COLORADO
Department of Health Care Policy & Financing

Family Planning Limited Benefit Plan FAQ

Frequently Asked Questions for Limited Family Planning Services ***Version 3*** *December 2023*

In July 2022, a new Medical Assistance (MA) program was created in the Colorado Benefits Management System (CBMS) for limited Family Planning Services.

What is the Family Planning Limited Benefit Plan?

The Family Planning Limited Benefits plan covers family planning and related services for eligible individuals who don't qualify for full Medicaid coverage due to their income.

What do Family Planning Benefits cover?

Family planning includes medically necessary services intended to delay, prevent, or plan for a pregnancy. Family planning services include different kinds of birth control, such as oral, implanted, or permanent contraceptives, and office visits to discuss a member's family planning options. Family planning-related services are screenings, testing, and treatment services provided under a family planning visit, including STI testing and treatment, cervical cancer prevention, and other preventive health care services.

Who is eligible for the Family Planning Limited Benefit Plan?

Applicants will first be evaluated for a Medical Assistance category that provides full coverage. If the applicant does not meet the requirements for full coverage medical assistance, Family Planning Limited Benefits can be offered if the applicant specifically states on their application that they want to apply for Family Planning Benefits. Family Planning Limited Benefit Plan is for individuals of any age or gender who are not pregnant or incarcerated. The income limit for this program has been expanded up to 260% of the Federal Poverty Level (FPL).

Will Family Planning Limited Benefit Plan participants receive a renewal?

Yes, just like any other MA program, they will receive a renewal.

How does someone apply for the Family Planning Limited Benefit Plan?

Starting in October 2023, the Family Planning Limited Benefit Plan is an opt-in program. If the member does not opt-in, they will not automatically be evaluated for eligibility. The following question was added to the paper and PEAK application:

PAPER: *Does this person want to apply for Family Planning Benefits? Family planning provides health care and counseling for preventing, delaying, or planning a pregnancy.*

PEAK: *Does this person want to apply for Family Planning Benefits?*

To be considered for this benefit, the member must answer **Yes**. If an applicant answers No, or leaves the question BLANK, they will not be evaluated for the Family Planning Limited Benefit Plan.

Members may be evaluated for this benefit during renewal and will be asked in their renewal packet under each household member, "Does this person want to apply for Family Planning Benefits?"

Why are members and applicants given the option to opt-out or opt-in?

Federal guidance for Family Planning Limited Benefit Plan requires that individuals be given the option, at application, to opt in or out of consideration for the family planning limited benefit Plan category. All applicants will automatically be opted-out to this program unless they have requested to opt-in.

Can an applicant opt out of receiving the Family Planning Limited Benefit Plan?

Yes. They can opt-out of receiving the Family Planning Limited Benefit Plan by selecting "No" to the question on the application that says, "Does this person want to apply for Family Planning Benefit Plan?"

How can people opt-out of the Family Planning Limited Benefit Plan after they have been enrolled?

People already receiving the Family Planning Limited Benefit Plan can request to opt-out at any time one of these ways:

- Online with their PEAK account at Colorado PEAK
    1. Sign in to their PEAK account.
    2. From the landing page, go to the 'Benefits overview' section and find the member's name.
    3. Next to Health First Colorado (Colorado Medicaid), select "End Benefits."
    4. The options are "Opt [NAME} out of Family Planning Benefits" or "Opt [NAME] out of Medical Assistance.
    5. To end the Family Planning benefits, select "Opt [NAME] out of **Family Planning Benefits**.

Note: If "Family Planning" is the only active medical assistance benefit, then ending Family Planning will discontinue their MA.

- Contact their county Department of Human Services to make a verbal request.
- Send a written request to their county Department of Human Services.

Does Family Planning Limited Benefit Plan offer retroactive coverage?

Yes, only if the person receiving the benefit requests retro coverage. Retroactive coverage may be granted during the three months preceding the date of application if eligible. For Family Planning Limited Benefit Plan services, retro coverage is only available to start on July 1, 2022. People in this benefit cannot receive coverage for family planning or family planning-related services before July 1, 2022.

Why are children and older adults enrolled in this program if they didn't ask for these services?

The bill requirements for the Family Planning Limited Benefit Plan services specified no restrictions on any age or gender. Therefore, any age can become eligible for this category. If someone has applied for Medical Assistance, they will first be evaluated for a Medical Assistance category that provides full coverage. If they do not meet the requirements for full coverage, Family Planning Limited Benefits will be active only if they specifically selected on their application that they would like to apply for Family Planning Benefits.

Is Family Planning Limited Benefit Plan available for males as well?

Yes, the Family Planning Limited Benefit Plan has no restrictions on gender.

Is there an age guideline for Family Planning Limited Benefit Plan?

No, the Family Planning Limited Benefit Plan has no restrictions on age.

Is it correct for babies under one year old to be enrolled in Family Planning Limited Benefit Plan?

Children born to Health First Colorado or CHP+ eligible mothers and under a year old are eligible to receive Medicaid or CHP+ Needy Newborn coverage guaranteed until the newborn turns one year old.

If you see newborn members being incorrectly enrolled, please open a help desk ticket on the case to determine where the errors (if any) are. If the newborn was not born to a mother receiving Health First Colorado or CHP+ coverage, and the applicant said Yes that they want to apply for Family Planning benefits on the application, then enrollment in family planning services may be correct. Otherwise, the Family Planning radio button selection should remain blank in CBMS.

Children who are over the MAGI Child income thresholds of 142% of the FPL, but under the CHP+ 260% FPL, may not qualify for CHP+ and have other health insurance, may be placed in the Family Planning limited services category.

Why weren't applicants enrolled in another program versus just the Family Planning Limited Benefit Plan?

For this program to be offered to applicants, the applicant cannot be eligible for a Medical Assistance category that provides full coverage. When applicants run through the eligibility hierarchy, eligibility is evaluated for all other categories before enrolling them into this category.

Can people approved for Family Planning Limited Benefit Plan have other health insurance?

Yes, they are allowed to have other health insurance; Family Planning Limited Benefit Plan will become the secondary or payer of last resort. People do not need to opt-out of Family Planning Services to enroll in other health insurance.

How do people who have Family Planning Limited Benefit Plan qualify for and enroll in other health insurance?

Anyone with the Family Planning Limited Benefit Plan will have their details sent to Connect for Health Colorado so they can start to shop for other insurance.

They can apply for coverage and financial help through Connect for Health Colorado in several ways, such as online, with a local certified expert, by phone, by post mail, or by fax.

For more information on how you can direct people to shop for coverage, visit Connect for Health Colorado.

If someone is approved for the Family Planning Limited Benefit Plan, and CBMS shows a denial for APTC, can they still shop for health insurance through the Marketplace?

Yes. Anyone approved for the Family Planning Limited Benefits Plan can still shop for health insurance through the Marketplace and potentially qualify for an Advanced Premium Tax Credit (APTC). HCPF will send the member an approval Notice of Action (NOA) for Family Planning, which will include information on how they can shop for other health insurance through the Marketplace. CBMS is not designed to calculate APTC amounts, so it will send the member's information to the Marketplace to make a determination. Anyone approved for Family Planning should contact the Marketplace to complete an application, qualify for financial help, and enroll in a health insurance plan.

Do people need to opt-out of the Family Planning Limited Benefit Plan to be evaluated for other Medical Assistance categories?

Because the Family Planning Limited Benefit Plan category is near the end of the medical assistance hierarchy, the applicant has already been evaluated for other categories before determining that they meet this criterion.

If someone decides to opt-out of their Family Planning Services, they will be re-evaluated to determine if they meet eligibility requirements for all other categories. If they are found not eligible for any other medical assistance category, they will receive a termination due to not meeting the eligibility criteria for other programs.

Why is the household size bigger for people who are covered by Family Planning Limited Benefit Plan?

Federal and legislative guidance tells us that we need to count each applicant who is being considered and eligible for the Family Planning Limited Benefit Plan as a household of two. Other household members who are not being considered for Family Planning Limited Benefit Plan will be counted as one in addition to any other household members.

Can people be pregnant and eligible for Family Planning Limited Benefit Plan?

No, the Family Planning Limited Benefit plan is for individuals who are **not** pregnant. If they becomes pregnant, they need to report their pregnancy. When their pregnancy details are updated in CBMS, the member should be re-evaluated into the correct eligibility program based on their change in circumstances.

What happens if the applicant meets Citizenship or Lawful

Presence requirements and selects “yes” on the Emergency Medicaid and Reproductive health question but selects “no” to the family planning benefits?

Eligibility sites are encouraged to contact the applicant to confirm whether they do or do not need Family Planning or Reproductive Health Care services to help determine which services the applicant needs.

If eligibility sites are unable to get in contact with the applicant, the eligibility worker will continue to process the application with the selections made on the application. The eligibility worker will need to complete a case comment on the reason for the outreach and the outcome.

What happens if the applicant does not meet Citizenship or Lawful Presence requirements and selects “no” on the Emergency Medicaid and Reproductive health question but selects “yes” for family planning benefits?

Eligibility sites are encouraged to contact the applicant to confirm whether they do or do not need Family Planning or Reproductive Health Care services to help determine which services the applicant needs.

If eligibility sites are unable to get in contact with the applicant, the eligibility worker will continue to process the application with the selections made on the application. The eligibility worker will need to complete a case comment on the reason for the outreach and the outcome.

Is Presumptive Eligibility (PE) available for Family Planning Limited Benefit Plan?

Yes, applicants can apply for and receive PE for Family Planning. Applicants cannot receive Family Planning limited Benefit Plan PE more than once every 12 months.

Can eligible Family Planning Limited Benefit Plan participants qualify for Medicare Savings Program as a secondary eligibility category?

Yes. They may also qualify for the Medicare Savings Program as a secondary eligibility category. Medicare-eligible members who qualify for the Medicare Savings Program (MSP) with QMB or SLMB category will see the Family Planning Limited Benefits as a primary benefit.

Can those eligible for the Family Planning Limited Benefit Plan qualify for MSP, QMB or SLMB programs as a secondary category?

Applicants must still meet all eligibility criteria, such as income and resources, to receive MSP as a secondary. Check to see if an AIRP packet is being sent out and if it has been returned. If the applicant should be eligible and not enrolling, then a Help Desk ticket must be opened on the case.

Should people remain locked into MSP QMB and SLMB instead of receiving the Family Planning Limited Benefit Plan during the Public Health Emergency (PHE) and COVID-19 Unwind?

Yes, members who completed a renewal during the PHE and were previously on QMB/SLMB remain locked into QMB/SLMB due to COVID logic, even if they meet eligibility criteria for Family Planning services. Members will remain on QMB/SLMB since it is considered a higher benefits category during the PHE *only*.

If members requested Family Planning Limited Benefit Plan and meet all eligibility criteria for QMB/SLMB, and a help desk ticket and request for Family Planning services was added to the case through an MA override, then at the end of the PHE, CBMS will be updated automatically (no user action required) to end-date any MSP overrides completed during the continuous coverage period. The Medical Assistance (MA) override end date will be set to match and align with the case's MA renewal month to ensure members will remain in their applicable MSP override aid code through the end of their case renewal month.

For example, if the case MA renewal is May 2023 the Medical Assistance override end date should be set as May 31, 2023. Once run through the Medical Assistance ex parte process, the individual/cases will be subjected to all rules associated with the Medical Assistance programs and the Medical Assistance renewal process. This process pertains to MSP overrides only.

Why are people locked into Family Planning Limited Benefit Plan during the PHE and COVID-19 Unwind, even if they opt-out?

Opting out of any medical assistance services is not an exception to removing benefits from a member. Members will remain covered unless they have requested that they are no longer seeking assistance, also known as a voluntary termination.

Why does the applicant's household size look bigger when not all household members are passing for Family Planning Limited Benefit Plan services?

Only during the PHE and COVID-19 Unwind, members may be locked into other categories even though they are over income for that specific category. But because that member would have been eligible for Family Planning Limited Benefit Plan even though they are passing for another category, they will still count as a household of two. Other household members who are not being considered for Family Planning Limited Benefits will be counted as one in addition to any other household members.

For example, a family of three received their renewal, and the mom is locked into MAGI Adult, the child is locked into CHP+, and the father is passing for Family Planning Limited Benefit Plan. The household income is $7,000.00 a month. The household size is calculated as a family of 6 because the mom is over income MAGI Adult and the child is over income for CHP+, and they would normally be assessed and determined eligible for Family Planning Limited Benefit Plan services just like the father; however, because of the PHE locking them into the higher benefit categories, they remain in MAGI Adult and CHP+.

Normally, outside of the PHE**, if** the mom was eligible for MAGI adult and the child was eligible for CHP+ eligible, the father would be over income for Family Planning services because the household would be a family of 4 (because only the dad counts as 2).

During the PHE and COVID-19 Unwind, why am I seeing people eligible for Family Planning Limited Benefit Plan as primary with the EMS=C indicator?

People may also qualify for Family Planning Limited Benefit Plan and meet the requirements for the COVID-19-only Medicaid eligibility category for uninsured individuals. Individuals who meet both the COVID-19 only and Family Planning eligibility requirements will have the Family Planning Limited Benefit Plan as primary with the EMS=C indicator. People receiving the optional uninsured COVID-19 group-related Emergency Medicaid Services (EMS=C) will be run through the eligibility hierarchy in the Colorado Benefits Management System (CBMS) at the end of the continuous coverage requirement PHE to determine if they are still eligible for the Family Planning Limited Benefit plan or if they are eligible for another Medical Assistance category. This group will not go through the renewal process.

Why are eligibility sites receiving applications for the Breast Cervical Cancer Program (BCCP) if the BCCP has been approved?

Applicants who applied for BCCP PE had an open case with Family Planning Limited Benefits and had an override completed in CBMS through a help desk ticket. Applicants were placed on BCCP correctly once the override was completed and received a Notice of Action.

Eligibility workers need to review the BCCP application and complete all data entry verifying that all the information on the application is entered into CBMS. Once the data entry is complete, eligibility sites need to run EDBC and reauthorize the case.

Are there any resources I can use that will help me learn about Family Planning Limited Benefit Plan?

Yes, a policy memo is on the HCPF website under “memo series." Trainings are also available.

- **LMS COLearn**
  - Training Materials: CBMS June Build 2022 Webinar Q&A
- **Memo Series**
- **Member New/Updates**

For more information contact

hcpf_maternalchildhealth@state.co.us