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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 18-0007

This file contains the following documents in the order listed:

1) Approval Letter (Deemed)
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3) Deemed 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

August 20, 2018

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Bimestefer:

This letter is in regard to the State Plan Amendment (SPA) submitted under transmittal number (TN) 18-0007. This SPA increases the hospital outpatient, pharmacy, and non-emergency services in the outpatient hospital emergency room co-payments as required by Colorado Revised Statute § 25.5-4-209(1)(c)(1) and promulgated at 10 Colorado Code of Regulations 2505-10, section 8.754.

Please be informed that this State Plan Amendment was deemed approved on June 15, 2018, pursuant to regulations at 42 CFR § 430.16, with an effective date of January 1, 2018. We are enclosing the CMS-179 and the amended plan page(s).

(TN) 18-0007 was deemed approved because the regional office did not process the SPA to approval before the 90th day. We regret this state plan amendment was deemed approved for these reasons and apologize for any inconvenience this matter may have caused the Colorado Medicaid program in the implementation of these important provisions.

CMS has reviewed (TN) 18-0007 and has some comments on this now deemed approved SPA. These comments are as follows:

Section 1916 and 1916A of the Social Security Act, as implemented in 42 CFR §§ 447.50-447.56, provides authority to states to assess cost sharing subject to the certain statutory and regulatory requirements. Colorado proposed increases to the drug, outpatient hospital, and non-emergency use of the emergency department copays that are consistent with or below the maximum allowable amounts established in regulation.

With respect to the non-emergency use of the emergency department copay, the state has attested that it complies with rules in § 447.54(d)(2), which requires that the hospital providing the care must –

(1) Conduct an appropriate medical screening under § 489.24 subpart G to determine that the individual does not need emergency services.
(2) Before providing non-emergency services and imposing cost sharing for such services:
(i) Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
(ii) Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
(iii) Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
(iv) Provide a referral to coordinate scheduling for treatment by the alternative provider.

Generally, CMS requires that state plan amendments (SPAs) describe state policies and procedures designed to ensure providers can comply with all the requirements of § 447.54(d) when states propose to impose a non-emergency use of the ER copay.

On the G1 page, Colorado has shared the following process:

> "The emergency status of an Emergency Department visit must be determined by the hospital/provider. The Colorado interChange will deduct a $6 co-payment amount, for all co-payment eligible members, from the UB-04 (837I) claim, based on the presence of Revenue Code 0456 or Revenue Code 0459 on the claim."

Although the SPA is already approved, we have several comments about this language we'd like to share for the state's consideration. First, the state plan page lacks a statement of policy regarding the definition of emergency/non-emergency visit. Although the SPA explains that the emergency determination is made by the hospital/provider, it is not clear that the state has issued a policy in conjunction with its cost-sharing policy for hospitals/providers to follow regarding whether or not the visit qualifies as an emergency to ensure that only non-emergent incidents are charged co-pays.

Secondly, it would be helpful for the SPA to explain the criteria hospitals use to designate a visit under Revenue Code 0456 and 0459 and for the SPA to describe in more easily accessible terms how these terms relate to non-emergencies. Generally, CMS discourages the use of codes in its description of the non-emergency use of the ER copay discussion because sometimes beneficiaries believe they are having emergencies, even when the incidents are not strictly emergencies when applying codes. Moreover, plain language provides better transparency. In addition, it would be helpful to understand how the state ensures that a hospital has some type of alternative provider network available after hours to which to send individuals who decide not to have non-emergency services at the ER (e.g., some states provide hospitals with Medicaid participating provider lists by zip code) as well as a process for making referrals. Because the state has elected to charge this increased copay, the state has a responsibility to ensure that the associated requirements can be followed by providers.

We would like to suggest a meeting regarding the state's current policy in this area to better understand the state's practices. Curtis Volesky will reach out to coordinate a meeting. We would like to also suggest that the state update these assurances to take into account the information provided in this letter with any future changes to its cost sharing state plan pages. CMS is also available to provide ongoing technical assistance as the state contemplates changes to its cost sharing policies.

If you have any questions concerning this letter, please contact Curtis Volesky at (303)-844-7033 or Richard Allen at 303-844-1370.

Sincerely,

[redacted]

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

cc: Gretchen Hammer
John Bartholomew
David DeNovellis
Russell Ziegler
Whitney McOwen

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-18-0007

Proposed Effective Date

01/01/2018 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Social Security Act Section 1916A / 42 CFR 447.52

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2017	$-3447134.00
Second Year	2018	$-4596179.00

Subject of Amendment

Increase hospital outpatient, pharmacy, and non-emergency services in the outpatient hospital emergency room co-payments as required by Colorado Revised Statute section 25.5-4-209(1)(c)(1) and promulgated at 10 Colorado Code of Regulations 2505-10, section 8.754.

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:

  Governor's letter dated 15 January, 2015

Signature of State Agency Official

Submitted By:	**Russell Zigler**
Last Revision Date:	**Mar 16, 2018**
Submit Date:	**Mar 16, 2018**

Medicaid Premiums and Cost Sharing

State Name: Colorado

OMB Control Number: 0938-1148

Transmittal Number: CO - 18 - 0007

Expiration date: 10/31/2014

Cost Sharing Requirements — Q1

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. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The emergency status of an Emergency Department visit must be determined by the hospital/provider. The Colorado interChange will deduct a $6 co-payment amount, for all co-payment eligible members, from the UB-04 (837I) claim, based on the presence of Revenue Code 0456 or Revenue Code 0459 on the claim.

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.

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

PRA Disclosure Statement

Medicaid Premiums and Cost Sharing

State Name: Colorado

OMB Control Number: 0938-1148

Transmittal Number: CO - 18 - 0007

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	4.00	$	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	3.00	$	Prescription	Per new prescription or refill	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
+	Non-emergency Services in the Hospital Outpatient Emergency Room	6.00	$	Visit		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.

	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

OMB Control Number: 0938-1148

Transmittal Number: CO - 18 - 0007

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 all 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

OMB Control Number: 0938-1148

Transmittal Number: CO - 18 - 0007

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

OMB Control Number: 0938-1148

Transmittal Number: CO - 18 - 0007

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