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Title of Rule: Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
Rule Number: CHP 20-12-02-C
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3558

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: CHP 20-12-02-C, Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
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) 110,140, 310 and 320, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text with the proposed text beginning at Section 50 through the end of Section 600.5. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

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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 rule change will amend 10 CCR 2505-3 sections 110,140,310 and 320 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act (ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during this Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories which includes the Child Health Plan Plus (CHP+) category. These policy changes will stay in place until the end of the Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Members who were evacuated from or unable to return to Colorado and are temporarily absent will maintain enrollment in the CHP+ program. Enrollment fees will be waived for members who are being redetermined and eligible for CHP+. required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all the CHP+ categories regardless of changes made for a redetermination or additional documentation for current CHP+ enrollee and allow them to continue eligibility through the end of the Public Health Emergency. At the end of emergency, the Department will process the redetermination and /or changes for all members whose eligibility was maintained during the emergency period.

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:

   Due to the Coronavirus (COVID-19) public health emergency rules need to be updated for the state to be in compliance with federal regulations.

3. Federal authority for the Rule, if any:

   Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 and Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136. The Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision.

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   25.5-8-107.(b)

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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.

   The proposed rules will impact members enrolled in the CHP+ programs. The rule updates will benefit members enrolled in CHP+ by remaining eligible during this Coronavirus (COVID-19) public health emergency.

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 proposed rule will help to determine eligibility correctly by applying regulations appropriately to help members remain eligible for the CHP+ programs during this Coronavirus (COVID-19) public health emergency.

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 expects that eligibility could potentially increase as members who are outside the state for the duration of the emergency will not be disenrolled. This will lead to an increase in expenditure for the Department as the member will be included in the monthly capitation payment. The Department also assumes that the waiving of enrollment fees for the CHP+ program will reduce revenues to the Department which will result in the increase of expenditures to the CHP+ Trust fund, Healthcare Affordability and Sustainability Fee (HAS) Cash Fund, and federal funds in order to fill the gap in revenue lost from the premiums. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

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

   The Department expects that inaction to the proposal to allow CHP+ member to retain eligibility outside the state will result in lack of care to those members who are outside the state during the emergency period who will need those services. The Department sees no benefit to inaction.

   In addition, the Department expects that inaction to the proposal to waive enrollment fees will cause potential members to not qualify because they are unable to pay the premiums due to the severity of the economic shock. The Department also sees no benefit to inaction.

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

   There are currently no less costly measures to the Department that will allow the Department to service members more effectively during the emergency period.

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.

   There are no alternative methods for the proposed rule that were considered

50 DEFINITIONS

50.1 "Applicant" shall mean a person applying or re-applying for benefits on behalf of a child and/or themselves.

50.2 "CBMS" shall mean Colorado Benefits Management System is the computer system that determines an applicant's eligibility for public assistance in the state of Colorado.

50.3 "Child" means a person who is less than nineteen years of age.

50.4 "Cost sharing" shall mean payments, such as copayments or enrollment fees that are due on behalf of the enrollee.

50.5 "Department" shall mean the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Children's Basic Health Plan as well as other State-funded health care programs.

50.6 "Dependent child" shall mean a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to graduate by age 19

50.7 "Effective Date" shall mean the first day of eligibility which is the date the application is received and date-stamped by the Eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

50.8 "Eligibility Site" shall mean a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

50.9 "Enrollee" shall mean an eligible person who is enrolled in the Children's Basic Health Plan.

50.10 "Essential Community Provider" means a healthcare provider that:

A. Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves medically indigent patients within its medical capability; and

B. Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

50.11 "Evidence of Coverage" or "EOC" shall mean any certificate, agreement, or contract issued to an enrollee from time-to-time by a Managed Care Organization (MCO) setting out the coverage to which the enrollee is or was entitled under the Children's Basic Health Plan.

50.12 "Grievance Committee" shall mean a conference with the Department or its Designee in which a contested decision regarding an applicant or enrollee is reexamined.

50.13 "Household" shall be determined by relationships to the tax filer as declared on the Single Streamlined Application and as required in 10 CCR 2505-10-8.100.4.E.

50.14 "Income" shall be any compensation from participation in a business, including wages, salary, tips, commissions and bonuses. The Modified Adjusted Gross Income is a methodology used to determine eligibility as required in 10 CCR 2505-10-8.100.4.C.

50.15 "Managed Care Organization" or "MCO" shall mean:

A. A carrier which meets the definition in §10-16-102 (8), C.R.S. with which the Department contracts to provide health care or dental services covered by the Children's Basic Health Plan; or,

B. Essential community providers and other health care and dental service providers with whom the Department contracted to provide health care services under the Children's Basic Health Plan using a managed care model.

50.16 "Presumptive Eligibility" shall mean children and pregnant women who have applied and appear to be eligible for the Children's Basic Health Plan shall be presumed eligible and may receive immediate temporary medical coverage.

50.17 "Unearned Income" shall be the gross amount received in cash or kind that is not earned from employment or self-employment.

50.18 "Woman" shall mean a female who is 19 years in age or older.

100 ELIGIBILITY

110 INDIVIDUALS ASSISTED UNDER THE PROGRAM

110.1 To be eligible for the Children's Basic Health Plan, an eligible person shall:

A.

1. Be less than 19 years of age; or

2. Be a pregnant woman

B. Fall into one of the following categories:

1. Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, the Northern Mariana Islands, American Samoa, or Swain's Island; or

2. Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

3. Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance who falls into one of the following categories:

a. Lawfully admitted for permanent residence under the U.S. Immigration and Nationality Act (hereafter referred to as the "INA"); or

b. Paroled into the United States for at least one year under 8 U.S.C § 1182(d)(5); or

c. Granted conditional entry under Section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

d. determined by the Eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. §1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Children's Basic Health Plan); or

4. Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

a. Lawfully residing in Colorado and is an honorably discharged military veteran; or

1. A spouse of such military veteran; or

2. An unremarried surviving spouse of such military veteran; or

3. An unmarried dependent child of such military veteran.7

b. Lawfully residing in Colorado and is on active duty in the United States Armed Forces, excluding military training; or

1. A spouse of such individual; or

2. An unremarried surviving spouse of such individual; or

3. An unmarried dependent child of such individual.

c. Granted asylum under Section 208 of the INA; or

d. Refugee under Section 207 of the INA; or

e. An individual with deportation withheld:

1. Under Section 243(h) of the INA, as in effect prior to September 30, 1996; or

2. Under Section 241(b)(3), as amended by P.L. 104-208 of the INA.

f. A Cuban or Haitian entrant, as defined under Section 501(e) of the U.S. Refugee Education Assistance Act of 1980; or

g. An individual who:

1. Was born in Canada and possesses at least 50 percent American Indian blood; or

2. Is a member of an Indian tribe, as defined in 25 U.S.C. Section 450(b)e.

h. Admitted into the United States as an Amerasian immigrant under Section 584 of the U.S. Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1988, as amended by P.L. 100-461; or

i. A lawfully admitted, permanent resident, who is a Hmong or Highland Lao veteran of the Vietnam conflict; or

j. An alien who was admitted in the United States on or after December 26, 2007 who is an Iraqi Special Immigrant under section 101(a)(27) of the INA; or

k. An alien who was admitted in the United States on or after December 26,2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA; and

5. Be a lawfully admitted non-citizen in the United States who falls into one of the categories:

a. granted temporary resident status in accordance with section 8 U.S.C. 1160 or 1255a; or

b. granted Temporary Protected Status (TPS) in accordance with section 8 U.S.C 1254a and pending applicants for TPS granted employment authorization;

c. granted employment authorization under section 8 CFR 274a.12(c);or

d. Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.

e. Deferred Enforced Departure (DED), pursuant to a decision made by the President

f. Granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum;

g. Granted an administrative stay of removal under section 8 CFR 241; or

h. Beneficiary of approved visa petition who has a pending application for adjustment of status.

i. Pending an application for asylum under section 8 U.S.C. 1158, or for withholding of removal under section 8 U.S.C. 1231, or under the Convention Against Torture who-

1. as been granted employment authorization; or

2. Is under the age of 14 and has had an application pending for at least 180 days.

j. Granted withholding of removal under the Convention Against Torture;

k. Citizens of Micronesia, the Marshall Islands, and Palau; or

l. Is lawfully present American Samoa under the immigration of laws of American Samoa.

m. A non-citizen in a valid nonimmigrant status, as defined in section 8 U.S.C. 1101(a)(15) or under section 8 U.S.C. 1101(a)(17); or

n. A non-citizen who has been paroled into the United States for less than one year under section U.S.C. 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings; or

o. A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C 1101(a)(27)(J).

C. For determinations of eligibility for the Children's Basic Health Plan, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 110.1.B and has declared that he or she has a legal immigration status.

1. The Verify Lawful Presence (VLP) interface will be used to verify immigration status as required in 10 CCR 2505-10-8.100.3.G.2

2. If the state cannot verify immigration status the individual will receive a Reasonable Opportunity Period as required in 10 CCR 2505-10-8.100.3.G.3

D. Be a resident of Colorado; and residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.

E. Have a household income greater than 133% but not exceeding 250% of the Federal Poverty Level (MAGI-equivalent), adjusted for household size for children under the age of 19; or

F. Have a household income greater than 185% but not exceeding 250% of the Federal Poverty Level (MAGI-equivalent), adjusted for household size for pregnant women.

G. Failure to complete an application or to provide required documentation in Section 130 will result in the denial of the incomplete application or individual applicant (s).

120 INSUFFICIENT ACCESS TO OTHER HEALTH COVERAGE

120.1 To be eligible for the Children's Basic Health Plan, an eligible person shall not:

A. Be covered under a group health plan or under health insurance coverage excluding Consolidated Omnibus Budget Reconciliation Act (COBRA); or

B. Be eligible to receive assistance under Title XIX of the Social Security Act; or

C. Be an inmate of a public institution or a patient in an institution for mental diseases.

120.2 The Department shall not require that applicants be uninsured for any period of time prior to becoming eligible for the Children's Basic Health Plan.

130 VERIFICATION REQUIREMENTS

130.1 To be eligible for the Children's Basic Health Plan, an applicant shall provide minimal verification as required in 10 CCR 2505-10-8.100.4.B.

140 REDETERMINATION

140.1 A redetermination of eligibility shall mean a case review and necessary verification to determine whether the client continues to be eligible to receive Medical Assistance. Eligibility shall be redetermined twelve (12) months since the last eligibility determination. An Eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

A. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program or if this information can be verified through an electronic data source. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the outcome will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

B. A redetermination form, approved by the Department, shall be mailed to the client at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed. The client shall not be required to return the form to the eligibility site. The only verification that may be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

The redetermination form shall direct clients to review current information and to take no action if there are no changes to report in the household. Eligibility sites and CBMS shall view the absence of reported changes from the client at this redetermination period as confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

C. Due to the Coronavirus COVID-19 Public Health Emergency, required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories regardless of changes made for a redetermination or additional documentation for current CHP+ enrollee and allow them to continue eligibility through the emergency declaration. Once the emergency declaration has concluded, the Department will process the redetermination and /or changes for all members whose eligibility was maintained during the emergency declaration.

150 CALCULATION OF HOUSEHOLD INCOME

150.1 Calculation of income for the Children's Basic Health Plan shall be determined as required in 10 CCR 2505-10-8.100.4.C

150.2 Income disregards for the Children's Basic Health Plan shall be determined as required in 10 CCR 2505-10-8.100.4.D

160 [Repealed eff. 12/30/2012]

170 PRESUMPTIVE ELIGIBILITY

170.1 A pregnant applicant or a child under the age of 19 may apply for presumptive eligibility for immediate temporary medical services through designated presumptive eligibility sites.

A. To qualify for presumptive eligibility, a child under the age of 19 shall have a declared household income that shall be greater than 133% but not exceed 250% of Federal Poverty Level (MAGI-equivalent); or

B. To qualify for presumptive eligibility, a pregnant women shall have an attested pregnancy, declare that her household's income shall be greater than 185% but not exceed 250% of the Federal Poverty Level (MAGI-equivalent); and

C. He/she shall be a United States citizen or a documented immigrant as defined in Section 110.

170.2 Presumptive eligibility sites shall be certified by the Department of Health Care Policy and Financing to make presumptive eligibility determinations. Sites shall be re-certified by the Department of Health Care Policy and Financing every 2 years to remain approved presumptive eligibility sites.

A. The presumptive eligibility site shall forward the application to the county within five business days of the received date.

170.3 The presumptive eligibility period begins on the date the applicant is determined eligible and ends with the earlier of:

A. The day an eligibility determination for Medical Assistance is made for the applicant(s); or

B. The last day of the month following the month in which a determination for presumptive eligibility was made.

170.4 The county or Medical Assistance site shall make an eligibility determination within 45 days from the date of application.

A. Presumptively eligible clients may appeal the county or Medical Assistance site's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in Section 600.

B. A presumptively eligible client may not appeal the end of a presumptive eligibility period.

180 Express Lane Eligibility

Express Lane Eligibility shall allow for automatic initiation of Medical Assistance enrollment by using available data and findings from other programs as listed below.

180.1 Free/Reduced Lunch Program

A. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district

1. Families will be given the option to opt into Medical Assistance coverage for their potentially eligible child.

2. Children who meet all necessary eligibility requirements as outlined in this volume will be automatically enrolled.

3. Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.

4. Any additionally required verification will be requested from the client through CBMS prior to being automatically enrolled.

5. Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in section 150.

6. If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the application for Medical Assistance.

B. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district

1. Families who are automatically enrolled Free/Reduced Lunch recipient children will not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

2. These families must apply for Medical Assistance in order to give consent for request of benefits.

180.2 Direct Certification

A. When an application for Food Stamps or Colorado Works has been submitted, families will be given the option to opt into Medical Assistance coverage for their potentially eligible children.

1. Children who meet all necessary eligibility requirements as outlined throughout sections 100 through 180 will be automatically enrolled,

2. Children who are only missing verification of U.S. citizenship and identity will receive 90 days of coverage while waiting for this verification.

3. Any additionally required verification will be requested from the client through CBMS prior to being automatically enrolled.

4. Eligibility is determined based on income declared on the Food Stamp or Colorado Works application as well as eligibility requirements outlined throughout this volume.

5. If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the Single Streamlined application for Medical Assistance.

6. Individuals whose eligibility is not determined through Express Lane Eligibility may also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

200 BENEFITS PACKAGE

210 The following are covered benefits including any applicable limitations:

A. Emergency Care and Urgent/After Hours Care;

B. Emergency Transport/Ambulance Services;

C. Hospital/Other Facility Services Including:

1. Inpatient;

2. Physician;

3. Outpatient/Ambulatory;

D. Medical Office Visits Including:

1. Physician;

2. Mid-Level Practitioner;

3. Specialist;

E. Diagnostic Services;

F. Preventative, Routine and Family Planning Services Including:

1. Immunizations;

2. Well-child visits;

3. Health maintenance visits;

G. Maternity Care Including:

1. Prenatal;

2. Delivery and inpatient well-baby care;

3. Postpartum care

H. Mental Illness Treatments such as:

1. Neurobiologically-based mental illness including:

a. Schizophrenia;

b. Schizoaffective disorder;

c. Bipolar affective disorder;

d. Major depressive disorder;

e. Specific obsessive compulsive disorder;

f. Panic disorder;

2. Mental disorders including:

a. Post traumatic stress disorder

b. Drug and alcohol disorders

c. Dysthymia

d. Cyclothymia

e. Social phobia

f. Agoraphobia with panic disorder

g. General anxiety

h. Anorexia Nervosa exclusive of residential treatment

i. Bulimia exclusive of residential treatment

3. All other mental illness;

a. Inpatient coverage;

b. Outpatient coverage;

I. Physical Therapy, Speech Therapy and Occupational Therapy shall be limited to 30 visits per diagnosis per year. Effective November 1, 2007, Physical, Speech and Occupational Therapy services shall be unlimited for children from birth up to the child's third birthday.

J. Durable Medical Equipment shall be limited to the lesser of the purchase price or rental price for medically necessary durable medical equipment that shall not exceed two thousand dollars per year.

K. Transplants must be medically necessary and are limited to:

1. Liver;

2. Heart;

3. Heart/lung;

4. Cornea;

5. Kidney;

6. Bone marrow which shall be limited to the following conditions:

    a. Aplastic anemia;

    b. Leukemia;

    c. Immunodeficiency disease;

    d. Neuroblastoma;

    e. Lymphoma;

    f. High risk stage ii and iii breast cancer;

    g. Wiskott aldrich syndrome;

7. Peripheral stem cell support which shall be limited to the following conditions:

    a. Aplastic anemia;

    b. Leukemia;

    c. Immunodeficiency disease;

    d. Neuroblastoma;

    e. Lymphoma;

    f. High risk stage II and III breast cancer;

    g. Wiskott aldrich syndrome;

L. Home health care;

M. Hospice care;

N. Prescription medication;

O. Kidney dialysis shall be excluded only if the member is also eligible for Medicare;

P. Skilled nursing facility care must be provided only when there is a reasonable expectation of measurable improvement in the members' health status.

Q. Vision services shall be limited to:

1. Vision screenings for age appropriate preventative care;

2. Referral required for refraction services;

3. Minimum fifty dollar benefit for eyeglasses;

R. Audiology services shall be limited to:

1. Hearing screenings for age appropriate preventative care;

2. Hearing aids without financial limitation for enrollees age 18 and under no more than once every five years unless medically necessary including:

    a. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child

    b. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

S. Intractable pain;

T. Autism;

U. Case management is covered only when medically necessary;

V. Dietary counseling/nutritional services shall be limited to:

1. Formula for metabolic disorders;

2. Total parenteral nutrition;

3. Enterals and nutrition products;

4. Formulas for gastrostomy tubes;

W. Dental services are limited to:

1. Those dental services described in the Children's Basic Health Plan dental Evidence of Coverage booklet provided to enrollees, who are less than nineteen years of age. Beginning October 1, 2019, the dental services listed below are covered benefits for enrolled pregnant women of any age, excepting Limited Orthodontic services under Section 210.W.1.h for pregnant women age nineteen and above. Children's Basic Health Plan dental services are provided by the dental MCO (or its designee) with which the Department has contracted for the applicable plan year to provide the following dental services;

    a. Diagnostic

    b. Preventive

    c. Restorative

    d. Endodontic

    e. Periodontic

    f. Prosthodontic

    g. Oral and Maxillofacial Surgery

    h. Limited Orthodontic, excepting pregnant women age nineteen and above.

    i. Adjunctive General Services

2. Orthodontic and prosthodontic treatment for cleft lip or cleft palate in newborns (covered as a medical service in accordance with section 10-16-104, C.R.S.); and

3. Treatment of teeth or periodontium required due to accidental injury to naturally sound teeth (covered as a medical service in accordance with section 10-16-104, C.R.S.). A physician or legally licensed dentist must perform treatment within 72 hours of the accident.

X. Therapies covered shall include:

1. Chemotherapy;

2. Radiation;

Y. The following are not covered benefits:

1. Acupuncture;

2. Artificial conception;

3. Biofeedback;

4. Storage Costs for umbilical blood;

5. Chiropractic care;

6. Convalescent care or rest cures;

7. Cosmetic surgery;

8. Custodial care;

9. Domiciliary care;

10. Duplicate coverage;

11. Government institution or facility services;

12. Hair loss treatments;

13. Hypnosis;

14. Infertility services;

15. Maintenance therapy;

16. Nutritional therapy unless specified otherwise;

17. Elective termination of pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest;

18. Personal comfort items;

19. Physical exams for employment or insurance;

20. Private duty nursing services;

21. Routine foot care;

22. Sex change operations;

23. Sexual disorder treatments;

24. Taxes;

25. Temporomandibular joint (TMJ) treatment, unless it has a medical basis;

26. Other therapies and treatments which are not medically necessary;

27. Vision services unless specified otherwise;

28. Vision therapy;

29. War-related conditions;

30. Weight-loss programs;

31. Work-related conditions;

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 205% of the Federal Poverty Level (MAGI-equivalent), the annual enrollment fee shall be:

1. $25.00 for a single eligible child; and

2. $35.00 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 Level, 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.

310.6 Due to the Coronavirus COVID-19 Public Health Emergency, an eligible applicant will be charged an enrollment fee. Existing members who are being re-enrolled will not be charged enrollment fees until after the Public Health Emergency has ended.

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 (MAGI-equivalent), all copayments shall be waived, except for emergency and care, which shall be $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 (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 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 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 (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 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. $5.00 per brand name prescription;

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

f. $5.00 per vision visit;

g. $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.

3. Due to the Coronavirus COVID-19 Public Health Emergency, members who are eligible for Children's Basic Health Plan will have waived laboratory copayments, specifically as it relates to laboratory copayments associated with COVID-19 testing.

D. For families with income, at the time of eligibility determination, between 201% and 250% of Federal Poverty Level (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 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. $10.00 per brand name prescription;

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

f. $10.00 per vision visit;

g. $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.

3, Due to the Coronavirus COVID-19 Public Health Emergency, members who are eligible for Children's Basic Health Plan will have waived laboratory copayments, specifically as it relates to laboratory copayments associated with COVID-19 testing.

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. Immunizations and related office visits; and

D. Routine preventive and diagnostic dental services.

330.4 Prenatal Care Program clients shall be exempt from cost sharing requirements.

400 ENROLLMENT

400.1 An applicant found eligible for Children's Basic Health Plan can elect to be enrolled the Children's Basic Health Plan.

410 SELECTION OF A MANAGED CARE ORGANIZATION

410.1

A. Once eligibility has been determined, an eligible person shall have the opportunity to select a participating MCO in the county of the eligible person's residence. If there is only one participating MCO available in the county of the eligible person's residence, the eligible person shall be enrolled in that MCO.

B. In the event the Department contracts with an MCO to provide dental services to Children's Basic Health Plan enrollees, an enrollee automatically will be enrolled with such MCO. No separate MCO election will be required.

410.2 MCO SELECTION

A. Upon determination of eligibility for the Children's Basic Health Plan program, if the eligible person has notified the Department or its designee of his/her chosen MCO prior to the last business day of the month in which eligibility was determined, the Department or its designee shall enroll the eligible person in that MCO.

B. Upon determination of eligibility for the Children's Basic Health Plan program, if the eligible person has not chosen an MCO, the Department or its designee shall enroll the eligible person in an MCO selected by the Department or its designee. In areas of the state where there is only one participating MCO available, the Department or its designee shall select that MCO and enroll the eligible person.

C. The Department or its designee shall notify the enrollee of the MCO selected. If the enrollee wants to change MCOs, the enrollee shall contact the Department or its designee within 90 days from the effective date of the MCO enrollment. An enrollee may also change a pending MCO enrollment before the effective date.

D. For renewal applications, the Department or its designee shall reassign the eligible person to the participating MCO the applicant approved for the previous enrollment period. If the eligible person wishes to change MCO enrollment, he/she shall notify the Department or its designee within his/her re-enrollment period.

410.3 In counties in which a participating MCO as defined in section 50.14.A is not available, the eligible person shall be enrolled in an MCO as defined in section 50.14.B.

410.4 Once an enrollee has selected an MCO or upon expiration of the timeframe to change, the enrollee shall remain enrolled in that MCO for the remainder of his/her eligibility period, unless the eligible person meets any of the disenrollment criteria set forth in section 440.

410.5 An eligible person shall have an opportunity to change to a different MCO serving the eligible person's geographic region, if one is available, during the applicant's annual redetermination period.

420 ENROLLMENT OF ALL ELIGIBLE PERSONS IN A FAMILY

420.1 If one eligible child from a family is enrolled in the Children's Basic Health Plan, all eligible children in that family must be enrolled in the Children's Basic Health Plan.

420.2 All eligible children in a family must be enrolled in the same MCO.

430 ENROLLMENT DATE

430.1 Eligibility for the Children's Basic Health Plan shall be effective on the latter of:

A. The first day of the month of application for Medical Assistance; or

B. The first day of the month the person becomes eligible for the Children's Basic Health Plan program.

430.2 Upon being enrolled in the Children's Basic Health Plan, continuous eligibility applies to children under the age of 19, who through an eligibility determination, reassessment or redetermination are found eligible for the Children's Basic Health Plan program. The continuous eligibility period may last for up to 12 months and will begin on the month of application or from the authorization date.

A. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, updates or corrections may be made to the child's case. Any changes to the child's case made during the 14-day no fault period may impact his or her eligibility for Medical Assistance.

B. A child's continuous eligibility period will end effective the earliest possible month, if any of the following occur:

i) Child is deceased

ii) Becomes an inmate of a public institutio

iii) The child states that she/he has moved out of the household permanently

iv) Is no longer a Colorado resident

v) Is unable to be located based on evidence or reasonable assumption

vi) Requests to be withdrawn from continuous eligibility

vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

ix) An eligible person shall not be enrolled in other health insurance coverage

430.3. If determined eligible, the enrollment date of a pregnant woman shall be effective as of the first of the month of the date of application or the first day of the month the pregnant woman becomes eligible. The enrollment span shall end at the end of the month following 60 days after the birth of the child or termination of the pregnancy. Once eligibility has been approved, coverage must be provided regardless of changes in the woman's financial circumstances, once the income verification requirements are met.

A. A pregnant women's eligibility period will end effective the earliest possible month, if any of the following occur:

i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period.

This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

430.4 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 before the 17th of the month.

B. The first of the second month following eligibility determination and MCO selection if eligibility is determined on or after the 17th of the month.

430.5 A child born to a mother who is enrolled in the Children's Basic Health Plan at the time of the child's birth is guaranteed coverage for one year.

A. To receive Medical Assistance under the Children's Basic Health Plan, the birth must be reported verbally or in writing to the County Department of Human Services or Eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn.

440 DISENROLLMENT

440.1 An enrollee shall be disenrolled from an MCO for the following reasons:

A. Administrative error on the part of the Department, the Department's designee, or the MCO, including but not limited to enrollment of a person who does not reside in the MCO's service area; or,

B. A change in the enrollee's residence to an area not in the MCO's service area; or,

C. When an enrollee's coverage is terminated as described in section 440.1A.

440.2 If an enrollee is disenrolled from an MCO for any of the reasons stated in section440.1 and there is another participating MCO available in the enrollee's county of residence, the enrollee shall be allowed to select a new MCO.

440.3 If the enrollee is enrolled in a MCO as defined in section 50.15B and a MCO as defined in section 50.15A becomes available in the child's county of residence, the enrollee will be disenrolled from the MCO as defined in section 50.15 B and enrolled in the MCO as defined in section 50.15A.

440.4 An enrollee may be disenrolled from both an MCO and/or the Children's Basic Health Plan for the following reasons:

A. Fraud or intentional misconduct, including but not limited to knowing misuse of covered services, knowing misrepresentation of membership status; or,

B. An enrollee's receipt of other health care coverage; or,

C. The admission of an enrollee into any federal, state, or county institution for the treatment of mental illness, narcoticism, or alcoholism, or into any correctional facility; or,

D. Ineligibility for the program, based on the guidelines set forth in the Children's Basic Health Plan eligibility rules; or,

E. Failure to comply with cost sharing requirements (annual enrollment fees and copayments) set forth in the Children's Basic Health Plan cost sharing rules; or,

F. There is not another participating MCO as defined in section 50.14 available in the enrollee's county of residence.

440.5 If an eligible person or an eligible person's family displays an ongoing pattern of behavior that is abusive to provider(s), staff or other patients; or, disruptive to the extent that the provider's ability to furnish services to the child or other patients is impaired, the eligible person may be disenrolled from his/her managed care organization. If there is another participating MCO available in the eligible person's county of residence, the Department may allow the eligible person to select a new MCO. If there is not another MCO available in the eligible person's county, the eligible person may be disenrolled from the Children's Basic Health Plan.

500 FINANCIAL MANAGEMENT

The Children's Basic Health Plan, being a non-entitlement program, must manage to its legislative appropriation. The Department shall track expenditures, caseload, and other financial information to make informed decisions on spending its appropriation. Expenditures may exceed State appropriations with approval of the Governor, but any General Fund over expenditure shall be limited to $250,000.

510 The Department shall make quarterly assessments of projected expenditures. If it appears the program may overspend its appropriation due to changes in enrollment, health care costs, funding, legislation, or other factors, the Department shall consider if adjustments to the program are necessary. The program may use, but is not limited to, any of the following financial management tools: waiting lists, adjustments of eligibility criteria and/or levels, instituting open enrollment periods, or temporary closure of the program.

600 APPEALS PROCESS

600.1 Applicants shall be notified of any action regarding the eligibility and enrollment status and cost sharing requirements for the enrollees' participation in the Children's Basic Health Plan and appeal rights regarding those actions by the Department or its designee.

600.2 The Department or its designee shall notify the applicant within ten (10) business days of a decision regarding eligibility, enrollment and cost sharing. The notice shall:

A. Be in writing;

B. Be in his/her primary language, to the extent practicable;

C. Describe to the applicant the reasons for the decision;

D. Document the authority for the decision (e.g. rule citation); and

E. Inform the applicant of his/her rights and responsibilities regarding the decision.

600.3 An applicant who disagrees with a denial regarding eligibility, enrollment, or cost sharing requirements may appeal in writing to the Children's Basic Health Plan Eligibility Vendor within thirty (30) calendar days of the date of the notification of denial of eligibility, enrollment, or cost sharing. The appeal shall be reviewed and processed within thirty (30) calendar days of receipt

and the results of the appeal shall be communicated to the applicant within ten (10) business days of the review. The following guidelines shall apply to the appeal process:

A. The Children's Basic Health Plan Eligibility Vendor will coordinate the appeals process with the county or Eligibility site that determined the initial eligibility, enrollment, or cost sharing decision within ten (10) business days after receipt of the appeal.

B. The county or Eligibility site that determined the initial eligibility, enrollment, or cost sharing decision shall:

1. Review the data entry of the application in the Department's eligibility system for accuracy and completeness within ten (10) business days after receipt of the appeal from the Children's Basic Health Plan Eligibility Vendor;

2. Correct or complete information in the Department's eligibility system if it is found to be incomplete or incorrect and re-run eligibility;

3. Maintain the original denial, if the information in the Department's eligibility system is complete and correct; and

4. Notify the applicant and the Children's Basic Health Plan Eligibility Vendor in writing once the review is complete with the results of the data entry review and the option of forwarding the appeal to the Grievance Committee.

600.4 If the applicant disagrees with the results of the appeal, the applicant may have their appeal reviewed by the Grievance Committee. The Grievance Committee's decision shall be final.

A. The Grievance Committee shall be conducted by an independent panel appointed by the Executive Director of the Department. The panel shall include at least three people from the Department or its designee not previously involved with the grievance. A person previously involved with the grievance may be present at the conference and appear before the panel to present information and answer questions, but shall not have a vote. The Department shall ensure that those appointed to the panel have sufficient experience to make an informed decision regarding the grievance under review.

B. The applicant may attend the Grievance Committee in person or by telephone.

C. The applicant may be represented by the person of the applicant's choice (i.e. legal counsel, friend, family member, etc.) during the Grievance Committee.

D. The applicant may have access to documents that were used by the Department or its designee in making the decision under appeal.

600.5 An enrollee who disagrees with a denial of benefits shall submit an appeal to the MCO he/she is enrolled in and shall follow the MCO's appeal process.

610 [Repealed eff.12/30/2012]