. IV; 4721, and in Vol. VII; 7021. Procedure for complaints is provided also on the notification form indicating that an aggrieved individual may file his complaint with the county or State Department of Public Welfare. The county department will make prompt investigation and corrective action will be promptly taken when discriminatory practices are found to exist. The individual is further notified that his complaint may also be filed with the appropriate Federal Agency.

Sub. #	6411 P
Accepted	12-27-68
Observed	

74-9

Tr. 3/19/74

Incorp. 12/13/74

Effective 12/11/73

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

STATE OF COLORADO

Section 7.4
Page 89

State Governor's Review

<u>Citation</u>	State Governor's Review
42 CFR 430.12(b)	<p>The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget, and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.</p> <p><input checked="" type="checkbox"/> Not applicable. See page 90.</p> <p><input type="checkbox"/> Does not wish to review any plan material.</p> <p><input type="checkbox"/> Wishes to review only the plan materials specified in the enclosed document.</p>

I hereby certify that I am authorized to submit this plan on behalf of the Department of Health Care Policy and Financing (Designated Single State Agency).



Kim Bimestefer, MBA
Department of Health Care Policy and Financing

Date: 1/8/18



COLORADO

Governor Jared Polis

October 11, 2019

Mary Marchioni
Branch Manager
Centers for Medicare & Medicaid Services
1961 Stout Street
Denver, CO 80294

Dear Ms. Marchioni:

We are pleased to designate the following individuals in the Department of Health Care Policy & Financing as the individuals authorized to submit the State Plan and/or State Plan Amendments regarding Colorado's Medicaid program, effective October 1, 2019:

- Kim Bimestefer, Executive Director
- John Bartholomew, Chief Financial Officer/Finance Offer Director
- Tracy Johnson, Medicaid Director/Health Programs Office
- Rachel Ollar Entrican, Legal Division Director

Please direct any questions to Lauren Reveley at (303) 866-2718 or lauren.reveley@state.co.us.

Sincerely,

A handwritten signature in black ink that reads "Jared Polis".

Jared Polis
Governor

TN No. 19-0034

Approval Date: 11/29/2019

Effective Date: 10/01/2019





Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Alternative Benefit Plan Populations

ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Expansion Adults

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s).

Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Yes

Any other information the state/territory wishes to provide about the population (optional)

Populations exempted from mandatory enrollment such as the medically frail will be offered the choice of the state's approved Medicaid state plan package.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V.20130724



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

The Alternative Benefit Plan using the Essential Health Benefits and subject to 1937 is fully aligned with Colorado's approved Medicaid state plan in that the approved state plan will include the same coverage of the EHB preventive services. However, note that Colorado's approved Medicaid state plan does and will not include Habilitative Services. Coverage of habilitative services is required in the Alternative Benefit Plan. The state has aligned all other benefits between the Colorado state plan and the Alternative Benefit Plan. Therefore, the benefits established in the state's approved state plan and ABP that is the state's approved state plan are considered in alignment and Colorado is not required to implement a medically frail determination process, which would result in a choice between the Alternative Benefit Plan and the state's approved state plan.

Furthermore, the mental health parity requirements will be met because there are no limitations and financial requirements applicable to mental health/substance use disorder (MH/SUD) benefits that are more restrictive than those applicable to medical/surgical benefits. MH/SUD benefits will have no limitations and are presumed to be no more restrictive than those applicable to medical/surgical benefits.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

- ☐ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ☒ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ☒ Benchmark Benefit Package.
- ☐ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ☐ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ☐ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ☐ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ☒ Secretary-Approved Coverage.
 - ☐ The state/territory offers benefits based on the approved state plan.
 - ☒ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

The Alternative Benefit Plan will include the same services that are traditionally available in through the state's approved state plan. In addition, the ABP will offer all remaining preventive services not currently offered in the state plan and habilitative services.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option.

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ☒ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ☐ Any of the largest three state employee health benefit plans by enrollment.



Alternative Benefit Plan

- ☐ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ☐ Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

Colorado chose to use the same base-benchmark for the ABP that the Colorado Marketplace is using for its qualified health plans. Indexing both Medicaid and QHPs to the same base-benchmark will help to ease transitions as clients churn across public and private coverage. To ease the transition of clients who churn across 1937 and 1905(a) coverage, Colorado will offer traditional state plan Medicaid benefits to the expansion population.

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

The state assures the accuracy of all information in ABP5 depicting amount, scope and duration parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V.20130801



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Alternative Benefit Plan Cost-Sharing

ABP4

☒ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Benefits Description

ABPS

The state/territory proposes a "Benchmark-Equivalent" benefit package. ☐ No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Colorado State LG A230 State Employee Health Plan (Kaiser)

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



Alternative Benefit Plan

☒ Essential Health Benefit 1: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Primary Care Illness/injury

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Specialist visits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Other practitioner office visit (Nurse, Physician

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

One routine annual physical exam, per SFY

Duration Limit:

No limitations

Scope Limit:

No limitations



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 6.d

Benefit Provided:

Outpatient Facility Fee (ASC)

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No Limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 9.

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No Limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Dialysis

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations



Alternative Benefit Plan

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 9.

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

9 months (life expectancy or until expiration)

Scope Limit:

See age differences below

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 18. A client aged 21 and over who has elected hospice is not eligible to receive curative services that are related to the treatment of the clients condition for which a diagnosis of terminal illness has been made. A client under the age of 21 is eligible to receive hospice services concurrently with services related to the treatment of the child's condition for which a diagnosis of terminal illness has been made. Clients ages 19 through 20 will receive medically necessary services through EPSDT.

Benefit Provided:

Chemotherapy

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Radiation

Source:

State Plan 1905(a)

Remove



Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Infusion Therapy

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a. Service may require prior authorization.

Benefit Provided:

Treatment for Temporomandibular Joint Disorders

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a



Alternative Benefit Plan

Benefit Provided:		Source:	Remove
Allergy Testing		State Plan 1905(a)	
Authorization:	Provider Qualifications:		
None	Medicaid State Plan		
Amount Limit:	Duration Limit:		
No Limitations	No Limitations		
Scope Limit:			
No Limitations			
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a			
			Add



Alternative Benefit Plan

☒ Essential Health Benefit 2: Emergency services

Collapse All ☐

Benefit Provided:

Emergency transportation / ambulance services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 24.a. Non-emergent medical transportation shall be provided as an administrative service. Emergency medical transportation shall be provided as a medical service.

Benefit Provided:

Emergency Room Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 24.e.

Benefit Provided:

Urgent care centers/facilities

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 2.a

Add



Alternative Benefit Plan

☒ Essential Health Benefit 3: Hospitalization

Collapse All ☐

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 1.a.

Benefit Provided:

Inpatient Physician and Surgical Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Reconstructive Surgery

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Bariatric Surgery

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Transplant

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-E

Benefit Provided:

Private Duty Nursing (IP Hospital)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations



Alternative Benefit Plan

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 1.a

Add



Alternative Benefit Plan

☒ Essential Health Benefit 4: Maternity and newborn care

Collapse All ☐

Benefit Provided:

Pre and postnatal care

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 comprehensive visit and 7-13 prenatal visits

Duration Limit:

Women of childbearing age; duration of pregnancy p

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, attachment 3.1-A section 20

Benefit Provided:

Delivery and All Inpatient Services for Maternity

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 1.a, 12, 28.i, 28.ii

Add



Alternative Benefit Plan

☒ Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided:

Inpatient psychiatric care

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 1.b. Services that are defined as experimental by the US Food and Drug Administration are not benefits. This benefit is not provided in an IMD.

Benefit Provided:

Inpatient psychiatric facility services (under 22)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

Only for clients under age 22.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 16. This benefit is not provided in an IMD. Clients ages 19-20 will receive this benefit through EPSDT. Benefit must remain in ABP to serve clients age 21 whose admission began prior to age 21.

Benefit Provided:

Individual psychotherapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation



Alternative Benefit Plan

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Individual brief psychotherapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Family psychotherapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:



Alternative Benefit Plan

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Group psychotherapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Behavioral health assessment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients



Alternative Benefit Plan

are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Pharmacological management

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Outpatient day treatment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.



Alternative Benefit Plan

Benefit Provided:

Emergency crisis services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient behavioral health benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Drug/alcohol assessment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Behavioral health counseling and therapy, individu

Source:

State Plan 1905(a)

Remove



Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Group therapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Alcohol/drug screening counseling

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Social/Amb Detox: physical assessment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Social/Amb Detox: evaluation of motivation

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation



Alternative Benefit Plan

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Social/Amb Detox: safety assessment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Social/Amb Detox: provision daily needs

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

No limitation



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Medication assisted treatment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.d. This is an outpatient substance use disorder benefit. NOTE: Behavioral health (mental health and substance use disorder) services are administered by behavioral health managed care organizations (BHOs) through Colorado Medicaid's 1915(b)(3) Community Behavioral Health Services waiver program. All full Medicaid clients are mandatorily enrolled into the program and therefore will not be subject to the identified limits for state plan services provided on a fee-for-service basis. BHOs will administer behavioral health services based on medical necessity and are incentivized to provide services beyond the state plan limits.

Benefit Provided:

Substance Abuse Disorder Inpatient Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

Medical services for the medical management of withdrawal symptoms. Not rehabilitation. Services for alcohol/drug detoxification are covered same as other medical conditions. Detoxification is the process removing toxic substances from body.



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 1.a

Add



Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

☒ Limit on days supply

☐ Limit on number of prescriptions

☒ Limit on brand drugs

☒ Other coverage limits

☒ Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 12.a. The state assures that the prescription drug coverage methods and standards it uses for in its Approved State Plan will be applied to recipients in the Alternative Benefit Plan.



Alternative Benefit Plan

☒ Essential Health Benefit 7: Rehabilitative and habilitative services and devices

Collapse All ☐

Benefit Provided:

Outpatient Rehabilitation Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

48 units of PT/OT per 12 months. 5 units/day all.

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 11.a, b, c. PT/OT is limited to 48 units of service per 12 months. Additional services may be prior authorized for units beyond 48. Speech therapy does not have an annual limit. PT is limited to 5 units per day, OT 5 units per day, ST 5 units per day for all ages and eligibilities.

The effective date for these service changes is December 1, 2017.

Benefit Provided:

Prosthetic devices

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 12.c.

Benefit Provided:

Habilitative Services

Source:

Other state-defined

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

48 units of PT/OT per 12 months. 5 units/day all.

Duration Limit:

No limitation



Alternative Benefit Plan

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services shall be provided by a licensed physical therapist or occupational therapist who is an approved Medicaid provider or a physical therapist assistant under the general supervision of a licensed physical therapist, or an occupational therapist assistant under the general supervision of a licensed occupational therapist.

A medical prescription for services is required and the service procedure must be a covered benefit of the Medicaid program.

A prior authorization request shall be effective for a length of time that is determined medically necessary not to exceed a maximum of 12 months.

Services shall be provided in accordance with 42 CFR 440.110.

There is not a lifetime limit on Habilitative therapy.

Habilitative PT/OT cannot be rendered on the same date of service as Rehabilitative PT/OT. Habilitative PT/OT units are in addition to the units available for Rehabilitative PT/OT. A client may have a total of 48 units for Habilitative therapy separate and distinct from 48 units of Rehabilitative therapy, per 12 months. Prior Authorization is required to exceed this limit.

Speech language pathology services may be provided by any of the following:

A certified speech language pathologist with a current certification issued by the Colorado Department of Regulatory Agencies (DORA).

A clinical fellow under the general supervision of an ASHA certified speech language pathologist.

A speech language pathology assistant A speech language pathology assistant is a person who has an associate degree from a technical training program in speech language pathology assistants scope of work as recommended in ASHA guidelines.

A medical prescription for services is required and the service procedure must be a covered benefit of the Medicaid program.

A prior authorization request shall be effective for a length of time that is determined medically necessary not to exceed a maximum of 12 months.

Diagnostic procedures provided by an audiologist for the purpose of determining general hearing levels or for the distribution of a hearing device are not a covered benefit except for the EPSDT eligible.

Speech language pathology services provided for simple articulation or academic difficulties that are not medical in origin are not a covered benefit.

There is no lifetime limit on Habilitative speech therapy.

Habilitative speech therapies cannot be rendered to a client on the same date of service as rehabilitative speech therapies.

The effective date for these service changes is December 1, 2017.

Benefit Provided:

Home Health Care Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

Acute: 60 days. Long term: 61+ days.



Alternative Benefit Plan

Scope Limit:

Adults limited to therapies for acute home health only. Children have long-term therapies covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 7.a, b, c, d.

Benefit Provided:

Nursing facility services (21+)

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

Limited to clients age 21 and over.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 4.a. Pursuant to 45 CFR 156.115 this does not include long-term/custodial nursing home care benefits which can be found in Other 1937 Covered Benefits that are not Essential Health Benefits. Habilitative therapies will not be available in this benefit. This benefit includes the 100 day short-term stay for rehabilitation therapies. Clients ages 19 through 20 will receive services through EPSDT.

Benefit Provided:

Durable Medical Equipment

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 7.c.

"Covered items are limited to ones that: 1. Have been prescribed by a physician and when applicable, be recommended by an appropriately licensed practitioner. 2. Are reasonable, appropriate and effective method for meeting the client's medical need. 3. Have an expected use that is in accordance with current medical standards or practices. 4. Are cost effective, which means that less costly and medically appropriate alternatives do not exist or do not meet treatment requirements. 5. Provide for a safe environment. 6. Are not experimental or investigational, but generally accepted by the medical community



Alternative Benefit Plan

as standard practice.7. Do not have as its primary purpose the enhancement of a client's personal comfort or to provide convenience for the client or caretaker.8. Are not related to routine personal hygiene, education, exercise, participation in sports, or cosmetic purposes.9. Are not duplicative or serve the same purpose as items already utilized by the client.10. Are Medically Necessary. Provided the above is met, covered Benefits include:1. DME2. Orthotics3. Prosthetics4. Disposable supplies5. Monitoring Equipment6. Repairs and replacement7. Specialized use rehabilitation equipment8. Oral and enteral formulas equipment, and supplies.9. Parenteral equipment and supplies.10. Facilitative Devices11. Complex Rehabilitation Technology12. Specialized eating utensils and other medically necessary activities of daily living aids.13. Oxygen and oxygen equipment"

Benefit Provided:

Hearing aids

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

Limited to clients ages 20 and under.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.I-A section 11.c.

Add



Alternative Benefit Plan

☒ Essential Health Benefit 8: Laboratory services

Collapse All ☐

Benefit Provided:

Laboratory Outpatient and Professional Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 3.a.

Benefit Provided:

X-Rays and Diagnostic Imaging

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 3.a.

Benefit Provided:

Imaging (CT/PET Scans, MRIs)

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 3.a.

Add



Alternative Benefit Plan

☒ Essential Health Benefit 9: Preventive and wellness services and chronic disease management

Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Preventive Care/Screening/Immunization

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.b, c.

Benefit Provided:

Nutritional Counseling

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Diabetes Education

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations



Alternative Benefit Plan

Scope Limit:

No Limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.a

Benefit Provided:

Routine foot care

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 service per 60 days

Duration Limit:

No Limitations

Scope Limit:

Acute care episodes allow any amount of medically necessary podiatrist services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 6.a

Add



Alternative Benefit Plan

☒ Essential Health Benefit 10: Pediatric services including oral and vision care Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Authorization:

Amount Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Source:

Provider Qualifications:

Duration Limit:



Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐



Alternative Benefit Plan

<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Primary Care Illness/injury - Duplication</div>	Source: Base Benchmark	<div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Remove</div>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">This base-benchmark benefit is covered under state plan benefit "physician services 5.a" placed within EHB 1.</div>		
Base Benchmark Benefit that was Substituted: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Specialist Visits - Duplication</div>	Source: Base Benchmark	<div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Remove</div>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">This base-benchmark benefit is covered under state plan benefit "physician services 5.a" placed within EHB 1.</div>		
Base Benchmark Benefit that was Substituted: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Other practitioner office visit - Duplication</div>	Source: Base Benchmark	<div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Remove</div>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">This base-benchmark benefit is covered under state plan benefits "Other licensed practitioners 6.d" placed within EHB 1.</div>		
Base Benchmark Benefit that was Substituted: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Outpatient Facility Fee (ASC) - Duplication</div>	Source: Base Benchmark	<div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Remove</div>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">This base-benchmark benefit is covered under state plan benefit "Clinic Services 9" placed within EHB 1.</div>		
Base Benchmark Benefit that was Substituted: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Outpatient Surgery Physician/Surgica - Duplication</div>	Source: Base Benchmark	<div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Remove</div>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">This base-benchmark benefit is covered under state plan benefits "Physician Services 5.a" placed within EHB 1.</div>		
Base Benchmark Benefit that was Substituted: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Dialysis - Duplication</div>	Source: Base Benchmark	<div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Remove</div>
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">This base-benchmark benefit is covered under state plan benefit "Clinic Services 9" placed within EHB 1.</div>		
<div style="display: flex; justify-content: space-between;">CO-19-0024Approval Date: 12/13/2019Effective Date: 07/01/2019</div>		



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Chemotherapy - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Physician Services 5.a" placed within EHB 1.

Base Benchmark Benefit that was Substituted:

Radiation - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Physician Services 5.a" placed within EHB 1.

Base Benchmark Benefit that was Substituted:

Infusion Therapy - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Physician Services 5.a" placed within EHB 1.

Base Benchmark Benefit that was Substituted:

Treatment for Temporomandibular Joint- Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Physician Services 5.a" placed within EHB 1.

Base Benchmark Benefit that was Substituted:

Hospice - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Hospice 18" placed within EHB 1.

Base Benchmark Benefit that was Substituted:

Allergy Testing - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Physician Services 5.a" placed within EHB 1.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Emergency Room Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Other medical care 24.e" placed within EHB 2.

Base Benchmark Benefit that was Substituted:

Emergency Transportation / Ambulance - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Other medical care 24.a" placed within EHB 2.

Base Benchmark Benefit that was Substituted:

Urgent care centers/facilities - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Outpatient Hospital Services 2.a" placed within EHB 2.

Base Benchmark Benefit that was Substituted:

Inpatient Hospital Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Inpatient Hospital Services 1.a" placed within EHB 3.

Base Benchmark Benefit that was Substituted:

Inpatient Physician and Surgical Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

(Duplication) This base-benchmark benefit is covered under state plan benefits "Physician Services 5.a" placed within EHB 1.

Base Benchmark Benefit that was Substituted:

Reconstruction Surgery - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefit "Physician Services 5.a" placed within EHB 3.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <div>Bariatric Surgery - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefit "Physician Services 5.a" placed within EHB 3.</div>		
Base Benchmark Benefit that was Substituted: <div>Transplant - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "Organ Transplant Services Supplement to Attachment 3.1-E" placed within EHB 3.</div>		
Base Benchmark Benefit that was Substituted: <div>Private Duty Nursing (IP Hospital) - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefit "Inpatient Hospital Services 1.a" and "Physician Services 5.a" placed within EHB 3.</div>		
Base Benchmark Benefit that was Substituted: <div>Pre and postnatal care - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefit "Extended Services for Pregnant Women 20" placed within EHB 4.</div>		
Base Benchmark Benefit that was Substituted: <div>Delivery and All Inpatient Services for Maternity</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>(Duplication) - This base-benchmark benefit is covered under state plan benefits "Inpatient Hospital Services 1.a, Nurse mid-wife services 17, Licensed or Otherwise state-approved freestanding birth centers 28.i and 28.ii" placed within EHB 4.</div>		
Base Benchmark Benefit that was Substituted: <div>Substance Abuse Disorder Outpatient Services</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>(Duplication) - This base-benchmark benefit is covered under state plan benefits "Rehabilitative services 13.d" placed within EHB 5.</div>		



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <input type="text" value="Mental / Behavioral Health Outpatient Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 13.d\"="" 5."="" ehb="" placed="" rehabilitative="" services="" type="text" value="(Duplication) - This base-benchmark benefit is covered under state plan benefits \" within=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Substance Abuse Disorder Inpatient Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 1.a\"="" 5."="" ehb="" hospital="" inpatient="" placed="" services="" type="text" value="(Duplication) - This base-benchmark benefit is covered under state plan benefits \" within=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Mental / Behavioral Health Inpatient Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 1.b\"="" 5."="" ehb="" hospital="" inpatient="" placed="" services="" type="text" value="(Duplication) - This base-benchmark benefit is covered under state plan benefits \" within=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Generic Drugs - Duplication"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 12.a\"="" 6."="" drugs="" ehb="" placed="" prescribed="" type="text" value="This base-benchmark benefit is covered under state plan benefits \" within=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Preferred Brand Drugs - Duplication"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 12.a\"="" 6."="" drugs="" ehb="" placed="" prescribed="" type="text" value="This base-benchmark benefit is covered under state plan benefits \" within=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Non-preferred Brand Drugs"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 12.a\"="" 6."="" drugs="" ehb="" placed="" prescribed="" type="text" value="This base-benchmark benefit is covered under state plan benefits \" within=""/>		



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Specialty Drugs - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Prescribed Drugs 12.a" placed within EHB 6.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "3.1b(Attachment) 3.1-A 7.c. (Supplement to Attachment) 3.1-A, 7 and 12.c" placed within EHB 7.

Base Benchmark Benefit that was Substituted:

Prosthetic Devices - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Prosthetic Devices 12.c" placed within EHB 7.

Base Benchmark Benefit that was Substituted:

Hearing Aids - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Audiology services 11.c" and "EPSDT 4.b" placed within EHB 7.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Nursing Facility Services 4.a, 24.d." placed within EHB 7.

Base Benchmark Benefit that was Substituted:

Home Health Care Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This base-benchmark benefit is covered under state plan benefits "Home Health Services 7.a-b." placed within EHB 7.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient Rehabilitation Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 11.a-c.\"="" 7."="" and="" ehb="" occupational,="" physical,="" placed="" speech="" therapies="" type="text" value="This base-benchmark benefit is covered under state plan benefits \" within=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Laboratory Outpatient and Professional Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 3.a\"="" 8."="" and="" ehb="" laboratory="" other="" placed="" services="" type="text" value="(Duplication) - This base-benchmark benefit is covered under state plan benefits \" within="" x-ray=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="X-Rays and Diagnostic Imaging"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 3.a\"="" 8."="" and="" ehb="" laboratory="" other="" placed="" services="" type="text" value="(Duplication) - This base-benchmark benefit is covered under state plan benefits \" within="" x-ray=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Imaging (CT/PET Scans, MRIs)"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 3.a\"="" 8."="" and="" ehb="" laboratory="" other="" placed="" services="" type="text" value="(Duplication) - This base-benchmark benefit is covered under state plan benefits \" within="" x-ray=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Preventive Care/Screening/Immunization"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 13.b\"="" 13.c,="" 9."="" ehb="" placed="" preventive="" screening="" services="" services,="" type="text" value="(Duplication) - This base-benchmark benefit is covered under state plan benefits \" within=""/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Nutritional Counseling - Duplication"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input 5.a\"="" 9."="" ehb="" physician="" placed="" services="" type="text" value="This base-benchmark benefit is covered under state plan benefits \" within=""/>		



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <div>Diabetes Education - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "Physician Services 5.a" placed within EHB 9.</div>		
Base Benchmark Benefit that was Substituted: <div>Routine foot care - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "Podiatrists' services, 6.a" placed within EHB 9.</div>		
Base Benchmark Benefit that was Substituted: <div>Well Baby Visits and Care - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "EPSDT, 4.b" placed within EHB 10.</div>		
Base Benchmark Benefit that was Substituted: <div>Routine Eye Exam for Children - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "EPSDT, 4.b" placed within EHB 10.</div>		
Base Benchmark Benefit that was Substituted: <div>Eye Glasses for Children - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "EPSDT, 4.b" placed within EHB 10.</div>		
Base Benchmark Benefit that was Substituted: <div>Dental Checkup for Children - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "EPSDT, 4.b" placed within EHB 10.</div>		



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: <div>Basic Dental Care - Child - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "EPSDT, 4.b" placed within EHB 10.</div>		
Base Benchmark Benefit that was Substituted: <div>Orthodontia - Child - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "EPSDT, 4.b" placed within EHB 10.</div>		
Base Benchmark Benefit that was Substituted: <div>Major Dental Care - Child - Duplication</div>	Source: Base Benchmark	<div>Remove</div>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <div>This base-benchmark benefit is covered under state plan benefits "EPSDT, 4.b" placed within EHB 10.</div>		
		<div>Add</div>



Alternative Benefit Plan

<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>	
Base Benchmark Benefit not Included in the Alternative Benefit Plan:		Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Chiropractic Care"/>			
Explain why the state/territory chose not to include this benefit:			
<input type="text" value="Benefit not covered in State Plan."/>			
Base Benchmark Benefit not Included in the Alternative Benefit Plan:		Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Infertility Treatment (artificial insemination.etc)"/>			
Explain why the state/territory chose not to include this benefit:			
<input type="text" value="Benefit not covered in State Plan."/>			
			<input type="button" value="Add"/>



Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Other 1937 Benefit Provided:

Rural health clinic services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other:

Source: Approved State Plan Amendment, 3.1-A section 2.b. This benefit is a service location specified in the state plan. It does not have any authorization requirements.

Other 1937 Benefit Provided:

FQHC services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other:

Source: Approved State Plan Amendment, 3.1-A section 2.c. This benefit is a service location specified in the state plan. It does not have any authorization requirements.

Other 1937 Benefit Provided:

Other screening services (SBIRT)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

2 full screens, 4 brief interventions, per SFY

Duration Limit:

No limitations

Scope Limit:

No limitations

Other:

Source: Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 13.c. No



Alternative Benefit Plan

prior authorizations required.

Other 1937 Benefit Provided:

Intermediate care facility services, ICF/IID

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other:

Source: Reference Approved State Plan Amendment, attachment 3.1-A section 15.

Other 1937 Benefit Provided:

Targeted case management: developmental disability

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

240 units, per SFY

Duration Limit:

No limitations

Scope Limit:

For individuals with a developmental disability

Other:

Source: Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 19.a. Prior authorization is not required.

Other 1937 Benefit Provided:

Extended services for pregnant women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

During pregnancy + 60 days postpartum

Scope Limit:

No limitations



Alternative Benefit Plan

Other:

Source: Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 20. Prior authorization is not required.

Other 1937 Benefit Provided:

Ophthalmologist or Optometrist Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

See below

Scope Limit:

See below

Other:

Source: Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 6.b.

A. These are services for clients ages 21 and over. These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider.

1) One routine non-pediatric eye exam per calendar year, when medically necessary to diagnose, manage, or treat a client with signs or symptoms of injury or disease of the eye.

2) Determination of the refractive state (an exam to test for visual acuity and the need for corrective lenses), only in these situations:

a.) As part of the diagnostic eye exam described in (1). b.) After eye surgery.

B. These are the services for clients ages 20 and younger (EPSDT program). These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider.

1) Routine vision screening and diagnostic eye exams.

2) Orthoptic vision treatment services.

The effective date for these service changes is December 1, 2017.

Other 1937 Benefit Provided:

Pediatric or family nurse practitioner services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other:

Source: Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 24.g. Prior authorization is not required.



Alternative Benefit Plan

Other 1937 Benefit Provided:		Source:	Remove
PACE		Section 1937 Coverage Option Benchmark Benefit Package	
Authorization:	Provider Qualifications:		
Other	Medicaid State Plan		
Amount Limit:	Duration Limit:		
No limitation	No limitation		
Scope Limit:			
The PACE program is for individuals age 55+.			
Other:			
Source: See Approved State Plan Amendment, attachment 3.1-A section 27 and Supplement 3 Limitations to Care and Services - PACE Services.			

Other 1937 Benefit Provided:		Source:	Remove
Other practitioners' services		Section 1937 Coverage Option Benchmark Benefit Package	
Authorization:	Provider Qualifications:		
Other	Medicaid State Plan		
Amount Limit:	Duration Limit:		
No limitations	No limitations		
Scope Limit:			
No limitations			
Other:			
Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 6.d. Prior authorization is not required. Approved group: State licensed psychologists, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, Physician Assistants, Certified Nurse Midwives and Certified Nurse Practitioners.			

Other 1937 Benefit Provided:		Source:	Remove
Face to face tobacco cessation for pregnant women		Section 1937 Coverage Option Benchmark Benefit Package	
Authorization:	Provider Qualifications:		
Other	Medicaid State Plan		
Amount Limit:	Duration Limit:		
Intermediate 5 units. intensive 3 units. Per year	No limitations		
Scope Limit:			
Only for pregnant women.			



Alternative Benefit Plan

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 4.d. Prior authorization is not required.

Other 1937 Benefit Provided:

Nursing facility services (21+)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation

Scope Limit:

Limited to clients age 21 and over.

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 4.a This is covered to the extent of custodial care. Non-custodial Skilled nursing facility care is in EHB 7 "Nursing facility services (21+)" benefit.

Other 1937 Benefit Provided:

Targeted case management: nurse-home visitor

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

15 units per month

Duration Limit:

No limitations

Scope Limit:

First-time pregnant women and their first baby up to the child's second birthday.

Other:

Reference Approved State Plan Amendment, supplement 1B to attachment 3.1-A, and attachment 4.19 B item #19. Prior authorization is not required.

Other 1937 Benefit Provided:

Targeted case management: behavioral health

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitation

Duration Limit:

No limitation



Alternative Benefit Plan

Scope Limit:

Medicaid clients enrolled in the Colorado Medicaid Community Behavioral Health Services Program (a Section 1915(b) waiver program) who have or are being assessed for a mental health (behavioral health) diagnosis(es) covered under that program.

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 19a. Prior authorization is not required. Additional limitations: An individual who has been assessed and determined not to have a mental health (behavioral health) diagnosis(es) covered by the Colorado Medicaid Behavioral Health Services Program is eligible for case management services under this State Plan Amendment for only ten business days after the date the determination was made.

Other 1937 Benefit Provided:

Targeted case management: substance abuse

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

4 units per DOS, no limit per SFY

Duration Limit:

No limitation

Scope Limit:

No limitations

Other:

Reference Approved State Plan Amendment, supplement 1C to attachment 3.1-A. Prior authorization is not required.

Other 1937 Benefit Provided:

Private duty nursing

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

16 hours per day

Duration Limit:

No limitation

Scope Limit:

No limitation

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 8.

Private Duty Nursing is face-to-face skilled nursing that is more individualized and continuous than the nursing care that is available under the Home Health benefit or routinely provided in a hospital or nursing facility. Private Duty Nursing is provided in the home, or outside the home when normal life activities take the client away from the home. Private Duty Nursing shall not be reimbursed in a hospital or nursing facility.



Alternative Benefit Plan

Private Duty Nursing services provided to eligible clients shall be provided through Medicaid licensed Home Health agencies. To be eligible for Private Duty Nursing, a Medicaid client must meet medical necessity criteria. Private Duty Nursing services are provided by a registered nurse or a licensed practical nurse, under the direction of the recipient's physician. Private Duty Nursing services may be provided by one nurse to more than one client at the same time, in the same setting, at a reduced rate.

The amount of Medicaid reimbursed Private Duty Nursing per day may not exceed the hours that are determined necessary under the medical criteria up to sixteen hours per day. For EPSDT clients ages 19 through 20, Private Duty Nursing will be provided up to the amount of medical need. All Private Duty Nursing services must be prior authorized.

Other 1937 Benefit Provided:

Dental Services - Adults

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See other box, below.

Duration Limit:

See other box, below.

Scope Limit:

Adults, age 21 and over.

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 10. Prior authorization is sometimes required.

Other 1937 Benefit Provided:

Dentures - Adults

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See other box, below.

Duration Limit:

See other box, below.

Scope Limit:

Adults, age 21 and over.

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 12.b. Prior authorization is required.

1. Complete and Partial Removable Prosthetics are a benefit for recipients age 21 and older based on medical necessity. Services consist of fabrication of complete or partial dentures and are subject to Prior Authorization Requests.

A. Complete Dentures are limited to one set every 7 years, includes initial 6 months of relines.

B. Partial Dentures are limited to one set every 7 years.



Alternative Benefit Plan

For clients under 21 years of age, denture benefits are provided in accordance with the Early, Periodic, Screening, Diagnosis and Treatment (EPDST) service category. See Supplement to Attachment 3.1-A, section 4b.

Other 1937 Benefit Provided:

School-based mental health services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

Only available to children with Individual Education Programs.

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 4.b(I). Prior authorization is not required.

Other 1937 Benefit Provided:

Outpatient Hospital Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

Routine and annual physical examinations are not provided unless determined to be medically necessary based upon a medical diagnosis, complaint or symptom.

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 2.a. Prior authorization is not required.

Other 1937 Benefit Provided:

Family Planning Services and Supplies

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations



Alternative Benefit Plan

Scope Limit:

No Limitations

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 4.c. Prior authorization is not required.

A. The Department of Health Care Policy and Financing (the Department) covers family planning services and supplies, with the exception of infertility services and supplies. The Department covers family planning services and supplies, as noted under Section 1905(a)(4)(c) of the Social Security Act and 42 CFR 441. 20.13. The Department covers services to prevent teen pregnancies as a family planning service. Medicaid Teen Pregnancy Prevention services are provided by providers contracted with the department and are as described below:

I. Intensive individual or group counseling/ educational services, identified and approved by the Department. Services provide counseling in the following areas:

- a. Making informed, responsible, healthy individualized decisions about family planning and reproductive health choices; including abstinence, contraception, safe sexual practices and risk reduction choices;
- b. Making informed, responsible decisions about reproductive health and the effect of alcohol and drug use on decision- making and pregnancy risk;
- c. Contraception use, including potential health benefits and/ or adverse effects.

EPSDT services that are medically necessary will be provided to individuals under 21 years of age.

Other 1937 Benefit Provided:

Medical and surgical services - dentist

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 5.b. Prior authorization is not required.

Other 1937 Benefit Provided:

Eyeglasses and Contact Lenses

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

See below



Alternative Benefit Plan

Scope Limit:

See below

Other:

Reference Approved State Plan Amendment, supplement to attachment 3.1-A section 12.d. The effective date of the most recent update to this service is December 1, 2017.

Other 1937 Benefit Provided:

Intermediate care facility services, ICF/IID

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other:

Reference Approved State Plan Amendment, attachment 3.1-A section 15a., b.

Other 1937 Benefit Provided:

Nurse-midwife services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other:

Reference Approved State Plan Amendment, attachment 3.1-A section 17.

Other 1937 Benefit Provided:

Ambulatory prenatal care

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

Outpatient services only. Labor and delivery are not covered.

Other:

Reference Approved State Plan Amendment, attachment 3.1-A section 21.

Other 1937 Benefit Provided:

Certified pediatric family nurse practitioner serv

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

No Limitations

Scope Limit:

No Limitations

Other:

Reference Approved State Plan Amendment, attachment 3.1-A section 23.

Other 1937 Benefit Provided:

Nursing Facility services under 21

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitation

Duration Limit:

No Limitation

Scope Limit:

No Limitation

Other:

Reference Approved State Plan Amendment, attachment 3.1-A section 24.d

Add



Alternative Benefit Plan

☐

Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V.20130814



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Benefits Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. ☐

Prescription Drug Coverage Assurances

- ☒ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.
- ☒ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- ☒ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- ☒ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- ☒ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☒ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☒ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☒ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☒ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☒ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☒ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.



Alternative Benefit Plan

- ☒ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☒ Managed care.
- ☒ Managed Care Organizations (MCO).
 - ☒ Prepaid Inpatient Health Plans (PIHP).
 - ☐ Prepaid Ambulatory Health Plans (PAHP).
 - ☒ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

- ☒ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The implementation plan for the Alternative Benefit Plan (ABP) under managed care has and will include public and tribal noticing, and messaging through stakeholder forums and provider bulletins. The department is also currently holding individual meetings with health plans, behavioral health organizations (BHOs), Regional Collaborative Organizations (RCCOs) and providers to discuss the details of the ABP. The health plans, BHOs and RCCOs will further communicate with providers and members how the Alternative Benefit Plan will affect them. Lastly, the department is negotiating managed care contract amendments to include the expansion population and will continue to monitor performance on an ongoing basis.

Furthermore, implementation includes changes to the MMIS system that allow provider reimbursement for new services that were not offered through traditional Medicaid. Several USPSTF A and B recommended preventive services were identified as procedures that were not formerly reimbursed but needed to become so in order to meet assurance standards. CPT and HCPCS codes were chosen to represent the new preventive services and are identically available for existing State Plan benefits as well as the Alternative Benefit Plan. These changes will be appropriately communicated to providers and clients.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

☐ Yes

The managed care program is operating under (select one):

☐ Section 1915(a) voluntary managed care program.

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- ☐ Section 1915(b) managed care waiver.
- ☒ Section 1932(a) mandatory managed care state plan amendment.
- ☐ Section 1115 demonstration.
- ☐ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

Plan Model and Structure: Denver Health is a staff-model HMO, similar to the Kaiser model. Denver Health physicians are employees of the organization and are salaried. Denver Health Medicaid Choice (DHMC) is a full-risk capitation contract. Capitation payments are made monthly and DHMC provides all covered services to enrolled clients from these monies. In Colorado, Medicaid behavioral health is carved out from physical health contracts, so it is not included in DHMC. Certain other services are also carved out and paid directly by HCPF where such an arrangement makes sense. An example is non-emergent transportation, which HCPF provides through contracts with State counties and their vendors.

Plan Services: DHMC provides comprehensive physical health care including inpatient and outpatient hospital care, acute home health care, office visits, laboratory, radiology, DME and prescription drugs. Members can access all services without co-payments. Adult preventative care, family planning and the full range of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services are covered. Members select a Primary Care Physician who coordinates all aspects of their care.

DHMC operates 9 community health centers and 12 school-based clinics in underserved neighborhoods throughout the Denver metropolitan area.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PIHP: Prepaid Inpatient Health Plan

The managed care delivery system is the same as an already approved managed care program.

The managed care program is operating under (select one):

- ☒ Section 1915(a) voluntary managed care program.
- ☐ Section 1915(b) managed care waiver.
- ☐ Section 1115 demonstration.
- ☐ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

Plan Model and Structure: The plan is a 1915(a), non-risk Prepaid Inpatient Health Plan (PIHP). Rocky Mountain Health Plan (RMHP) has a network of physicians and contracts with the majority of them through the Mesa County Individual Practice Association (MCIPA). Through its contracts with the IPA, RMHP pays a negotiated amount for each provider service that is the same irrespective of the patient's insurance coverage. RMHP is an Administrative Services Organization (ASO) model, which means RMHP receives and adjudicates claims from its providers, repackages the claims to the Medicaid Fee Schedule, and submits them to Colorado Medicaid for payment. Claims are then paid to RMHP by the State on a fee-for-service basis.

RMHP receives a small monthly fee (per member per month) for their work in 1) claims adjudication and 2) care management/

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coordination, which includes a variety of clinical quality and disease management programs.

Plan Services: RMHP provides comprehensive physical health care including inpatient and outpatient hospital care, acute home health care, office visits, laboratory, radiology, DME and prescription drugs. Adult preventative care, family planning and the full range of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services are covered. Members select a Primary Care Physician who coordinates all aspects of their care. Members are also assigned a case manager who helps them understand and use their RMHP Medicaid benefits and relevant community resources.

Additional Information: PIHP (Optional)

Provide any additional details regarding this service delivery system (optional):

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program.

Yes

The PCCM program is operating under (select one):

- ☐ Section 1915(b) managed care waiver.
- ☒ Section 1932(a) mandatory managed care state plan amendment.
- ☐ Section 1115 demonstration.
- ☐ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

May 2011

Describe program below:

The Accountable Care Collaborative (ACC) Program builds on the existing Primary Care Case Management (PCCM) Program. The program is designed to affordably optimize client health, functioning and self-sufficiency. The four main goals of the ACC program are ensuring access to a focal point of care or medical home, coordinating medical and non-medical care, improving member and provider experiences and providing the necessary data to support these functions.

The ACC program utilizes Regional Care Coordination Organizations (RCCO's) to accomplish program objectives. RCCOs, Primary Care Medical Providers (PCMP) and data and information from a Statewide Data and Analytics Contractor (SDAC) combine to optimize the delivery of outcome-based healthcare service delivery. The aim of the RCCO is to achieve health outcomes while ensuring comprehensive care coordination. This aim includes a medical home level of care for every member. These objectives are attained through the RCCOs' primary responsibilities of network development, provider support, medical management and care coordination, accountability and reporting.

The ACC Program utilizes a voluntary passive enrollment model. Clients have the opportunity to opt out of the program should they choose but they must make a specific request to the Department.

Additional Information: PCCM (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- ☒ Traditional state-managed fee-for-service

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☐ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The majority of clients will be served through a fee-for-service delivery system where providers are paid a fee for each service they provide. The department describes its payment methodologies for mandatory and optional Medicaid services in its approved Medicaid State Plan. All such state plan amendments are consistent with federal statutes and regulations.

The department typically develops its rates based on the cost of providing the service, a review of what commercial payers reimburse in the private market or a percentage of what Medicare pays for equivalent services.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

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OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

☐ Managed Care Organizations (MCO).

☒ Prepaid Inpatient Health Plans (PIHP).

☐ Prepaid Ambulatory Health Plans (PAHP).

☐ Primary Care Case Management (PCCM).

☐ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☒ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

PIHP: Prepaid Inpatient Health Plan

The managed care delivery system is the same as an already approved managed care program.

☐ Yes

The managed care program is operating under (select one):

☐ Section 1915(a) voluntary managed care program.

☒ Section 1915(b) managed care waiver.

☐ Section 1115 demonstration.

☐ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

Behavioral Health Organization Program:

Approval Date: 12/13/2019

Effective Date: 07/01/2019



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This is a statewide managed care program that provides comprehensive mental health services to all Coloradans with Medicaid. Medicaid members are assigned to a Behavioral Health Organization (BHO) based on where they live. BHOs arrange or provide for medically necessary mental health services to clients in their service areas. There are five BHOs statewide: Access Behavioral Care (ABC); Behavioral Healthcare Inc (BHI); Colorado Health Partnerships (CHP); Foothills Behavioral Health Partnerships (FBHP); Northeast Behavioral Health Partnerships (NBHP). These five BHO contracts go through a competitive bid process every five years and within each 5 year period, the Department has the option of renewing or not renewing the contract on a yearly basis.

Eligibility:

Colorado residents who are U.S. citizens or legal permanent residents for at least five years are eligible. Individuals must have a mental health diagnosis that is covered by the program to receive covered services.

Services Available:

- Inpatient hospital psychiatric care
- Outpatient hospital services
- Psychiatrist services
- Individual and group therapy
- Medication management
- Clinic case management services
- Emergency services
- Vocational services
- Clubhouse/drop-in centers
- Residential services
- Assertive Community Treatment
- Recovery services
- Respite services
- Prevention/early intervention activities
- Home and Community-Based services for children/youth

Cost Sharing:

There are no co-pays for Medicaid mental health services. However, members with other insurance must use that insurance first before using Medicaid benefits.

Additional Information: PIHP (Optional)

Provide any additional details regarding this service delivery system (optional):

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PRA Disclosure Statement

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Attachment 3.1-C- ☐

Employer Sponsored Insurance and Payment of Premiums

ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

Yes

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The Medicaid agency pays all premiums deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan as specified in the qualified employer sponsored coverage without regard to limitations specified in section 1916 or section 1916A of the Act for eligible individuals under age 19 who have access to and elect to enroll in such coverage. The eligible individual is entitled to services covered by the State plan which are not included in the employer sponsored coverage.

When coverage for eligible family members under age 19 is not possible unless an ineligible parent enrolls, the Medicaid agency pays premiums for enrollment of the ineligible parent and at the parent option other ineligible family members the agency also pays deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan for the ineligible parent.

To determine cost effectiveness, the Medicaid agency determines whether the annual cost of an applicant's commercial health insurance is less than the estimated total cost of the applicant's annual medical expenses, out-of-pocket costs, and administrative costs. If the commercial health insurance is less, the client is eligible for this program. For qualified employer sponsored coverage the employer must contribute at least 40 percent of the premium cost.

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums.

No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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Attachment 3.1-C- ☐

General Assurances

ABP10

Economy and Efficiency of Plans

- ☒ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

Compliance with the Law

- ☒ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- ☒ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- ☒ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

- ☒ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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