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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-15-0005

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
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

December 19, 2017

Tom Massey, Acting Executive Director
Department of Health Care Policy & Financing
303 East 17th Avenue, 7th Floor
Denver, CO 80203

RE: Colorado #15-0005

Dear Mr. Massey:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 15-0005. This SPA provides that Colorado's cost sharing rules comply with federal cost sharing rules which went into effect January 1, 2014. Notably, the state attests that it applies and implements the exemption for American Indian/Native Alaskan beneficiaries in accordance with regulatory requirements, limits cost-sharing charged to 5 percent of the aggregate household income, tracks cost-sharing charged to ensure that the limit is not exceeded, and confirms that cost sharing policies comport with federal statutory and regulatory requirements. With this SPA, the state has elected to update the cost sharing pages to the new MMDL format.

Please be informed that this State Plan Amendment was approved today with an effective date of August 26, 2017. We are enclosing the CMS-179 and the amended plan page(s).

While the approved SPA indicates that the state does not charge co-pays for non-emergency use of an emergency department, Colorado separately provided information that the state does charge such a co-pay. This copay has been included as an outpatient hospital co-pay. However, in order to properly capture this non-emergency copay, this co-pay must be separately identified in the G-1 page of the state plan, with assurances that the state is meeting the requirements identified in 42 CFR §447.54. Discussions with the state identified that Colorado plans to submit a new cost sharing SPA in the near future to increase co-pays for pharmacy, outpatient hospital, and non-emergency use of an emergency room with an effective date of January 1, 2018. We will work with Colorado to ensure the state follows all requirements needed to assess the co-pay for non-emergency use of an emergency department as part of our review of the upcoming SPA to increase cost sharing in the state. Lastly, the state will need to ensure proper public notice and tribal consultation have been completed with the submission of the proposed changes to cost sharing levels.

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

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Gretchen Hammer
John Bartholomew
David DeNovellis
Russell Ziegler

Medicaid Premiums and Cost Sharing: 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 15-0005

Proposed Effective Date

08/26/2017 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$0.00
Second Year	2016	$0.00

Subject of Amendment

Provides Colorado's assurance that American Indian/Native Alaskan beneficiaries are exempt from cost sharing. Transfers existing, approved Colorado co-pay standards to this format.

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:	**Russell Zigler**
Last Revision Date:	**Dec 13, 2017**
Submit Date:	**Jan 30, 2015**

Medicaid Premiums and Cost Sharing

State Name: Colorado

OMB Control Number: 0938-1148

Transmittal Number: CO - 15 - 0005

Expiration date: 10/31/2014

Cost Sharing Requirements	G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☒ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. No

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. No

■ All drugs will be considered preferred drugs.

Medicaid Premiums and Cost Sharing

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

V.20140415

Medicaid Premiums and Cost Sharing

State Name: Colorado

OMB Control Number: 0938-1148

Transmittal Number: CO - 15 - 0005

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Hospital outpatient visit	3.00	$	Visit		X
+	Physician home or office visit (M.D. or D.O.)	2.00	$	Visit		X
+	Clinic visit (Rural Health, FQHC, and Public Health)	2.00	$	Visit		X
+	Brief, individual, group, and partial care community mental health center visits	2.00	$	Visit	Except services which fall under Home and Community Based Service programs	X
+	Pharmacy	1.00	$	Prescription	Per prescription or refill for generic or multi-source drugs	X
+	Pharmacy	3.00	$	Prescription	Per prescription or refill for single-source or brand name drugs	X
+	Optometrist	2.00	$	Visit		X
+	Podiatrist	2.00	$	Visit		X
+	Inpatient hospital	10.00	$	Day		X
+	Psychiatric services	0.50	$	15 minute	Per unit of service (defined as 15 minute segments)	X
+	Durable medical equipment / supplies	1.00	$	Day	Per date of service	X
+	Laboratory services	1.00	$	Day	Per date of service	X
+	Radiology services	1.00	$	Day	Per date of service	X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item:

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Medicaid Premiums and Cost Sharing

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+							X

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.	No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

V.20160722

Medicaid Premiums and Cost Sharing

State Name: Colorado

Transmittal Number: CO - 15 - 0005

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to <u>all</u> medically needy individuals.	No

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 40 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.20140415

Medicaid Premiums and Cost Sharing

State Name: Colorado

Transmittal Number: CO - 15 - 0005

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

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 40 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.20140415

Medicaid Premiums and Cost Sharing

State Name: Colorado

Transmittal Number: CO - 15 - 0005

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. | Yes

Indicate below the age of the exemption:

- (●) Under age 19
- ( ) Under age 20
- ( ) Under age 21
- ( ) Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. | No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- [■] Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- [■] Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- [■] Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- [■] Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- [■] Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- [■] To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - [☒] The state accepts self-attestation
  - [☐] The state runs periodic claims reviews
  - [☒] The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - [☒] The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☒ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

MMIS identifies individuals that have met the 5% cost sharing limit and exempts such individuals from further copays.

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

The percentage of family income used for the aggregate limit is:

- (●) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

[■] The state calculates family income for the purpose of the aggregate limit on the following basis:

- ( ) Quarterly
- (●) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. [Yes]

[■] Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

[☒] As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

[ ] Managed care organization(s) track each family's incurred cost sharing, as follows:

[☒] Other process:

During the eligibility determination process, Colorado Benefits Management System (CBMS) identifies all the individuals within a case who make up a household based on the MAGI rules. Each combination of individuals that make up a Household within the case, based on the MAGI rules, is assigned a unique household number. Each Household must also have a person designated as the Head of Household. CBMS sends eligibility data to MMIS (interChange) for each client and identifies both the case number and the household number to which they are attributed, as well as who the Head of Household is for that group. MMIS uses the case number/household number to uniquely identify the group of people that make up the household. MMIS uses the income information associated with the Head of Household (which is based on their tax filing data) to calculate the 5% monthly copay maximum. As claims/encounters are processed, MMIS accumulates copayment amounts from all individuals with the same household for the month. If/When the 5% copay maximum has been met by any combination of household individuals, a copayment maximum met indicator is set to 'Y'. The copayment maximum is reset for each month.

[■] Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

A hard copy letter will be sent to the Head of Household when the monthly copay limit for the family has been met. Once the MMIS Member Portal is activated, these copay letters will be available electronically on the portal. This web portal will display alerts and notifications. One notification will be whether or not the client is co-payment eligible. When the MMIS calculates that the family's 5% co-pay limit has been reached, each client in the family will

have their web portal notification display 'co-payment exempt' for the remainder of the month. This status will change back to 'co-payment eligible' when the next month begins.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

All recipient appeals follow the appeal process prescribed in 10 CCR 2505-10, Section 8.057.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Financial reimbursement equal to the amount of over-charged co-payment will be made to the client upon verification of the documentation included in their appeal complaint.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Client income and other eligibility determinate factors are transmitted to the MMIS/Interchange from the Eligibility and Enrollment system. This process initiates when clients submit changed information to the county or through the eligibility web portal, or when the Colorado Department of Revenue transmits updated client income records to the Eligibility and Enrollment system. Changes to family aggregate limits will not occur without updated client information being received from the Eligibility and Enrollment system.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). **No**

PRA Disclosure Statement

V.20140415