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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-24-0041

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

December 18, 2025

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 Director Adela Flores-Brennan:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) CO-24-0041, submitted on June 19, 2024, with additional information submitted on December 18, 2025, has been approved. These updates are effective October 30, 2023.

Through this SPA, the state removes outdated CHIP state plan language to ensure that the plan reflects the state's approved program policies. Specifically, Colorado is removing the following language:

- Eligibility level that was modified through previously approved CHIP SPA CO-13-0015,
- Enrollment fee that was eliminated through previously approved CHIP SPA CO-23-0039, and
- Exception to the continuous eligibility period for children with other health insurance that is no longer permissible.

Your Project Officer is Kristin Pacek. She is available to answer your questions concerning this amendment and other CHIP-related matters and can be reached at Kristin.Pacek@cms.hhs.gov .

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Jessica Stephens/

Jessica Stephens
Acting Deputy Director

SPA #39

Date Amendment #39 Submitted: **August 2, 2023**
Date Amendment #39 Approved: **October 30, 2023**
Date Amendment #39 Effective: **07/01/2023**
Date Amendment #39 Implemented: **07/01/2023**

Effective July 1, 2023, Colorado clarifies that the state does not collect enrollment fees or premiums in its CHIP program.

SPA #40

Date Amendment #40 Submitted: **November 16, 2024**
Date Amendment #40 Approved: **January 15, 2025**
Date Amendment #40 Effective: **January 1, 2025**
Date Amendment #40 Implemented: **January 1, 2025**

SPA CO-24-0040-0002: This SPA implements the From Conception to End of Pregnancy (FCEP) population in CHIP, effective January 1, 2025, and revising the CS27 to reflect FCEP are provided with continuous eligibility.

SPA CO-24-0040-A: This SPA updates the CHIP state plan regarding the FCEP population and implements a new health services initiative to provide postpartum care to mothers whose newborns were previously eligible for FCEP in CHIP.

SPA #41

Date Amendment #41 Submitted: **June 19, 2024**
Date Amendment #41 Approved: **December 18, 2025**
Date Amendment #41 Effective: **October 30, 2023**
Date Amendment #41 Implemented: **October 30, 2023**

Through this SPA, the state removes outdated CHIP state plan language to ensure that the plan reflects the state's approved program policies.

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 ~~08/19/2022~~September 30, 2023. A copy of the relevant page of the consultation log is attached.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

See Attachment 1 for a description of children's insurance status by income and race and ethnicity.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.1005.

4.1.2 ☑ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group: CHP+ is available to children 0 through 18 years of age with family income at or below 2650% FPL.

4.1.2.1-PC ☐ Age:_____through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☑ Income of each separate eligibility group (if applicable): To be eligible, a child must be from a family whose annual income is at or below 2650% of the federal poverty level. Family size and income criteria are described in Attachment 2.

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 ☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 ☑ Residency (so long as residency requirement is not based on length of time in state): A resident is anyone who is: 1) a U.S. citizen; or 2) a documented legal immigrant who has had an Alien Registration Card for 5 years or more and 3) a resident of Colorado. The state accepts self-declaration of residency.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because the child is eligible for Medicaid, not for reasons of disability status.

4.1.7 ☑ Access to or coverage under other health coverage: Both the application and the separate "Insurance Form" ask families questions about other insurance coverage. The plan administration seeks information about all other access to health care coverage, both public and private, on the application form before the child is enrolled in the plan and from providers once the child is determined eligible for the plan. A child will be found ineligible if the child: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) is a member of a family that is eligible for health benefits coverage under a State health benefits plan based on a family members employment with a public agency in the State; or 4) has had coverage under an employer plan with at least a 50% employer contribution during the three months prior to application. The Health Care Program for Children with Special Needs is not considered a private health plan and children covered under this plan may still be covered by CHP+.

If the State finds that a child enrolled in CHP+ is retroactively eligible for Medicaid, the State will notify the family that the child will be disenrolled from CHP+ and enrolled into Medicaid in 10 days. The State may choose to enroll the child into Medicaid sooner than 10 days if the Medicaid benefit package offers necessary services that the CHP+ plan does not cover.

4.1.8 ☑ Duration of eligibility, not to exceed 12 months: Once a child has been accepted, he or she is continuously eligible for one year from the first day of the month of application unless the child moves from the state, turns 19 years old, or becomes eligible for or enrolled in Medicaid., ~~or other private insurance~~.

4.1.9 ☐ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☐ States should specify whether Social Security Numbers (SSN) are required. Social Security Numbers are not required.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility. Children ages 0-18 may be continuously eligible. Once a child has been determined eligible, the child is continuously eligible for one year from the first day of the month of application unless the child moves from the state, turns 19 years old, or becomes eligible for or enrolled in Medicaid., ~~or private health insurance~~.

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

described in 42 CFR 457.342(a) cross-referencing 435.926(d).

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.

Once the State has re-determined eligibility, a letter is sent to households that are above 150% and up to and including 2650% of the FPL to notify them ~~that they owe an enrollment fee and have 30 days from the date of re-determination to submit an enrollment fee. Coverage begins when the State receives the enrollment fee. If the enrollment fee is not submitted by the end of the 30-day period, the client's coverage will end at the end of the redetermination period. Once the client pays the enrollment fee, coverage will resume.~~

During a state or federally-declared disaster and at the state's discretion, the state may implement the following changes to its enrollment and redetermination policies for beneficiaries living and/or working in state or federally-declared disaster areas:

- The state may temporarily use the regulatory timeliness exception for timely processing of CHIP applications under 42 CFR 457.340(d)(1).
- The state may temporarily use the regulatory timeliness exception for timely processing of CHIP renewals under 42 CFR 457.340(d)(1).

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.

~~The applicant must pay the annual enrollment fee in order for the child(ren) to enroll in CHP+.~~ Once the State has determined eligibility (or automatic redetermination has occurred), a letter is sent to households that are above 150% and up to and including 26~~5~~0% of the FPL to notify them. As of July 1, 2022 CHP+ does not require an enrollment fee. ~~that they owe an enrollment fee and have 30 days from the date of determination (or redetermination) to submit an enrollment fee~~. ~~Coverage begins when the State receives the enrollment fee. If the enrollment fee is not submitted by the end of the 30 day period, the client will be denied for non payment and will have to re-apply.~~