Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-23-0039

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

October 30, 2023

Adela Flores-Brennan
Medicaid Director
Colorado Department of Health Care Policy and Financing
Medicaid & Child Health Plan Plus (CHP+)
1570 Grant Street
Denver, CO 80203-1818

Dear Adela Flores-Brennan:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) CO-23-0039, submitted on August 2, 2023, has been approved. Through this SPA, Colorado permanently removes enrollment fees for all CHIP beneficiaries. CO-23-0039 has an effective date of July 1, 2023.

Your title XXI project officer is Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 410-786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

SPA number: CO-23-0039

Purpose of SPA: To clarify that Colorado does not collect enrollment fees or premiums in the CHIP program.

Date Amendment #39 submitted: 08-02-2023
Proposed effective date: 07-01-2023

1.4-TC **Tribal Consultation.** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The State included consultation on this SPA in the tribal consultation log dated August 19, 2022. A copy of the relevant page of the consultation log is attached.

4.3 **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350).

Both initial eligibility and annual renewal eligibility for CHP+ are determined either at the main office or at a decentralized eligibility site.

Applications may be received by mail or by Fax at the central office or during face-to-face interviews at the decentralized sites. Applicants may also complete applications online or drop off paper applications in person during central office business hours.

The State has developed and implemented an eligibility, enrollment, and application tracking system for CHP+. The system uses a sophisticated business rules engine and state-of-the-art secure Internet technologies to reduce the overall cost of administration and increase the speed and accuracy of screening for Medicaid eligibility, determining eligibility for CHP+ and enrolling children into the program.

Current employment income, self-employment income and cash income from other sources reported are used to qualify families with employment or retirement income. Verification of earned income is verified through the Income and Eligibility Verification System (IEVS), which extracts wage information reported by employers to the Colorado Department of Labor and Employment.

ELIGIBILITY DETERMINATION AND RENEWAL

Redetermination of Eligibility

Persons enrolled in CHP+ are enrolled for a period of twelve months. Renewal letters and packets are mailed to families at least 45 days before the day their CHP+ coverage terminates. Reminder letters are mailed to the family 30 days before the end-of-coverage date. Families are encouraged to return their completed renewal application at least 30 days prior to termination to allow continuity of care through their HMO. If the family does not resubmit a complete application by the ending date of coverage, the person's eligibility may still be renewed. The only penalty is interrupted coverage.

At redetermination, renewal requires the same financial documentation as was required at the time of the family's original application. A family will be fully processed for eligibility at each renewal period.

Enrollment in Health Plans All CHIP eligible children and prenatal individuals are enrolled into managed care organizations. At the time of eligibility determination and annually at the time of redetermination, members are notified which MCO they have been passively enrolled into. If the member wants to change MCO enrollment, members who live in service areas with multiple MCOs participating will have 90 days from the effective date of MCO enrollment at the time of eligibility determination and redetermination to contact the Department or its designee in order to select a different MCO. Once a member has selected an MCO or upon expiration of the 90-day period, the enrollee shall remain enrolled in that MCO until the time of redetermination.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1 Limitation on Enrollment. Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42CFR, 457.305(b))

☐ Check here if this section does not apply to your State.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c)).

8.2.1. Premiums: Colorado does not impose premiums or enrollment fees as of July 1, 2022.

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

American Indian/Alaska Natives are exempt from co-payments.

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

A. For families with income, at the time of eligibility determination, less than 101% of the federal poverty level, all copayments shall be waived, except for emergency and urgent/after hours care, which shall be three dollars per use (co-pay is waived if client is admitted to the hospital).

B. For families with income, at the time of eligibility determination, between 101% and 155% of the federal poverty level, the copayment is:
   1. Two dollars per office visit;
   2. Two dollars per outpatient mental health or substance abuse visit;
   3. One dollar per prescription;
   4. Two dollars per physical therapy, occupational therapy, or speech therapy visit;
   5. Two dollars per vision visit;
   6. Three dollars per use of emergency care and urgent/after hours care. (Co-pay is waived if client is admitted to the hospital.)
   7. Two dollars per trip for emergency transport/ambulance.
   8. Two dollars per inpatient hospital visit.
   9. Two dollars per inpatient hospital stay, for physician services in the hospital.
   10. Two dollars per outpatient hospital or ambulatory surgery center visit.

C. For families with income, at the time of eligibility determination, between 156% and 212% of federal poverty level, the copayment is:
   1. Five dollars per office visit;
   2. Five dollars per outpatient mental health or substance abuse visit;
   3. Three dollars per generic prescription;
   4. Ten dollars per brand name prescription;
   5. Five dollars per physical therapy, occupational therapy, or speech therapy visit;
   6. Five dollars per vision visit;
   7. Twenty dollars per use of urgent/after hours care.
   8. Thirty dollars per use of emergency care (co-pay is waived if client is admitted to the hospital.)
   9. Fifteen dollars per trip for emergency transport/ambulance.
   10. Twenty dollars per inpatient hospital visit.
   11. Five dollars per inpatient hospital stay for physician services in the hospital.
   12. Five dollars per outpatient hospital or ambulatory surgery center visit.
   13. Five dollars per date of service for laboratory and imaging services.

D. For families with income, at the time of eligibility determination, between 213% and 259% of federal poverty level, the copayment is:
   1. Ten dollars per office visit;
   2. Ten dollars per outpatient mental health or substance abuse visit;
   3. Five dollars per generic prescription;
   4. Fifteen dollars per brand name prescription;
   5. Ten dollars per physical therapy, occupational therapy, or speech therapy visit;
   6. Ten dollars per vision visit;
   7. Thirty dollars per use of urgent/after hours care.
   8. Fifty dollars per use of emergency care (co-pay is waived if client is admitted to the hospital.)
   9. Twenty-five dollars per trip for emergency transport/ambulance.
   10. Fifty dollars per inpatient hospital visit.
   11. Ten dollars per inpatient hospital stay for physician services in the hospital.
   12. Ten dollars per outpatient hospital or ambulatory surgery center visit.
   13. Ten dollars per date of service for laboratory and imaging services.

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state assures the following:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:

- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

8.3 Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(A)) (42CFR 457.505(b))

The Department worked closely with CHP+ stakeholders before putting forth this proposal to increase copayments. This change has been adopted into rule and was subject to the public rulemaking process. Stakeholders testified in favor of this change because it was a more acceptable alternative to the one put forth by the State Legislature, which would have increased cost sharing over 1000%. After rule adoption, the rules are published in the Colorado Register and posted to the Secretary of State website.

The Department gives CHP+ members and applicants a chart that describes plan options, and copayments based on income and family size.

8.7 Provide a description of the consequences for an enrollee or applicant who does not pay a charge (42CFR 457.570 and 457.505(c)).

Guidance:	Section 8.8.1is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.