THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Children's Basic Health Plan Rule Concerning the Implementation of the Long Bill Provision on CHP+ Pre-HMO Period
Rule Number:	MSB 11-09-20-B
Division / Contact / Phone:	Child Health Plan Plus / Alan S. Kislowitz / 303-866-3646

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-09-20-B, Revision to the Children's Basic Health Plan Rule Concerning the Implementation of the Long Bill Provision on CHP+ Pre-HMO Period
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 10 CCR 2505-3 Section 430.1, 430.2.A and 430.2.B , Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-03).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at 10 CCR 2505-3 from §430 ENROLLMENT DATE through the end of text at §430.2.B with the new text provided. This change is effective December 30, 2011.

*to be completed by MSB Board Coordinator

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Title of Rule:	Revision to the Children's Basic Health Plan Rule Concerning the Implementation of the Long Bill Provision on CHP+ Pre-HMO Period
Rule Number:	MSB 11-09-20-B
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STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed revision will change the CHP+ enrollment date from retrospective to a prospective date. This proposed revision is included in the HCPF budget reduction initiative part of SB-11 209 which was passed by the General Assembly.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

   N/A

3. Federal authority for the Rule, if any:

   42 C.F.R. Section 457.340(f)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   SB-11 209 and C.R.S. Section 25.5-8-108

Initial Review	**10/14/2011**	Final Adoption	**11/18/2011**
Proposed Effective Date	**12/30/2011**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Children's Basic Health Plan Rule Concerning the Implementation of the Long Bill Provision on CHP+ Pre-HMO Period
Rule Number:	MSB 11-09-20-B
Division / Contact / Phone:	Child Health Plan Plus / Alan S. Kislowitz / 303-866-3646

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   CHP+ children and CHP+ providers will be affected by this change. CHP+ children that do not require immediate care will be affected through having their 12-month guaranteed enrollment period begin with their selected Health Maintenance Organization (HMO) in the first day of the month following eligibility determination rather than retroactively to the date of application. This ensures continuity of care, effective care management, and efficiently ties children to their medical home immediately upon enrollment. The Department anticipates that this process change will result in budget savings due to children receiving services through a health maintenance organization rather than the State's Managed Care Network (SMCN), where the State is fully at risk for the cost of all claims incurred.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The CHP+ program for children will change from retrospective to prospective enrollment similar to private sector commercial health insurance carriers.

   Affected children whose application is processed on or before the 25th day of the month will be enrolled in their CHP+ HMO the first day of the next month. Affected children whose application is processed after the 25th day of the month will be enrolled the first day of the second month following the process date (e.g., application process date January 26th → enrolled in HMO March 1st, application process date January 24th → enrolled in HMO February 1st).

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

Modifications to the Colorado Benefits Management System are necessary to implement this change, and are estimated to require 388 hours for design, development, and testing at $104 per

hour, for a total cost of $40,352. This funding was appropriated to the Department and the Department of Human Services in the FY 2011-12 Long Bill (SB 11-209).

The proposed change will shorten the length of enrollment in CHP+, which would result in avoided costs in the SMCN, where the State is fully liable for all costs incurred by enrollees, and would also eliminate any retroactive payments to HMOs for the period between the application date and the enrollment date in the HMO. The Department estimates that the savings to the State will be approximately $4 million in FY 2011-12 and $8 million per year in FY 2012-13 forward.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Without the proposed rule, the State would forgo the opportunity to realize savings of approximately $4 million in FY 2011-12 and $8 million per year in FY 2012-13 forward. The Department would lose the ability to streamline and simplify the CHP+ enrollment process, and the existing confusion among providers and members around CHP+ enrollment would continue.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   None

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   None

430 ENROLLMENT DATE

430.1 If determined eligible, ~~an eligible person's date~~ the effective date of eligibility in the Children's Basic Health Plan shall be the ~~received date~~ first day of the month following eligibility determination of an application by a delegated entity.

A. If determined eligible, the enrollment span of a pregnant woman shall begin on the date the application is received by a delegated entity and shall end 60 days after the birth of the child or termination of the pregnancy.

B. If determined presumptively eligible, a pregnant woman's presumptive eligibility enrollment span shall be from the date of presentation at the presumptive eligibility site up to 60 calendar days.

430.2 An eligible person's enrollment date in the selected MCO shall be no later than:

A. The first of the month following eligibility determination and MCO selection if eligibility is determined on or before the ~~21st~~ 25th of the month.

B. The first of the second month following eligibility determination and MCO selection if eligibility is determined after the ~~21st~~ 25th of the month.

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule: Enrollment Fees and Copayments, Section 300

Rule Number: MSB 11-08-30-A

Division / Contact / Phone: Medicaid and CHP+ Programs Office / Bill Heller / 3244

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-08-30-A, Enrollment Fees and Copayments, Section 300
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 300, Enrollment Fees and Copayments, Colorado Department of Health Care Policy and Financing, Medical Assistance (10 CCR 2505-3).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Please replace current text at 10 CCR 2505-3 from §300 ENROLLMENT FEES AND COPAYMENTS through the end of §330.3.E with the new text provided from §300 through the end of §330.3.D. This change is effective January 01, 2012.

*to be completed by MSB Board Coordinator

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule: Enrollment Fees and Copayments, Section 300

Rule Number: MSB 11-08-30-A

Division / Contact / Phone: Medicaid and CHP+ Programs Office / Bill Heller / 3244

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule amendment includes three major changes to increase cost-sharing for clients of the Children's Basic Health Plan: (1) For families above 205% of the Federal Poverty Level (FPL), it triples the current annual enrollment fees from $25 to $75 for families with one child, and from $35 to $105 for families with two or more children; (2) adds co-payments for four services that previously had no co-payments; and (3) increases co-payments for some services.

   The intent of these changes is to foster a sense of responsibility in the health care decisions of clients while minimizing negative impacts to families and generating savings to the State.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 457

4. State Authority for the Rule:

   25.5-8-107, C.R.S.
   25.5-1-301 through 25.5-1-303, CRS (2010)

Initial Review	**10/14/2010**	Final Adoption	**11/18/2011**
Proposed Effective Date	**01/01/2012**	Emergency Adoption	

DOCUMENT #01

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule: Enrollment Fees and Copayments, Section 300

Rule Number: MSB 11-08-30-A

Division / Contact / Phone: Medicaid and CHP+ Programs Office / Bill Heller / 3244

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This rule change will affect families whose children receive benefits through the Children's Basic Health Plan.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   This rule change will require families above 205% FPL to pay three times more in enrollment fees as they did before the change (changing from $25 to $75 for one child, and changing from $35 to $105 for two or more children). This rule amendment also adds copayments for four services (emergency transportation, inpatient hospital, physician services in the hospital, and outpatient hospital) and increases some copayment amounts, according to a sliding scale based on income.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department anticipates that any cost to implement changes to the Colorado Benefits Management System to increase the annual enrollment fees could be absorbed within existing resources. For co-payment changes, the Department assumes that it will incorporate changes to the co-payment structure into its rate setting process for the FY 2012-13 rates, and thus there will be no additional administrative costs for this initiative. The savings to the state associated with these changes are estimated to be approximately $1,609,382.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The rule change will result in savings for the state and will foster in clients a sense of responsibility for their health care utilization.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   This proposed rule is the least intrusive way to have CHP+ families share the cost of their health care, and foster a sense of ownership and responsibility for health care utilization.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   During the 2011 Legislative Session, the General Assembly passed SB 11-213 "Concerning Enrollee Cost-Sharing for Children Enrolled in the Children's Basic Health Plan." This legislation would have resulted in a 1,000% increase in costs to the families affected by the new premiums. Because of the anticipated negative impact this would have on enrollment in CHP, the Department chose the alternatives contained in this rule amendment. These changes will have a much smaller impact on families than the original proposal.

300 ENROLLMENT FEES AND COPAYMENTS

310 ANNUAL ENROLLMENT FEES AND DUE DATE

310.1 For eligible children, the following annual enrollment fees shall be due prior to enrollment in the Children's Basic Health Plan:

A. For families with income, at the time of eligibility determination, less than 151% of the federal poverty level, the annual enrollment fee shall be waived.

B. For families with income, at the time of eligibility determination, between 151% and ~~250~~205% of the federal poverty, the annual enrollment fee shall be:

1. ~~Twenty-five~~$25.00 ~~dollars~~ for a single eligible child; and

2. ~~Thirty-five~~$35.00 ~~dollars~~ for two or more eligible children.

3. Waived for families who include an eligible pregnant woman.

C. For families with income, at the time of eligibility determination, greater than 205% and up to 250% of the federal poverty, the annual enrollment fee shall be:

1. $75.00 for a single eligible child; and

2. $105.00 for two or more eligible children.

3. Waived for families who include an eligible pregnant woman

310.2 If the required enrollment fee is not received with the application for the Children's Basic Health Plan, the Department or its designee shall notify the applicant:

A. That applicable enrollment fees are a requirement for enrollment;

B. That fees shall be due within thirty (30) days of the date of notification;

C. Of effective date of enrollment if payment is received; and

D. That the application shall be denied if payment is not received by the due date indicated.

310.3 The application shall be denied if payment is not received by the due date indicated on the notification.

310.5 Once enrollment has occurred, the annual enrollment fee is non-refundable.

320 COPAYMENTS

320.1 The following copayments shall be due for enrollees at the time of service:

A. For families with income, at the time of eligibility determination, less than 101% of the federal poverty level, all copayments shall be waived, except for emergency and ~~urgent/after hours~~ care, which shall be ~~three dollars~~$3.00 per use and urgent/after hours care, which shall be $1.00 per use.

B. For families with income, at the time of eligibility determination, between 101% and 150% of the federal poverty level, the copayment shall be:

1. Effective until June 30, 2012:

a. ~~Two dollars~~$2.00 per office visit;

b~~2~~. ~~Two dollars~~$2.00 per outpatient mental health or substance abuse visit;

c~~3~~. ~~One dollar~~$1.00 per generic or brand name prescription;

d~~4~~. ~~Two dollars~~$2.00 per physical therapy, occupational therapy or speech therapy visit;

e~~5~~. ~~Two dollars~~$2.00 per vision visit;

f~~6~~. ~~Three dollars~~$3.00 per use of emergency care and urgent/after hours care;~~.~~

2. Effective July 1, 2012:

a. $2.00 per office visit;

b. $2.00 per outpatient mental health or substance abuse visit;

c. $1.00 per generic or brand name prescription;

d. $2.00 per physical therapy, occupational therapy or speech therapy visit;

e. $2.00 per vision visit;

f. $3.00 per use of emergency care (co-payment is waived if client is admitted to the hospital);

g. $1.00 per use of urgent/after hours care;

h. $2.00 per trip for emergency transport/ambulance services;

i. $2.00 per inpatient hospital visit;

j. $2.00 per inpatient hospital visit for physician services in the hospital;

k. $2.00 per outpatient hospital or ambulatory surgery center visit.

C. For families with income, at the time of eligibility determination, between 151% and 200% of federal poverty level, the copayment shall be:

1. Effective until June 30, 2012:

a. ~~Five dollars~~$5.00 per office visit;

b~~2~~. ~~Five dollars~~$5.00 per outpatient mental health or substance abuse visit;

c~~3~~. ~~Three dollars~~$3.00 per generic prescription;

d~~4~~. ~~Five dollars~~$5.00 per brand name prescription;

e5. ~~Five dollars~~$5.00 per physical therapy, occupational therapy or speech therapy visit;

f6. ~~Five dollars~~$5.00 per vision visit;

g7. ~~Fifteen dollars~~$15.00 per use of emergency care and urgent/after hours care;~~.~~

2. Effective July 1, 2012:

a. $5.00 per office visit;

b. $5.00 per outpatient mental health or substance abuse visit;

c. $3.00 per generic prescription;

d. $10.00 per brand name prescription;

e. $5.00 per physical therapy, occupational therapy or speech therapy visit;

f. $5.00 per vision visit;

g. $30.00 per use of emergency care ((co-payment is waived if client is admitted to the hospital)

h. $20.00 per use of urgent/after hours care;

i. $5.00 per date of service for laboratory and radiology/imaging services

j. $15.00 per trip for emergency transport/ambulance services;

k. $20.00 per inpatient hospital visit;

l. $5.00 per inpatient hospital visit for physician services;

m. $5.00 per outpatient hospital or ambulatory surgery center visit.

D. For families with income, at the time of eligibility determination, between 201% and 250% of federal poverty level, the copayment shall be:

1. Effective until June 30, 2012:

a. ~~Ten dollars~~$10.00 per office visit;

b2. ~~Ten dollars~~$10.00 per outpatient mental health or substance abuse visit;

c3. ~~Five dollars~~$5.00 per generic prescription;

d4. ~~Ten dollars~~$10.00 per brand name prescription;

e5. ~~Ten dollars~~$10.00 per physical therapy, occupational therapy or speech therapy visit;

f6. ~~Ten dollars~~$10.00 per vision visit;

g~~7~~. ~~Twenty dollars~~$20.00 per use of emergency care and urgent/after hours care.

2. Effective July 1, 2012:

a. $10.00 per office visit;

b. $10.00 per outpatient mental health or substance abuse visit;

c. $5.00 per generic prescription;

d. $15.00 per brand name prescription;

e. $10.00 per physical therapy, occupational therapy or speech therapy visit;

f. $10.00 per vision visit;

g. $50.00 per use of emergency care (co-payment is waived if client is admitted to the hospital);

h. $30.00 per use of urgent/after hours care;

i. $10.00 per date of service for laboratory and radiology/imaging services

j. $25.00 per trip for emergency transport/ambulance services;

k. $50.00 per inpatient hospital visit;

l. $10.00 per inpatient hospital visit for physician services;

m. $10.00 per outpatient hospital or ambulatory surgery center visit.

330 COST SHARING LIMITATIONS

330.1 American Indians and Alaskan Natives shall be exempt from cost sharing requirements. American Indian shall mean a member of a federally recognized Indian tribe, band, or group, or a descendant in the first or second degree of any such member. Alaskan Native shall mean an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior.

330.2 The maximum yearly cost sharing requirements for families of enrollees shall be 5% of income.

330.3 No copayments shall apply to preventive services. For the purpose of this section, preventive services shall mean:

A. All healthy newborn and newborn inpatient visits, including routine screening whether provided on an inpatient or outpatient basis;

B. Routine examinations;

~~C. Laboratory tests;~~

~~D~~C. Immunizations and related office visits; and

~~E~~D. Routine preventive and diagnostic dental services.