Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-14-0046

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

Region VIII

November 18, 2014

Susan E. Birch, MBA, BSN, RN, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203-1818

RE: Colorado #14-0046

Dear Ms. Birch:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 14-0046. This amendment concerns the addition of an annual maximum to the adult dental benefit and the addition of an adult denture benefit to Colorado's Alternative Benefit Plan to maintain the State's assurance that the ABP matches regular Medicaid. The annual maximum to the Adult Dental benefit and an Adult Denture benefits were added to Colorado's State Plan effective July 1, 2014 through approved CO SPA 14-036.

Please be informed that this State Plan Amendment was approved November 17, 2014 with an effective date of October 1, 2014. We are enclosing the Summary Form (formerly the CMS-179) and the amended plan page(s).

In order to track expenditures associated with this amendment, Colorado should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage report on the Form CMS-64.9 VIII and those not enrolled in the new adult group, claims should be reported on the Form CMS-64.9 Base.

This amendment would affect expenditures reported on 8- Dental Services.

If you have any questions concerning this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

/s/

Mary Marchioni
Acting Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Suzanne Brennan
Max Salazar
Pat Connally
John Bartholomew
Barb Prehmus

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: Colorado

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

CO 14-0046

Proposed Effective Date

07/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Social Security Act Sections 1902(a)(10)(A)(i)(VIII);1937(a)(1)(A) and (B); 1937(a)(2);1937(b); 1902(a)(30)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Addition of Adult Denture Benefit and addition of an annual maximum to the Adult Dental benefit to the Alternative Benefit Plan to conform to these additions to the Colorado Medicaid state plan.

Governor's Office Review

- **Governor's office reported no comment**
- **Comments of Governor's office received**
  Describe:
- **No reply received within 45 days of submittal**
- **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By:	**Barbara Prehmus**
Last Revision Date:	**Oct 14, 2014**
Submit Date:	**Sep 23, 2014**

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

Attachment 3.1-C- [ ] OMB Expiration date: 10/31/2014

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

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- [ ]

OMB Expiration date: 10/31/2014

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: Alternative Benefit Plan

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. No

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

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):

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

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. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

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.

Alternative Benefit Plan

- [x] 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.

- [x] 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.

- [x] 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.

- [x] The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- [x] 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

V.20130807

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: Kaiser Ded/CO HMO 1200D

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

V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

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.

Alternative Benefit Plan

○ 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: July 1, 2009

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. 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: July 1, 2011

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, reprices 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/

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 the 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

○ 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):

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.20130718

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.

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: July 1, 2013

Describe program below:

Behavioral Health Organization Program:

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):

PRA Disclosure Statement

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- [ ]

OMB Expiration date: 10/31/2014

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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Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

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. Yes

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.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

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

V.20130807