DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Changes to the Revision of the Renewal process for Sections 140 and 430
Rule Number: CHP 21-06-03-B
Division / Contact / Phone: Office of Medicaid Operations / Melissa Torres-Murillo / 5052

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 21-06-03-B, Revision to the Medical Assistance Rule concerning Changes to the Revision of the Renewal process for Sections 140 and 430
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) 140 and 430 , 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)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 140 with the proposed text beginning at 140 through the end of 140. This rule is effective March 1, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Changes to the Revision of the Renewal process for Sections 140 and 430
Rule Number: CHP 21-06-03-B
Division / Contact / Phone: Office of Medicaid Operations / Melissa Torres-Murillo / 5052

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 140 and 430 based on 42 C.F.R §457.315, §457.340, and §457.343 as this pertains to the renewal process for medical assistance. All policy revisions will align with federal regulations for the state to be in compliance with completing redeterminations. There will be new changes to the renewal process for both MAGI and Non-MAGI Programs which include the Child Health Plan Plus (CHP+) program. Updates will now allow members to receive an eligibility determination using up-to-date information, before initiating a renewal packet to the head of household. All members must be determined eligible at renewal if so, the household will not receive a renewal packet or be required to submit additional information. These members will receive an approval notice and only be directed to take action if the information used is not accurate. Members who are determined ineligible or if additional information is needed at renewal, will receive a renewal packet and be required to review, update, and sign the renewal. The signature form will be added to the renewal packet including the member's rights and responsibilities, penalty, and perjury language. Changes will also require members who are terminated at renewal to return the signed renewal form or failure to provide requested documentation, to complete a new application after ninety days from the termination date. The new application date will be the first of the month in which it is returned if returned within ninety days from the termination date. Members who are terminated at renewal and turn in their application or missing information within ninety days will have a new application date that starts the first of the month in which the renewal is returned. Members will also be given the option to request retro coverage within the 90-day period for any months in which coverage is reinstated. Department eligibility policy will be updated to reflect these changes in the Colorado Benefits Management System (CBMS). These updates will be added for all Medical Assistance programs which include the Child Health Plan Plus (CHP+) program to increase accurate and timely eligibility redeterminations ensuring that Colorado provides medical assistance only to members who remain eligible and reduce enrollment of ineligible individuals. In addition, a new unearned income type of Earned Income tax Credits will be added to policy to align with MAGI rules. CBMS updates are not required for this new unearned income type. Lastly, an update to policy language will be made for the Reasonable Opportunity Period (ROP) for income verification that reduced the ROP from 90 days to 30 days. These updates were previously approved in MSB 20-09-21-A, and the updates are to align with policy, with no CBMS updates required.

Initial Review	**12/10/21**	Final Adoption	**01/14/22**
Proposed Effective Date	**03/01/22**	Emergency Adoption	

DOCUMENT #

DO NOT PUBLISH THIS PAGE

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 C.F.R §457.315, §457.340, §457.343, and §457.380

4. State Authority for the Rule:

   C.R.S. § 25.5-8-104
   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021)

Initial Review	**12/10/21**	Final Adoption	**01/14/22**
Proposed Effective Date	**03/01/22**	Emergency Adoption	

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Changes to the Revision of the Renewal process for Sections 140 and 430
Rule Number: CHP 21-06-03-B
Division / Contact / Phone: Office of Medicaid Operations / Melissa Torres-Murillo / 5052

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 rule will impact all applicants/members who have reached their redetermination period in MAGI and Non-MAGI Medical Assistance Programs. The rule update will benefit applicants/members who are found eligible at the beginning of their renewal period, by giving eligible members automatic determinations and eliminating the need for applicants/members to review a renewal packet. Ineligible applicants/members will be required to review and update any information on their renewal packet and return it with their missing documentation and a signature form.

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 allow members to receive an accurate and timely eligibility determination by using the renewal review process which contains up-to-date information. This includes providing automatic medical assistance determinations to individuals who remain eligible for MAGI and Non-MAGI Medical assistance programs, which will allow the department to eliminate making payments for ineligible individuals.

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 updating the renewal process will not impact costs through caseload changes as these policy changes do not affect a member's eligibility. If a household receives a renewal packet, it will be due to someone in the household not being eligible for Medicaid or CHP+. The Department will take steps to make the signature requirement as easy to complete as possible for members so to not cause disruption in the member's enrollment.

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

The probable costs of this policy include updating the Department's eligibility systems to comply with CMS guidance.

The probable benefits to the policy are the Department would be in compliance with CMS rules.

The probable costs of inaction would be that the Department would be out of compliance with CMS rules which would threaten the Department's ability to receive a federal match for the Departments' programs.

There are no obvious benefits to inaction

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

   The Department does not have any less costly method of implementing this update for the renewal process.

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.

100 ELIGIBILITY

140 REDETERMINATION

140.1 "RA redetermination of eligibility" shall means a case review and necessary verification to determine whether the member client continues to be eligible to receive Medical Assistance. "Reconsideration period" means the 90-day period following termination of eligibility. Eligibility shall be redetermined at least every twelve (12) months since the last eligibility determination. An Eligibility site may redetermine eligibility through telephone, mail, or online electronically means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

A. Ex Parte Review: A redetermination form is not requiredwill not to be sent to the client member 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 – this process is referenced as Ex Parte Review. The use of telephonic or electronic redeterminations shall be noted in the case record. –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 the redetermination month, and all other eligibility requirements are met, no request shall be made of the client an td hen an approval notice of the outcome will go to the clientbe sent for all eligible members of the household who are requesting assistance. This approval notice shall include directions on how to view the information used to determine eligibility. 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. If all required information is not available and/or the information received does not support a finding of eligibility, Aa redetermination form will be issued to the household at least 30 days prior to the end of the eligibility period., approved by the Department, The redetermination form shall be prepopulated with the current information on file and mailed sent to the client household at least 30 days prior to the first of the month in which completion of eligibility redetermination period endingis due. As part of the ex parte review,The redetermination form shall be used to inform the client member will be informed of the redetermination and any verification needed to determine eligibility. The redetermination form requires a signature form to be returned from the member. 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 members clients to verify that the information provided is accurate or to report any changes to the information. review current information and and to take no action if there are no changes to report in the household Members must complete and return the redetermination form with necessary verifications and the signature form. Eligibility sites and CBMS shall view tIf a member fails to sign the signature form or comply with any he absence of reported changes from the client at this redetermination period as failure to complete the redetermination process.confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

C. Members who return properly completed redetermination forms and requested information during the reconsideration period shall not be required to submit a new application of eligibility. If redetermination forms and requested information are not returned within 90 days after the termination, the member must submit a new application to obtain enrollment in the program. ~~if the member fails to submit a redetermination form~~For individuals who are determined to be eligible for Medical Assistance within the reconsideration period, the effective date of coverage will be the first day of the month in which the redetermination form was returned. If the member has a gap in coverage due to submitting the redetermination within the reconsideration period, the member can request up to three months in retro coverage.

D. 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.

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 institution

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 30~~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 30~~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.