

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 20-04-29-B
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3558

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 (COVIS-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.

4. State Authority for the Rule:

Initial Review

Proposed Effective Date

5/8/2020

Final Adoption

Emergency Adoption

5/8/2020

DOCUMENT #14

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25.5-1-301 through 25.5-1-303, C.R.S. (2019);
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 (COVIS-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.

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

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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

1 **50 DEFINITIONS**

2 50.1 “Applicant” shall mean a person applying or re-applying for benefits on behalf of a child and/or
3 themselves.

4 50.2 “CBMS” shall mean Colorado Benefits Management System is the computer system that
5 determines an applicant’s eligibility for public assistance in the state of Colorado.

6 50.3 “Child” means a person who is less than nineteen years of age.

7 50.4 “Cost sharing” shall mean payments, such as copayments or enrollment fees that are due on
8 behalf of the enrollee.

9 50.5 “Department” shall mean the Colorado Department of Health Care Policy and Financing which is
10 responsible for administering the Colorado Medical Assistance Program and Children’s Basic
11 Health Plan as well as other State-funded health care programs.

12 50.6 “Dependent child” shall mean a child who lives with a parent, legal guardian, caretaker relative or
13 foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to
14 graduate by age 19

15 50.7 “Effective Date” shall mean the first day of eligibility which is the date the application is received
16 and date-stamped by the Eligibility site or the date the application was received and date-
17 stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a
18 date-stamp, the application date is the date that the application was signed by the client.

19 50.8 “Eligibility Site” shall mean a location outside of the Department that has been deemed by the
20 Department as eligible to accept applications and determine eligibility for applicants.

21 50.9 “Enrollee” shall mean an eligible person who is enrolled in the Children’s Basic Health Plan.

22 50.10 “Essential Community Provider” means a healthcare provider that:

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

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

29 50.11 “Evidence of Coverage” or “EOC” shall mean any certificate, agreement, or contract issued to an
30 enrollee from time-to-time by a Managed Care Organization (MCO) setting out the coverage to
31 which the enrollee is or was entitled under the Children’s Basic Health Plan.

32 50.12 “Grievance Committee” shall mean a conference with the Department or its Designee in which a
33 contested decision regarding an applicant or enrollee is reexamined.

34 50.13 “Household” shall be determined by relationships to the tax filer as declared on the Single
35 Streamlined Application and as required in 10 CCR 2505-10-8.100.4.E.

36 50.14 “Income” shall be any compensation from participation in a business, including wages, salary,
37 tips, commissions and bonuses. The Modified Adjusted Gross Income is a methodology used to
38 determine eligibility as required in 10 CCR 2505-10-8.100.4.C.

- 1 50.15 "Managed Care Organization" or "MCO" shall mean:
- 2 A. A carrier which meets the definition in §10-16-102 (8), C.R.S. with which the Department
3 contracts to provide health care or dental services covered by the Children's Basic Health
4 Plan; or,
- 5 B. Essential community providers and other health care and dental service providers with
6 whom the Department contracted to provide health care services under the Children's
7 Basic Health Plan using a managed care model.

8 50.16 "Presumptive Eligibility" shall mean children and pregnant women who have applied and appear
9 to be eligible for the Children's Basic Health Plan shall be presumed eligible and may receive
10 immediate temporary medical coverage.

11 50.17 "Unearned Income" shall be the gross amount received in cash or kind that is not earned from
12 employment or self-employment.

13 50.18 "Woman" shall mean a female who is 19 years in age or older.

14 **100 ELIGIBILITY**

15 **110 INDIVIDUALS ASSISTED UNDER THE PROGRAM**

16 110.1 To be eligible for the Children's Basic Health Plan, an eligible person shall:

- 17 A.
- 18 1. Be less than 19 years of age; or
- 19 2. Be a pregnant woman
- 20 B. Fall into one of the following categories:
- 21 1. Be a citizen or national of the United States, the District of Columbia, Puerto
22 Rico, Guam, the United States Virgin Islands, the Northern Mariana Islands,
23 American Samoa, or Swain's Island; or
- 24 2. Be a lawfully admitted non-citizen who entered the United States prior to August
25 22, 1996, or
- 26 3. Be a non-citizen who entered the United States on or after August 22, 1996 and
27 is applying for Medical Assistance who falls into one of the following categories:
- 28 a. Lawfully admitted for permanent residence under the U.S. Immigration
29 and Nationality Act (hereafter referred to as the "INA"); or
- 30 b. Paroled into the United States for at least one year under 8 U.S.C §
31 1182(d)(5); or
- 32 c. Granted conditional entry under Section 203(a)(7) of the INA, as in effect
33 prior to April 1, 1980; or
- 34 d. determined by the Eligibility site, in accordance with guidelines issued by
35 the U.S. Attorney General, to be a spouse, child, parent of a child, or
36 child of a parent who, in circumstances specifically described in 8 U.S.C.

- 1 §1641(c), has been battered or subjected to extreme cruelty which
2 necessitates the provision of Medical Assistance (Children's Basic
3 Health Plan); or
- 4 4. Be a non-citizen who arrived in the United States on any date, who falls into one
5 of the following categories:
- 6 a. Lawfully residing in Colorado and is an honorably discharged military
7 veteran; or
- 8 1. A spouse of such military veteran; or
9 2. An unremarried surviving spouse of such military veteran; or
10 3. An unmarried dependent child of such military veteran.⁷
- 11 b. Lawfully residing in Colorado and is on active duty in the United States
12 Armed Forces, excluding military training; or
- 13 1. A spouse of such individual; or
14 2. An unremarried surviving spouse of such individual; or
15 3. An unmarried dependent child of such individual.
- 16 c. Granted asylum under Section 208 of the INA; or
- 17 d. Refugee under Section 207 of the INA; or
- 18 e. An individual with deportation withheld:
- 19 1. Under Section 243(h) of the INA, as in effect prior to September
20 30, 1996; or
- 21 2. Under Section 241(b)(3), as amended by P.L. 104-208 of the
22 INA.
- 23 f. A Cuban or Haitian entrant, as defined under Section 501(e) of the U.S.
24 Refugee Education Assistance Act of 1980; or
- 25 g. An individual who:
- 26 1. Was born in Canada and possesses at least 50 percent
27 American Indian blood; or
- 28 2. Is a member of an Indian tribe, as defined in 25 U.S.C. Section
29 450(b)e.
- 30 h. Admitted into the United States as an Amerasian immigrant under
31 Section 584 of the U.S. Foreign Operations, Export Financing, and
32 Related Programs Appropriation Act of 1988, as amended by P.L. 100-
33 461; or
- 34 i. A lawfully admitted, permanent resident, who is a Hmong or Highland
35 Lao veteran of the Vietnam conflict; or

- 1 j. An alien who was admitted in the United States on or after December 26,
2 2007 who is an Iraqi Special Immigrant under section 101(a)(27) of the
3 INA; or
- 4 k. An alien who was admitted in the United States on or after December
5 26,2007 who is an Afghan Special Immigrant under section 101(a)(27) of
6 the INA; and
- 7 5. Be a lawfully admitted non-citizen in the United States who falls into one of the
8 categories:
- 9 a. granted temporary resident status in accordance with section 8 U.S.C.
10 1160 or 1255a; or
- 11 b. granted Temporary Protected Status (TPS) in accordance with section 8
12 U.S.C 1254a and pending applicants for TPS granted employment
13 authorization;
- 14 c. granted employment authorization under section 8 CFR 274a.12(c);or
- 15 d. Family Unity beneficiary in accordance with section 301 of Pub. L. 101-
16 649, as amended.
- 17 e. Deferred Enforced Departure (DED), pursuant to a decision made by the
18 President
- 19 f. Granted Deferred Action status (excluding Deferred Action for Childhood
20 Arrivals (DACA)) as described in the Secretary of Homeland Security's
21 June 15,2012 memorandum;
- 22 g. Granted an administrative stay of removal under section 8 CFR 241; or
- 23 h. Beneficiary of approved visa petition who has a pending application for
24 adjustment of status.
- 25 i. Pending an application for asylum under section 8 U.S.C. 1158, or for
26 withholding of removal under section 8 U.S.C. 1231, or under the
27 Convention Against Torture who-
- 28 1. as been granted employment authorization; or
- 29 2. Is under the age of 14 and has had an application pending for at
30 least 180 days.
- 31 j. Granted withholding of removal under the Convention Against Torture;
- 32 k. Citizens of Micronesia, the Marshall Islands, and Palau; or
- 33 l. Is lawfully present American Samoa under the immigration of laws of
34 American Samoa.
- 35 m. A non-citizen in a valid nonimmigrant status, as defined in section 8
36 U.S.C. 1101(a)(15) or under section 8 U.S.C. 1101(a)(17); or

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

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

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

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

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

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

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

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

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

26 **120 INSUFFICIENT ACCESS TO OTHER HEALTH COVERAGE**

- 27 120.1 To be eligible for the Children's Basic Health Plan, an eligible person shall not:

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

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

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

- 32 120.2 The Department shall not require that applicants be uninsured for any period of time prior to
- 33 becoming eligible for the Children's Basic Health Plan.

34 **130 VERIFICATION REQUIREMENTS**

- 35 130.1 To be eligible for the Children's Basic Health Plan, an applicant shall provide minimal verification
- 36 as required in 10 CCR 2505-10-8.100.4.B.

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1 **140 REDETERMINATION**

2 140.1 A redetermination of eligibility shall mean a case review and necessary verification to determine
3 whether the client continues to be eligible to receive Medical Assistance. Eligibility shall be
4 redetermined twelve (12) months since the last eligibility determination. An Eligibility site may
5 redetermine eligibility through telephone, mail, or electronic means. The use of telephone or
6 electronic redeterminations should be noted in the case record and in CBMS case comments.

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

16 B. A redetermination form, approved by the Department, shall be mailed to the client at least
17 30 days prior to the first of the month in which completion of eligibility redetermination is
18 due. The redetermination form shall be used to inform the client of the redetermination
19 and verification needed. The client shall not be required to return the form to the eligibility
20 site. The only verification that may be required at redetermination is the minimum
21 verification needed to complete a redetermination of eligibility.

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

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

34 **150 CALCULATION OF HOUSEHOLD INCOME**

35 150.1 Calculation of income for the Children's Basic Health Plan shall be determined as required in 10
36 CCR 2505-10-8.100.4.C

37 150.2 Income disregards for the Children's Basic Health Plan shall be determined as required in 10
38 CCR 2505-10-8.100.4.D

39 **160 [Repealed eff. 12/30/2012]**

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42 **170 PRESUMPTIVE ELIGIBILITY**

- 1 170.1 A pregnant applicant or a child under the age of 19 may apply for presumptive eligibility for
2 immediate temporary medical services through designated presumptive eligibility sites.
- 3 A. To qualify for presumptive eligibility, a child under the age of 19 shall have a declared
4 household income that shall be greater than 133% but not exceed 250% of Federal
5 Poverty Level (MAGI-equivalent); or
- 6 B. To qualify for presumptive eligibility, a pregnant women shall have an attested
7 pregnancy, declare that her household's income shall be greater than 185% but not
8 exceed 250% of the Federal Poverty Level (MAGI-equivalent); and
- 9 C. He/she shall be a United States citizen or a documented immigrant as defined in Section
10 110.
- 11 170.2 Presumptive eligibility sites shall be certified by the Department of Health Care Policy and
12 Financing to make presumptive eligibility determinations. Sites shall be re-certified by the
13 Department of Health Care Policy and Financing every 2 years to remain approved presumptive
14 eligibility sites.
- 15 A. The presumptive eligibility site shall forward the application to the county within five
16 business days of the received date.
- 17 170.3 The presumptive eligibility period begins on the date the applicant is determined eligible and ends
18 with the earlier of:
- 19 A. The day an eligibility determination for Medical Assistance is made for the applicant(s); or
- 20 B. The last day of the month following the month in which a determination for presumptive
21 eligibility was made.
- 22 170.4 The county or Medical Assistance site shall make an eligibility determination within 45 days from
23 the date of application.
- 24 A. Presumptively eligible clients may appeal the county or Medical Assistance site's failure
25 to act on an application within 45 days from date of application or the denial of an
26 application. Appeal procedures are outlined in Section 600.
- 27 B. A presumptively eligible client may not appeal the end of a presumptive eligibility period.

28 **180 Express Lane Eligibility**

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

31 180.1 Free/Reduced Lunch Program

- 32 A. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced
33 Lunch application at a participating school district
- 34 1. Families will be given the option to opt into Medical Assistance coverage for their
35 potentially eligible child.
- 36 2. Children who meet all necessary eligibility requirements as outlined in this
37 volume will be automatically enrolled.

- 1 3. Children who meet all necessary eligibility requirements except verification of
2 U.S. citizenship and identity will receive 90 days of eligibility while awaiting this
3 verification.
- 4 4. Any additionally required verification will be requested from the client through
5 CBMS prior to being automatically enrolled.
- 6 5. Eligibility is based on income declared on the Free/Reduced Lunch application as
7 well as eligibility requirements outlined in section 150.
- 8 6. If it would be found that a child does not satisfy an eligibility requirement for
9 Medical Assistance, the child's eligibility will be evaluated using the application
10 for Medical Assistance.
- 11 B. Recipients of the Free/Reduced Lunch Program who were not required to submit a
12 Free/Reduced Lunch application at a participating school district
- 13 1. Families who are automatically enrolled Free/Reduced Lunch recipient children
14 will not be forwarded to the Department for Express Lane Eligibility in compliance
15 USDA confidentiality guidelines.
- 16 2. These families must apply for Medical Assistance in order to give consent for
17 request of benefits.

18 180.2 Direct Certification

- 19 A. When an application for Food Stamps or Colorado Works has been submitted, families
20 will be given the option to opt into Medical Assistance coverage for their potentially
21 eligible children.
- 22 1. Children who meet all necessary eligibility requirements as outlined throughout
23 sections 100 through 180 will be automatically enrolled,
- 24 2. Children who are only missing verification of U.S. citizenship and identity will
25 receive 90 days of coverage while waiting for this verification.
- 26 3. Any additionally required verification will be requested from the client through
27 CBMS prior to being automatically enrolled.
- 28 4. Eligibility is determined based on income declared on the Food Stamp or
29 Colorado Works application as well as eligibility requirements outlined throughout
30 this volume.
- 31 5. If it would be found that a child does not satisfy an eligibility requirement for
32 Medical Assistance, the child's eligibility will be evaluated using the Single
33 Streamlined application for Medical Assistance.
- 34 6. Individuals whose eligibility is not determined through Express Lane Eligibility
35 may also submit a separate Single Streamlined Application for Medical
36 Assistance to determine eligibility.

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38 **200 BENEFITS PACKAGE**

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- 1 **210** **The following are covered benefits including any applicable limitations:**
- 2 A. Emergency Care and Urgent/After Hours Care;
- 3 B. Emergency Transport/Ambulance Services;
- 4 C. Hospital/Other Facility Services Including:
- 5 1. Inpatient;
- 6 2. Physician;
- 7 3. Outpatient/Ambulatory;
- 8 D. Medical Office Visits Including:
- 9 1. Physician;
- 10 2. Mid-Level Practitioner;
- 11 3. Specialist;
- 12 E. Diagnostic Services;
- 13 F. Preventative, Routine and Family Planning Services Including:
- 14 1. Immunizations;
- 15 2. Well-child visits;
- 16 3. Health maintenance visits;
- 17 G. Maternity Care Including:
- 18 1. Prenatal;
- 19 2. Delivery and inpatient well-baby care;
- 20 3. Postpartum care
- 21 H. Mental Illness Treatments such as:
- 22 1. Neurobiologically-based mental illness including:
- 23 a. Schizophrenia;
- 24 b. Schizoaffective disorder;
- 25 c. Bipolar affective disorder;
- 26 d. Major depressive disorder;
- 27 e. Specific obsessive compulsive disorder;
- 28 f. Panic disorder;

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- 1 2. Mental disorders including:
- 2 a. Post traumatic stress disorder
- 3 b. Drug and alcohol disorders
- 4 c. Dysthymia
- 5 d. Cyclothymia
- 6 e. Social phobia
- 7 f. Agoraphobia with panic disorder
- 8 g. General anxiety
- 9 h. Anorexia Nervosa exclusive of residential treatment
- 10 i. Bulimia exclusive of residential treatment
- 11 3. All other mental illness;
- 12 a. Inpatient coverage;
- 13 b. Outpatient coverage;
- 14 I. Physical Therapy, Speech Therapy and Occupational Therapy shall be limited to 30 visits per
15 diagnosis per year. Effective November 1, 2007, Physical, Speech and Occupational Therapy
16 services shall be unlimited for children from birth up to the child's third birthday.
- 17 J. Durable Medical Equipment shall be limited to the lesser of the purchase price or rental price for
18 medically necessary durable medical equipment that shall not exceed two thousand dollars per
19 year.
- 20 K. Transplants must be medically necessary and are limited to:
- 21 1. Liver;
- 22 2. Heart;
- 23 3. Heart/lung;
- 24 4. Cornea;
- 25 5. Kidney;
- 26 6. Bone marrow which shall be limited to the following conditions:
- 27 a. Aplastic anemia;
- 28 b. Leukemia;
- 29 c. Immunodeficiency disease;
- 30 d. Neuroblastoma;

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- 1 e. Lymphoma;
- 2 f. High risk stage ii and iii breast cancer;
- 3 g. Wiskott aldrich syndrome;
- 4 7. Peripheral stem cell support which shall be limited to the following conditions:
- 5 a. Aplastic anemia;
- 6 b. Leukemia;
- 7 c. Immunodeficiency disease;
- 8 d. Neuroblastoma;
- 9 e. Lymphoma;
- 10 f. High risk stage II and III breast cancer;
- 11 g. Wiskott aldrich syndrome;
- 12 L. Home health care;
- 13 M. Hospice care;
- 14 N. Prescription medication;
- 15 O. Kidney dialysis shall be excluded only if the member is also eligible for Medicare;
- 16 P. Skilled nursing facility care must be provided only when there is a reasonable expectation of
17 measurable improvement in the members' health status.
- 18 Q. Vision services shall be limited to:
- 19 1. Vision screenings for age appropriate preventative care;
- 20 2. Referral required for refraction services;
- 21 3. Minimum fifty dollar benefit for eyeglasses;
- 22 R. Audiology services shall be limited to:
- 23 1. Hearing screenings for age appropriate preventative care;
- 24 2. Hearing aids without financial limitation for enrollees age 18 and under no more than
25 once every five years unless medically necessary including:
- 26 a. A new hearing aid when alterations to the existing hearing aid cannot adequately
27 meet the needs of the child
- 28 b. Services and supplies including, but not limited to, the initial assessment, fitting,
29 adjustments, and auditory training that is provided according to accepted
30 professional standards.
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- 1 S. Intractable pain;
- 2 T. Autism;
- 3 U. Case management is covered only when medically necessary;
- 4 V. Dietary counseling/nutritional services shall be limited to:
- 5 1. Formula for metabolic disorders;
- 6 2. Total parenteral nutrition;
- 7 3. Enterals and nutrition products;
- 8 4. Formulas for gastrostomy tubes;
- 9 W. Dental services are limited to:
- 10 1. Those dental services described in the Children's Basic Health Plan dental Evidence of
11 Coverage booklet provided to enrollees, who are less than nineteen years of age.
12 Beginning October 1, 2019, the dental services listed below are covered benefits for
13 enrolled pregnant women of any age, excepting Limited Orthodontic services under
14 Section 210.W.1.h for pregnant women age nineteen and above. Children's Basic Health
15 Plan dental services are provided by the dental MCO (or its designee) with which the
16 Department has contracted for the applicable plan year to provide the following dental
17 services;
- 18 a. Diagnostic
- 19 b. Preventive
- 20 c. Restorative
- 21 d. Endodontic
- 22 e. Periodontic
- 23 f. Prosthodontic
- 24 g. Oral and Maxillofacial Surgery
- 25 h. Limited Orthodontic, excepting pregnant women age nineteen and above.
- 26 i. Adjunctive General Services
- 27 2. Orthodontic and prosthodontic treatment for cleft lip or cleft palate in newborns (covered
28 as a medical service in accordance with section 10-16-104, C.R.S.); and
- 29
- 30 3. Treatment of teeth or periodontium required due to accidental injury to naturally sound
31 teeth (covered as a medical service in accordance with section 10-16-104, C.R.S.). A
32 physician or legally licensed dentist must perform treatment within 72 hours of the
33 accident.

-
- 1 X. Therapies covered shall include:
- 2 1. Chemotherapy;
- 3 2. Radiation;
- 4 Y. The following are not covered benefits:
- 5 1. Acupuncture;
- 6 2. Artificial conception;
- 7 3. Biofeedback;
- 8 4. Storage Costs for umbilical blood;
- 9 5. Chiropractic care;
- 10 6. Convalescent care or rest cures;
- 11 7. Cosmetic surgery;
- 12 8. Custodial care;
- 13 9. Domiciliary care;
- 14 10. Duplicate coverage;
- 15 11. Government institution or facility services;
- 16 12. Hair loss treatments;
- 17 13. Hypnosis;
- 18 14. Infertility services;
- 19 15. Maintenance therapy;
- 20 16. Nutritional therapy unless specified otherwise;
- 21 17. Elective termination of pregnancy, unless the elective termination is to save the life of the
- 22 mother or if the pregnancy is the result of an act of rape or incest;
- 23 18. Personal comfort items;
- 24 19. Physical exams for employment or insurance;
- 25 20. Private duty nursing services;
- 26 21. Routine foot care;
- 27 22. Sex change operations;
- 28 23. Sexual disorder treatments;

-
- 1 24. Taxes;
- 2 25. Temporomandibular joint (TMJ) treatment, unless it has a medical basis;
- 3 26. Other therapies and treatments which are not medically necessary;
- 4 27. Vision services unless specified otherwise;
- 5 28. Vision therapy;
- 6 29. War-related conditions;
- 7 30. Weight-loss programs;
- 8 31. Work-related conditions;
- 9 **300 ENROLLMENT FEES AND COPAYMENTS**
- 10 **310 ANNUAL ENROLLMENT FEES AND DUE DATE**
- 11 310.1 For eligible children, the following annual enrollment fees shall be due prior to enrollment in the
12 Children's Basic Health Plan:
- 13 A. For families with income, at the time of eligibility determination, less than 151% of the
14 Federal Poverty Level, the annual enrollment fee shall be waived.
- 15 B. For families with income, at the time of eligibility determination, between 151% and 205%
16 of the Federal Poverty Level (MAGI-equivalent), the annual enrollment fee shall be:
- 17 1. \$25.00 for a single eligible child; and
- 18 2. \$35.00 for two or more eligible children.
- 19 3. Waived for families who include an eligible pregnant woman.
- 20 C. For families with income, at the time of eligibility determination, greater than 205% and up
21 to 250% of the Federal Poverty Level, the annual enrollment fee shall be:
- 22 1. \$75.00 for a single eligible child; and
- 23 2. \$105.00 for two or more eligible children.
- 24 3. Waived for families who include an eligible pregnant woman
- 25 310.2 If the required enrollment fee is not received with the application for the Children's Basic Health
26 Plan, the Department or its designee shall notify the applicant:
- 27 A. That applicable enrollment fees are a requirement for enrollment;
- 28 B. That fees shall be due within thirty (30) days of the date of notification;
- 29 C. Of effective date of enrollment if payment is received; and
- 30 D. That the application shall be denied if payment is not received by the due date indicated.

1 310.3 The application shall be denied if payment is not received by the due date indicated on the
2 notification.

3 310.5 Once enrollment has occurred, the annual enrollment fee is non-refundable.

4 310.6 Due to the Coronavirus COVID-19 Public Health Emergency, an eligible applicant will be charged
5 an -enrollment fee. Existing members who are being re-enrolled -will not be charged enrollment
6 fees until after the Public Health Emergency has ended.

7 **320 COPAYMENTS**

8 320.1 The following copayments shall be due for enrollees at the time of service:

9 A. For families with income, at the time of eligibility determination, less than 101% of the
10 Federal Poverty Level (MAGI-equivalent), all copayments shall be waived, except for
11 emergency and care, which shall be \$3.00 per use and urgent/after hours care, which
12 shall be \$1.00 per use.

13 B. For families with income, at the time of eligibility determination, between 101% and 150%
14 of the Federal Poverty Level (MAGI-equivalent), the copayment shall be:

15 1. Effective until June 30, 2012:

16 a. \$2.00 per office visit;

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

18 c. \$1.00 per generic or brand name prescription;

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

20 e. \$2.00 per vision visit;

21 f. \$3.00 per use of emergency care and urgent/after hours care;

22 2. Effective July 1, 2012:

23 a. \$2.00 per office visit;

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

25 c. \$1.00 per generic or brand name prescription;

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

27 e. \$2.00 per vision visit;

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

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

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

32 i. \$2.00 per inpatient hospital visit;

- 1 j. \$2.00 per inpatient hospital visit for physician services in the hospital;
- 2 k. \$2.00 per outpatient hospital or ambulatory surgery center visit.
- 3 C. For families with income, at the time of eligibility determination, between 151% and 200%
4 of Federal Poverty Level (MAGI-equivalent), the copayment shall be:
- 5 1. Effective until June 30, 2012:
- 6 a. \$5.00 per office visit;
- 7 b. \$5.00 per outpatient mental health or substance abuse visit;
- 8 c. \$3.00 per generic prescription;
- 9 d. \$5.00 per brand name prescription;
- 10 e. \$5.00 per physical therapy, occupational therapy or speech therapy visit;
- 11 f. \$5.00 per vision visit;
- 12 g. \$15.00 per use of emergency care and urgent/after hours care
- 13 2. Effective July 1, 2012:
- 14 a. \$5.00 per office visit;
- 15 b. \$5.00 per outpatient mental health or substance abuse visit;
- 16 c. \$3.00 per generic prescription;
- 17 d. \$10.00 per brand name prescription;
- 18 e. \$5.00 per physical therapy, occupational therapy or speech therapy visit;
- 19 f. \$5.00 per vision visit;
- 20 g. \$30.00 per use of emergency care ((co-payment is waived if client is
21 admitted to the hospital)
- 22 h. \$20.00 per use of urgent/after hours care;
- 23 i. \$5.00 per date of service for laboratory and radiology/imaging services
- 24 j. \$15.00 per trip for emergency transport/ambulance services;
- 25 k. \$20.00 per inpatient hospital visit;
- 26 l. \$5.00 per inpatient hospital visit for physician services;
- 27 m. \$5.00 per outpatient hospital or ambulatory surgery center visit.
- 28 3. Due to the Coronavirus COVID-19 Public Health Emergency, members who are
29 eligible for Children's Basic Health Plan will have waived laboratory copayments.

1 specifically as it relates to laboratory copayments associated with COVID-19
2 testing.

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

5 1. Effective until June 30, 2012:

- 6 a. \$10.00 per office visit;
- 7 b. \$10.00 per outpatient mental health or substance abuse visit;
- 8 c. \$5.00 per generic prescription;
- 9 d. \$10.00 per brand name prescription;
- 10 e. \$10.00 per physical therapy, occupational therapy or speech therapy
11 visit;
- 12 f. \$10.00 per vision visit;
- 13 g. \$20.00 per use of emergency care and urgent/after hours care.

14 2. Effective July 1, 2012:

- 15 a. \$10.00 per office visit;
- 16 b. \$10.00 per outpatient mental health or substance abuse visit;
- 17 c. \$5.00 per generic prescription;
- 18 d. \$15.00 per brand name prescription;
- 19 e. \$10.00 per physical therapy, occupational therapy or speech therapy
20 visit;
- 21 f. \$10.00 per vision visit;
- 22 g. \$50.00 per use of emergency care (co-payment is waived if client is
23 admitted to the hospital);
- 24 h. \$30.00 per use of urgent/after hours care;
- 25 i. \$10.00 per date of service for laboratory and radiology/imaging services
- 26 j. \$25.00 per trip for emergency transport/ambulance services;
- 27 k. \$50.00 per inpatient hospital visit;
- 28 l. \$10.00 per inpatient hospital visit for physician services;
- 29 m. \$10.00 per outpatient hospital or ambulatory surgery center visit.

30 3, Due to the Coronavirus COVID-19 Public Health Emergency, members who are
31 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

- 1 state where there is only one participating MCO available, the Department or its designee
2 shall select that MCO and enroll the eligible person.
- 3 C. The Department or its designee shall notify the enrollee of the MCO selected. If the
4 enrollee wants to change MCOs, the enrollee shall contact the Department or its
5 designee within 90 days from the effective date of the MCO enrollment. An enrollee may
6 also change a pending MCO enrollment before the effective date.
- 7 D. For renewal applications, the Department or its designee shall reassign the eligible
8 person to the participating MCO the applicant approved for the previous enrollment
9 period. If the eligible person wishes to change MCO enrollment, he/she shall notify the
10 Department or its designee within his/her re-enrollment period.
- 11 410.3 In counties in which a participating MCO as defined in section 50.14.A is not available, the eligible
12 person shall be enrolled in an MCO as defined in section 50.14.B.
- 13 410.4 Once an enrollee has selected an MCO or upon expiration of the timeframe to change, the
14 enrollee shall remain enrolled in that MCO for the remainder of his/her eligibility period, unless the
15 eligible person meets any of the disenrollment criteria set forth in section 440.
- 16 410.5 An eligible person shall have an opportunity to change to a different MCO serving the eligible
17 person's geographic region, if one is available, during the applicant's annual redetermination
18 period.
- 19 **420 ENROLLMENT OF ALL ELIGIBLE PERSONS IN A FAMILY**
- 20 420.1 If one eligible child from a family is enrolled in the Children's Basic Health Plan, all eligible
21 children in that family must be enrolled in the Children's Basic Health Plan.
- 22 420.2 All eligible children in a family must be enrolled in the same MCO.
- 23 **430 ENROLLMENT DATE**
- 24 430.1 Eligibility for the Children's Basic Health Plan shall be effective on the latter of:
- 25 A. The first day of the month of application for Medical Assistance; or
- 26 B. The first day of the month the person becomes eligible for the Children's Basic Health
27 Plan program.
- 28 430.2 Upon being enrolled in the Children's Basic Health Plan, continuous eligibility applies to children
29 under the age of 19, who through an eligibility determination, reassessment or redetermination
30 are found eligible for the Children's Basic Health Plan program. The continuous eligibility period
31 may last for up to 12 months and will begin on the month of application or from the authorization
32 date.
- 33 A. The continuous eligibility period applies without regard to changes in income or other
34 factors that would otherwise cause the child to be ineligible.
- 35 i) A 14-day no fault period shall begin on the date the child is determined eligible
36 for Medical Assistance. During the 14-day period, updates or corrections may be
37 made to the child's case. Any changes to the child's case made during the 14-
38 day no fault period may impact his or her eligibility for Medical Assistance.

- 1 B. A child's continuous eligibility period will end effective the earliest possible month, if any
2 of the following occur:
- 3 i) Child is deceased
- 4 ii) Becomes an inmate of a public institutio
- 5 iii) The child states that she/he has moved out of the household permanently
- 6 iv) Is no longer a Colorado resident
- 7 v) Is unable to be located based on evidence or reasonable assumption
- 8 vi) Requests to be withdrawn from continuous eligibility
- 9 vii) Fails to provide documentation during a reasonable opportunity period as
10 specified in section 8.100.3.H.9
- 11 viii) Fails to provide a reasonable explanation or paper documentation when self-
12 attested income is not reasonably compatible with income information from an
13 electronic data source, by the end of the 90-day reasonable opportunity period.
14 This exception only applies the first-time income is verified following an initial
15 eligibility determination or an annual redetermination.
- 16 ix) An eligible person shall not be enrolled in other health insurance coverage
- 17 430.3. If determined eligible, the enrollment date of a pregnant woman shall be effective as of the first of
18 the month of the date of application or the first day of the month the pregnant woman becomes
19 eligible. The enrollment span shall end at the end of the month following 60 days after the birth of
20 the child or termination of the pregnancy. Once eligibility has been approved, coverage must be
21 provided regardless of changes in the woman's financial circumstances, once the income
22 verification requirements are met.
- 23 A. A pregnant women's eligibility period will end effective the earliest possible month, if any
24 of the following occur:
- 25 i) Fails to provide a reasonable explanation or paper documentation when self-
26 attested income is not reasonably compatible with income information from an
27 electronic data source, by the end of the 90-day reasonable opportunity period.
28 This exception only applies the first-time income is verified following an initial
29 eligibility determination or an annual redetermination.
- 30 430.4 An eligible person's enrollment date in the selected MCO shall be no later than:
- 31 A. The first of the month following eligibility determination and MCO selection if eligibility is
32 determined before the 17th of the month.
- 33 B. The first of the second month following eligibility determination and MCO selection if
34 eligibility is determined on or after the 17th of the month.
- 35 430.5 A child born to a mother who is enrolled in the Children's Basic Health Plan at the time of the
36 child's birth is guaranteed coverage for one year.
- 37 A. To receive Medical Assistance under the Children's Basic Health Plan, the birth must be
38 reported verbally or in writing to the County Department of Human Services or Eligibility

1 site. Information provided shall include the baby's name, date of birth, and mother's name
2 or Medical Assistance number. A newborn can be reported at any time by any person.
3 Once reported, a newborn meeting the above criteria shall be added to the mother's
4 Medical Assistance case, or his or her own case if the newborn does not reside with the
5 mother, according to timelines defined by the Department. If adopted, the newborn's
6 agent does not need to file an application or provide a Social Security Number or proof of
7 application for a Social Security Number for the newborn.

8 **440 DISENROLLMENT**

9 440.1 An enrollee shall be disenrolled from an MCO for the following reasons:

- 10 A. Administrative error on the part of the Department, the Department's designee, or the
11 MCO, including but not limited to enrollment of a person who does not reside in the
12 MCO's service area; or,
13 B. A change in the enrollee's residence to an area not in the MCO's service area; or,
14 C. When an enrollee's coverage is terminated as described in section 440.1A.

15 440.2 If an enrollee is disenrolled from an MCO for any of the reasons stated in section 440.1 and there
16 is another participating MCO available in the enrollee's county of residence, the enrollee shall be
17 allowed to select a new MCO.

18 440.3 If the enrollee is enrolled in a MCO as defined in section 50.15B and a MCO as defined in section
19 50.15A becomes available in the child's county of residence, the enrollee will be disenrolled from
20 the MCO as defined in section 50.15 B and enrolled in the MCO as defined in section 50.15A.

21 440.4 An enrollee may be disenrolled from both an MCO and/or the Children's Basic Health Plan for the
22 following reasons:

- 23 A. Fraud or intentional misconduct, including but not limited to knowing misuse of covered
24 services, knowing misrepresentation of membership status; or,
25 B. An enrollee's receipt of other health care coverage; or,
26 C. The admission of an enrollee into any federal, state, or county institution for the treatment
27 of mental illness, narcoticism, or alcoholism, or into any correctional facility; or,
28 D. Ineligibility for the program, based on the guidelines set forth in the Children's Basic
29 Health Plan eligibility rules; or,
30 E. Failure to comply with cost sharing requirements (annual enrollment fees and
31 copayments) set forth in the Children's Basic Health Plan cost sharing rules; or,
32 F. There is not another participating MCO as defined in section 50.14 available in the
33 enrollee's county of residence.

34 440.5 If an eligible person or an eligible person's family displays an ongoing pattern of behavior that is
35 abusive to provider(s), staff or other patients; or, disruptive to the extent that the provider's ability
36 to furnish services to the child or other patients is impaired, the eligible person may be disenrolled
37 from his/her managed care organization. If there is another participating MCO available in the
38 eligible person's county of residence, the Department may allow the eligible person to select a
39 new MCO. If there is not another MCO available in the eligible person's county, the eligible
40 person may be disenrolled from the Children's Basic Health Plan.

1 **500 FINANCIAL MANAGEMENT**

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

6 **510** The Department shall make quarterly assessments of projected expenditures. If it appears the
7 program may overspend its appropriation due to changes in enrollment, health care costs,
8 funding, legislation, or other factors, the Department shall consider if adjustments to the program
9 are necessary. The program may use, but is not limited to, any of the following financial
10 management tools: waiting lists, adjustments of eligibility criteria and/or levels, instituting open
11 enrollment periods, or temporary closure of the program.

12

13 **600 APPEALS PROCESS**

14 600.1 Applicants shall be notified of any action regarding the eligibility and enrollment status and cost
15 sharing requirements for the enrollees' participation in the Children's Basic Health Plan and
16 appeal rights regarding those actions by the Department or its designee.

17 600.2 The Department or its designee shall notify the applicant within ten (10) business days of a
18 decision regarding eligibility, enrollment and cost sharing. The notice shall:

- 19 A. Be in writing;
- 20 B. Be in his/her primary language, to the extent practicable;
- 21 C. Describe to the applicant the reasons for the decision;
- 22 D. Document the authority for the decision (e.g. rule citation); and
- 23 E. Inform the applicant of his/her rights and responsibilities regarding the decision.

24 600.3 An applicant who disagrees with a denial regarding eligibility, enrollment, or cost sharing
25 requirements may appeal in writing to the Children's Basic Health Plan Eligibility Vendor within
26 thirty (30) calendar days of the date of the notification of denial of eligibility, enrollment, or cost
27 sharing. The appeal shall be reviewed and processed within thirty (30) calendar days of receipt
28 and the results of the appeal shall be communicated to the applicant within ten (10) business
29 days of the review. The following guidelines shall apply to the appeal process:

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

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

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

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

- 1 3. Maintain the original denial, if the information in the Department's eligibility
2 system is complete and correct; and
- 3 4. Notify the applicant and the Children's Basic Health Plan Eligibility Vendor in
4 writing once the review is complete with the results of the data entry review and
5 the option of forwarding the appeal to the Grievance Committee.

6 600.4 If the applicant disagrees with the results of the appeal, the applicant may have their appeal
7 reviewed by the Grievance Committee. The Grievance Committee's decision shall be final.

8
9

- 10 A. The Grievance Committee shall be conducted by an independent panel appointed by the
11 Executive Director of the Department. The panel shall include at least three people from
12 the Department or its designee not previously involved with the grievance. A person
13 previously involved with the grievance may be present at the conference and appear
14 before the panel to present information and answer questions, but shall not have a vote.
15 The Department shall ensure that those appointed to the panel have sufficient experience
16 to make an informed decision regarding the grievance under review.
- 17 B. The applicant may attend the Grievance Committee in person or by telephone.
- 18 C. The applicant may be represented by the person of the applicant's choice (i.e. legal
19 counsel, friend, family member, etc.) during the Grievance Committee.
- 20 D. The applicant may have access to documents that were used by the Department or its
21 designee in making the decision under appeal.

22 600.5 An enrollee who disagrees with a denial of benefits shall submit an appeal to the MCO he/she is
23 enrolled in and shall follow the MCO's appeal process.

24 **610 [Repealed eff.12/30/2012]**

25

26 **Editor's Notes**

27 **History**

- 28 Entire rule eff. 07/30/2007.
29 Rule 210 emer. rule eff. 11/01/2007.
30 Rule 210 eff. 12/30/2007.
31 Rules 50.17-50.21, 100-110.1E, 150.3-150.3E, 170-170.2 emer. rules eff. 01/01/2008.
32 Rules 50.17-50.21; 100-110.1E; 150.3-150.3E; 170-170.2 eff. 03/30/2008.
33 Rules 500-510 eff. 11/30/2008.
34 Rule 210 eff. 12/30/2008.
35 Rule 110 eff. 03/30/2009.
36 Rule 150 emer. rule eff. 04/10/2009.
37 Rule 150 eff. 06/30/2009.
38 Rules 110.1 B 4-5, 150.1 Q-R eff. 11/30/2009.
39 Rule 130.1 B emer. rule eff. 01/01/2010; expired 03/11/2010.

- 1 Rule 130.1 B eff. 03/30/2010.
- 2 Rules 110.1 D, 150.3, 170.1, 310.1 B, 320.1 D emer. rules eff. 05/01/2010. Rule 110.1 D expired
- 3 08/07/2010.
- 4 Rule 140.1 emer. rule eff. 06/11/2010.
- 5 Rules 150.3, 170.1, 310.1 B, 320.1 D eff. 06/30/2010.
- 6 Rules 110.1 D, 140.1 eff. 08/30/2010.
- 7 Rules 110.1 B 4-5 eff. 10/30/2010.
- 8 Rules 130.1 A, 150.2 eff. 12/30/2010.
- 9 Rule 140.1 B emer. rule eff. 09/09/2011.
- 10 Rule 180 emer. rule eff. 10/14/2011.
- 11 Rule 140 1B eff. 11/30/2011.
- 12 Rules 180, 430 eff. 12/30/2011.
- 13 Rules 300-330 eff. 01/01/2012.
- 14 Rules 430.1-430.2 emer. rules eff. 01/13/2012.
- 15 Rules 170, 430 eff. 04/01/2012.
- 16 Rules 410.1 A, 410.2-410.4 eff. 11/30/2012.
- 17 Rules 50.9, 50.15-50.16, 120, 150.1 O-Q, 400.1 eff. 12/30/2012. Rules 160, 220, 340, 450, 610 repealed
- 18 eff. 12/30/2012.
- 19 Rules 170.5, 330.4 eff. 01/30/2013.
- 20 Rules 180.1 A.1, 180.1 A.6, 180.2 eff. 04/30/2013.
- 21 Rule 120 emer. rule eff. 05/10/2013.
- 22 Rule 120 eff. 07/30/2013.
- 23 Rules 50, 110.1.D-110.1.F, 130, 150, 170.1, 430 eff. 10/01/2013.
- 24 Rules 430.2-430.5 eff. 04/30/2014.
- 25 Rules 110.1 B.2, 170.1 C eff. 07/01/2015.
- 26 Rules 50-600.5 eff. 03/02/2017.
- 27 Rule 110 eff. 09/30/2017.
- 28 Rule 430.4 eff. 10/30/2017.
- 29 Rules 430.2-430.3 eff. 10/30/2018.
- 30 Rule 210 W emer. rule eff. 10/01/2019.
- 31 Rule 210 W eff. 12/30/2019.

32 Annotations

- 33 Rule 170.5 (adopted 12/14/2012) was repealed by Senate Bill 13-079 effective 05/15/2013.