Title of Rule: Revision to the Child Health Plan Plus Rule Concerning Waiving of Enrollment Fees, Sections 50.4 & 440.4
Rule Number: CHP 22-06-23-B
Division / Contact / Phone: Eligibility Policy / Jeffrey Jaskunas /303-866-3824

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 25.5-8 107(b) and 2505-3 section 310, 50.4 & 440.4 based on the passage of HB-1289. This bill removed section 107(b) in its entirety, which has the effect of removing the Department's authority to charge and/or collect an enrollment fee for CHP+ eligible members.

   As a result of this statutory change, prior amendments made due to 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 must be amended. Policy revisions will ensure continued align with federal regulations for the state and compliance during this Coronavirus (COVID-19) Public Health Emergency. These changes will impact Child Health Plan Plus (CHP+). These policy changes will stay in place as directed by HB 1289.

   The policy changes are specific to the CHP+ program. Enrollment fees will be waived for all CHP+ eligible clients at the times of initial determination and renewal. Required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all the CHP+ categories according to its prior rule submission guidelines and categories to allow continued eligibility through the end of the Public Health Emergency as authorized in our State Plan Amendments and Waivers.

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 passage of HB 1289 and the Coronavirus (COVIS-19) public health emergency rules need to be updated for the state to be in compliance with state law and 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		Final Adoption	
Proposed Effective Date	**07/08/22**	Emergency Adoption	**07/08/22**

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4. State Authority for the Rule:

   House Bill 22-1289 & Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022)

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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 newly enrolled in the CHP+ programs and members being redetermined at renewal. The rule updates will benefit members enrolled in CHP+ by remaining eligible during and after this Coronavirus (COVID-19) Public Health Emergency without having to pay an enrollment fee.

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 serves two aims. First, it complies with the directives of HB22-1289, which directs the removal of 25.5-8-107(b) from C.R.S. Secondly, it 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 without having to pay an enrollment fee.

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 first aim of this amendment is expected to result in a decrease in revenue collected by the Department through enrollment fee payments by CHP+ beneficiaries. This decrease is forecasted at $400,000 in state funds per per annuum.

   Through the second aim, 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 remove CCR 25.5-8-107(b) to eliminate CHP+ enrollment fees will leave the Program in a position of non-compliance with state law. The Department sees no benefit to inaction.

   In addition, the Department expects that inaction to the proposal to eliminate 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.

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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.

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.~~

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~~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.~~

~~310.4 The enrollment fees stated in this section shall apply to applications received on or after January 1, 2001.~~

~~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.~~

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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.

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

4 440.3 If the enrollee is enrolled in a MCO as defined in section 50.15B and a MCO as defined in section
5 50.15A becomes available in the child's county of residence, the enrollee will be disenrolled from
6 the MCO as defined in section 50.15 B and enrolled in the MCO as defined in section 50.15A.

7 440.4 An enrollee may be disenrolled from both an MCO and/or the Children's Basic Health Plan for the
8 following reasons:

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

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

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

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

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

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

20 440.5 If an eligible person or an eligible person's family displays an ongoing pattern of behavior that is
21 abusive to provider(s), staff or other patients; or, disruptive to the extent that the provider's ability
22 to furnish services to the child or other patients is impaired, the eligible person may be disenrolled
23 from his/her managed care organization. If there is another participating MCO available in the
24 eligible person's county of residence, the Department may allow the eligible person to select a
25 new MCO. If there is not another MCO available in the eligible person's county, the eligible
26 person may be disenrolled from the Children's Basic Health Plan.

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