THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Applications for Long Term Care Benefits, Section 8.100.
Rule Number:	MSB 10-04-30-A
Division / Contact / Phone:	Client and Community Relations / Eric Stricca / 303-866-4475

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS
SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 10-04-30-A, Revision to the Medical Assistance Rule Concerning Applications for Long Term Care Benefits, Section 8.100.
3. This action is an adoption of: amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.7.D & 8.100.7.B, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert the two new unnumbered paragraphs directly following §8.100.3.B.1 and before §8.100.3.B.2

Please insert two new paragraphs (§8.100.3.C.6, et. al. and §8.100.3.C.7.) directly following current text at §8.100.3.C.5

Please replace current text from §8.100.7.A through §8.100.7.A.7 with new text provided from §8.100.7.A through §8.100.7.A.3; §8.100.7.A

Please replace current text from §8.100.7.B through §8.100.7.B.5 with new text provided from §8.100.7.B through §8.100.7.B.3

Please replace current text from §8.100.7.C.2.c. through §8.100.7.D with new text provided from §8.100.7.C.2.c. through §8.100.7.D.

All other text is provided for clarification only. This change is effective 03/30/2011

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Applications for Long Term Care Benefits, Section 8.100.
Rule Number:	MSB 10-04-30-A
Division / Contact / Phone:	Client and Community Relations / Eric Stricca / 303-866-4475

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 amends 10 C.C.R. 2505-10, Section 8.100.7.D. to remove the requirement that Supplemental Security Income (SSI) or Old Age Pension (OAP) A or B with a SISC code A or B Medicaid recipients must submit an application to be determined eligible to receive Long-Term Care services.

The 1915(c) Waivers define the valid categories of Medicaid for which a client may be eligible to receive the waiver's Home and Community Based Services (HCBS). With the exception of the Children's HCBS Waiver, the valid categories of Medicaid are SSI, Old Age Pension (OAP) A or B and the 300% Special Income group. Clients who receive SSI and OAP A or B Medicaid need only be assessed to meet the level of care for HCBS to receive the services. They do not need to submit an application and are not subject to another financial eligibility determination.

When an SSI or OAP recipient is in need of Long-Term Care Nursing Facility Services, they must be redetermined for eligibility under the 300% Special Income category. A new application is not required, as the need for nursing facility services is only a change in circumstance which requires a redetermination of eligibility for Medicaid. If the client is eligible for both SSI or OAP A or B and the 300% Special Income category, they have the opportunity to accept eligibility for the 300% Special Income group which covers the mandated state plan services as well as the Long-Term Care Nursing Facility Services.

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:

3. Federal authority for the Rule, if any:

Initial Review	**01/14/2011**	Final Adoption	**02/11/2011**
Proposed Effective Date	**04/01/2011**	Emergency Adoption	

DOCUMENT #05

The Federal authority for the proposed rule is located at 42 C.F.R. 435.909 and 435.404 and Section 1915(c) of the Social Security Act.

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2009);

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Applications for Long Term Care Benefits, Section 8.100.
Rule Number:	MSB 10-04-30-A
Division / Contact / Phone:	Client and Community Relations / Eric Stricca / 303-866-4475

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.

   Clients that have already been determined Medicaid eligible under the State Plan categories who are in need of Long-Term Care Home and Community Based Services will benefit from the proposed rule.

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 impact the proposed rule will have is that clients who are already Medicaid eligible will no longer have to submit a new application when in need of Long-Term Care Nursing Facility or Home and Community Based Services. In addition to reducing the administrative costs and time frames at the Eligibility Sites, it will enable the clients to quicker access to the Nursing Facility or Home and Community Based Services.

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.

   At this time it will be a manual process outside of CBMS. Until the change is scheduled to be implemented and placed on the CBMS change pipeline there will be no costs.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Inaction would result in being out of federal compliance and could jeopardize federal match.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   N/A

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.

   N/A

8.100.3.B. Residency Requirements

1. Individuals shall make application in the county in which they live. Individuals held in correctional facilities or who are held in community corrections programs shall apply for the Medical Assistance Program in the county specified as the county of residence upon release. Individuals who reside in a county but who do not reside in a permanent dwelling nor have a fixed mailing address shall be considered eligible for the Medical Assistance Program, provided all other eligibility requirements are met. In no instance shall there be a durational residency requirement imposed upon the applicant, nor shall there be a requirement for the applicant to reside in a permanent dwelling or have a fixed mailing address. If an individual without a permanent dwelling or fixed mailing address is hospitalized, the county where the hospital is located shall be responsible for processing the application to completion. If the individual moves prior to completion of the eligibility determination the origination eligibility site completes the determination and transfers the case as applicable.

   For applicants in Long Term Care institutions

   The county of domicile for all Long Term Care clients is the county in which they are physically located and receiving services.

2. A resident of Colorado is defined as a person that is living within the state of Colorado and considers Colorado to be their place of residence at the time of application. For institutionalized individuals who are incapable of indicating intent as to their state of residence, the state of residence shall be where the institution is located unless that state determines that the individual is a resident of another state, by applying the following criteria:

   a. for any institutionalized individual who is under age 21 or who is age 21 or older and incapable of indicating intent before age 21, the state of residence is that of the individual's parent(s) or legally appointed guardian at the time of placement;

   b. for any institutionalized individual who became incapable of indicating intent at or after age 21, (1) the state of residence is the state in which the person was living when he or she became incapable of indicating intent, or (2) if this cannot be determined, the state of residence is the state in which the person was living when he or she was first determined to be incapable of indicating intent;

   c. upon placement in another state, the new state is the state of residence unless the current state of residence is involved in the placement. If a current state arranged for an individual to be placed in an institution located in another state, the current state shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent;

   d. in the case of conflicting opinions between states, the state of residence is the state where the individual is physically located.

3. For purposes of this section on establishing an individual's state of residence, an individual is considered incapable of indicating intent if:

a. the person has an I.Q. of 49 or less or has a mental age of 7 or less, based on standardized tests as specified in the persons in medical facilities section of this volume;

b. the person is judged legally incompetent; or

c. medical documentation, or other documentation acceptable to the eligibility site, supports a finding that the person is incapable of indicating intent.

4. Residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.

5. A non-resident shall mean a person who considers his/her place of residence to be other than Colorado. Any person who enters the state to receive Medical Assistance or for any other reason is a non-resident, so long as they consider their permanent place of residence to be outside of the state of Colorado.

8.100.3.C. Transferring Requirements

1. When a family or individual moves from one county to another within Colorado, the client shall report the change of address to the eligibility site responsible for the current active Medical Assistance Program case(s). If a household applies in the county in which they live and then moves out of that county during the application determination process, the originating eligibility site shall complete the processing of that application before transferring the case. The originating eligibility site shall electronically transfer the case to the new county of residence in CBMS.

2. The originating eligibility site must notify the receiving eligibility site of the client's transfer of Medical Assistance. The originating eligibility site may notify the receiving eligibility site by telephone that a client has moved to the receiving county. If the family or individual wishes to apply for other types of assistance, they shall submit a new application to the receiving eligibility site.

3. If the household is transferring the current Medical Assistance case, the receiving eligibility site cannot mandate a new application, verification, or an office visit to authorize the transfer. The receiving eligibility site can request copies of specific case documents to be forwarded from the originating eligibility site to verify the data contained in CBMS.

4. If the originating eligibility site closes a case for the discontinuation reason of "unable to locate," the applicant shall reapply at the receiving eligibility site for the Medical Assistance Program.

5. If a case is closed for any other discontinuation reason than "unable to locate" and the client provides appropriate information to overturn the discontinuation with the originating eligibility site, then, upon transfer, the receiving eligibility site shall reopen the case with case comments in CBMS. These actions shall be performed according to timeframes defined by the Department. Please review the Department User Reference Guide for timeframes.

6. When a recipient moves from his/her home to a nursing facility in another county or when a recipient moves from one nursing facility to another in a different county:

a. the initiating eligibility site will transfer the case electronically in the eligibility system to the eligibility site in which the nursing facility is located when the individual is determined eligible; and

b. The following items shall be furnished by the initiating eligibility site to the new eligibility site in hard copy format:

i) 5615 that was sent to the nursing facility indicating the case transfer; and

ii) Identification and citizenship documents; and

iii) The ULTC 100.2.

7. When transferring a case, the initiating eligibility site will send an AP-5615 form to the nursing facility administrator of the new nursing facility showing the date of case closure and the current patient payment at the time of transfer. Should the Medical Assistance Program reimbursement be interrupted, the receiving eligibility site will have the responsibility to process the application and back date the Medical Assistance eligibility date to cover the period of ineligibility.

8.100.7 Long Term Care Medical Assistance Eligibility

8.100.7.A. **Persons in Long-Term Care Institutions or Other Residential Placement ~~Persons in Medical Facilities or Other Residential Placement~~**

1. For Long–Term Care services to be covered in a Long-Term Care institution, a client must be determined eligible under the Institutionalized 300% Special Income category. If the client is already Medicaid eligible, a new application is not required but a redetermination must be performed.

   For a client entering a Long-Term Care Institution from the community, the Eligibility Site must notify the Single Entry Point/Case Management Agency, upon receipt of the application or client request, to schedule the institutional level of care assessment. This is not applicable to a client being discharged from a hospital, nursing facility or Long-Term Home Health.

   For purposes of applying the special income standard for the aged, disabled or blind persons in Long-Term Care Institutions, gross income means income before application of deductions, exemptions or disregards appropriate to the SSI program.

   Medical Assistance will be provided beginning the first day of the month following the month during which a child under the age of 18 ceases to live with his or her parent(s). Once determined to meet the institutional requirement, parental income and resources will cease to be deemed available to the child because the child is institutionalized and not living in the parents' home.

   ~~For the purpose of applying the special income standard for aged, disabled or blind persons in medical facilities, gross income means income before application of any deductions, exemptions or disregards appropriate to the SSI program.~~

2. Eligibility under the Institutionalized 300% Special Income category will be provided to applicants who:

   ~~Medical Assistance shall be provided to an institutionalized adult who meets the following criteria:~~

   a. ~~Has~~ Have attained the age of 65 years or;

   b. Have met the requirements according to the definition of disability or blindness applicable to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) ~~as stated in Title 20 of the Code of Federal Regulations~~; and

   ~~is disabled according to the definition of disability and blindness applicable to Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), as stated in Title 20 of the Code of Federal Regulations. This includes individuals who meet the disability requirement by virtue of age; and~~

   ~~b~~c. Have been institutionalized for at least 30 consecutive days in a Long–Term Care institution. The 30 day consecutive stay may be a combination of days in a hospital, Long–Term Care institution, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE). Supporting documentation must be provided from the beginning of the institutionalized period. The beginning of the institutionalized

period is the first 15 days. This documentation shall include the ULTC 100.2 and/or medical records which must be verified by a physician, hospital, or case manager. If a client dies prior to the 30th day and the supporting documentation was submitted at the beginning of the institutionalized period or prior to the death of the client, whichever is earliest, the client shall be determined to have met the 30 consecutive day requirement.

Once the 30 consecutive days of institutionalization requirement has been met, Medical Assistance benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date.

~~Has been institutionalized for at least 30 consecutive days. The 30 day consecutive stay may be a combination of days in a hospital, Long Term Care institution, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE). Supporting documentation must be provided at the beginning of the institutionalized period. This documentation shall include the ULTC 100.2 and/or medical records which must be verified by a physician, hospital, or case manager. If documentation verifies that the applicant will be institutionalized for 30 consecutive days, and the applicant dies prior to the 30th day, he/she will be eligible for the time of institutionalization.~~

~~Following 30 consecutive days of institutionalization, Medical Assistance benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date.~~

~~c~~d. ~~Is~~ Are in a facility eligible for Medical Assistance Program reimbursement if the individual is in a hospital or Long Term Care institution; and

~~d~~e. ~~Whose~~ Have gross income that does not exceed 300% of the current individual SSI benefit level or;~~.~~

Are in a Long-Term Care institution (excluding hospital) whose gross income exceeds the 300% level and who establishes an income trust in accordance with the rules on income trusts in section 8.100.7 of this volume;

~~This special income standard must be applied for:~~

~~i) A person 65 years of age or older, or disabled or blind receiving care in a hospital, nursing facility, or an HCBS or PACE program or~~

~~ii) A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement.~~

i. This special income standard must be applied for:

1) A person 65 years of age or older, or disabled or blind receiving care in a hospital, nursing facility; or

2) A person who is not SSI eligible needing Long-Term Care from HCBS or PACE;or

3) A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement; and

~~e~~. ~~Is in a Long Term Care institution or in an HCBS or PACE program and whose gross income exceeds the 300% level and who establishes an income trust in accordance with the rules on income trusts in section 8.100.7 of this volume; and~~[e1]

~~f~~g. ~~Whose~~ Have resources that conform with the regulations regarding resource limits and exemptions set forth in section 8.100.5 of this volume; and

h. If married, Income and resources conform to rules set forth at 8.100.7.C and 8.100.7.K; and

~~g~~i. ~~Who has~~Have not transferred assets for less than fair market value on or after the look-back date defined in section 8.100.7.F.2.d. which would incur a penalty period of ineligibility in accordance with the regulations on transfers without fair consideration in section 8.100.7 of this volume;~~.~~ and

~~h~~j. Have ~~Submit~~ submitted trust documents to the Department if the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of trust. The Department shall determine the effect of the trust on Medical Assistance Program eligibility.

~~3. When assistance is provided to an individual who is admitted to a nursing facility on or after January 1, 1981, the county of domicile immediately prior to admission to the nursing facility must be determined. This information is entered into the automated system.~~

~~4. The county of domicile for all Long Term Care clients is the county in which they are physically located and receiving services. The exemption of the principle place of residence remains in affect as long as there is an intent to return to the home and the home has not been transferred in a way that would eliminate the resource exemption. If the home is in another state and there is intent to return then the client is not a Colorado resident. When a Long Term Care client changes counties for the purposes of receiving benefits their case record should be transferred in CBMS to the county where the client is physically residing according to rules located in section 8.100.3 under Transferring Requirements.~~

~~5. When a recipient moves from his/her home to a nursing facility in another county or when a recipient moves from one nursing facility to another in a different county:~~

~~a. the initiating eligibility site will transfer the case electronically in the eligibility system to the eligibility site in which the nursing facility is located when the individual is determined eligible; and~~

~~b. The following items shall be furnished by the initiating eligibility site to the new eligibility site in hard copy format:~~

~~i) 5615 that was sent to the nursing facility indicating the case transfer~~

~~ii) Identification and citizenship documents~~

~~iii) ULTC 100.2~~

6 When transferring a case, the initiating eligibility site will send an AP-5615 form to the nursing facility administrator of the new nursing facility showing the date of case closure and the current patient payment at the time of transfer. Should the Medical Assistance Program reimbursement be interrupted, the receiving eligibility site will have the responsibility to process the application and back date the Medical Assistance eligibility date to cover the period of ineligibility[e2].

7. Medical Assistance must be provided to an institutionalized child less than 18 years of age who:

a. has income and assets that exceed the SSI limits, but whose gross family income does not exceed 300% of the current SSI benefit level; and

i) meets all other SSI program definitions and requirements; and

ii) has been determined to be institutionalized for at least 30 consecutive days The 30-day consecutive stay must be in a medical facility and may be a combination of days in a hospital, Long Term Care institution, or receiving services from a HCBS program as an HCBS recipient. For example, an individual hospitalized on March 10 cannot meet this requirement until April 8. Following 30 consecutive days of institutionalization, Medical Assistance benefits start as of the first day when institutionalization began (March 10 in the example), assuming that all other eligibility requirements were met as of that date; or

b. is determined by the federal Social Security Administration to be SSI eligible because he/she meets all SSI eligibility criteria, including financial, due to the disregard to family income or assets because the child is institutionalized and not living in the parents' home. Medical Assistance will be provided beginning the first day of the month following the month during which the child ceases to live with his or her parent(s).

83. An appeal process is available to children identified by C.R.S. 27-10.3-101 to 108, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Department of Human Services (9 CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to Medical Assistance eligibility

8.100.7.B. Persons Receiving Requesting Long-term Care through Home And Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE)

Individuals determined to be eligible for the Old Age Pension State Only Medical Assistance shall not be eligible for Home & Community Based Services[e3].

1. Medical Assistance mustHCBS or PACE shall be provided to persons who:

a. except for the level of their income would be eligible for SSIare SSI or OAP Medicaid eligible; or;

b. have gross income which does not exceed 300% of the current individual SSI benefit levelare eligible under the Institutionalized 300% Special Income category described at 8.100.7.A; and

c. ~~will receive Home and Community Based Services.~~have been assessed by the Single Entry Point/Case Management Agency to have met the functional level of care and will remain in the community by receiving HCBS or the PACE.

2. A client who is already Medicaid eligible does not need to submit a new application. The client must request the need for Long–Term Care services and the Eligibility Site must redetermine the client's eligibility.

~~For purposes of evaluating resources, the eligibility site must apply the criteria specified in section 8.100.5.~~

~~3. For purposes of applying the 300% of the current individual SSI benefit level, gross income means income before application of any deductions, exemptions, or disregards appropriate to the SSI program. Individuals who are eligible to receive Home and Community Based Services under the 300% income standard are eligible effective from the first day of service provision.~~

~~4. Income and resources of spouses living in the same household for a full calendar month or more must be considered as available to each other, whether or not they are actually contributed, and evaluated in accordance with rules contained in section 8.100.5. The rules in section 8.100.7.K will also apply.~~

~~5~~3. For individuals served in Alternative Care Facilities (ACF), income in excess of the personal needs allowance and room and board amount for the ACF shall be applied to the Medical Assistance charges for ACF services. The total amount allowed for personal need and room and board cannot exceed the State's Old Age Pension Standard.

8.100.7.C. Treatment of Income and Resources for Married Couples

1. The income of a community spouse is not deemed to the institutionalized spouse in determining eligibility. If both spouses are institutionalized, their individual income is counted in determining their own eligibility. The income of one institutionalized spouse is not deemed to the other institutionalized spouse when determining eligibility.

2. The income and resources of both spouses are counted in determining eligibility for either or both spouses with the following exceptions:

   a. If spouses share the same room in an institution, the income of the individual spouse is counted in determining his or her eligibility, and each spouse is allowed the $2000 limit for resources.

   b. Beginning the first month following the month the couple ceases to live together, only the income of the individual spouse is counted in determining his or her eligibility.

   c. If one spouse is applying for ~~Long~~ Long-Term Care in a ~~Long~~ Long-Term Care institution or Home and Community Based Services (HCBS), refer to the rules on Treatment of Income and Resources for Institutionalized Spouses.

3. Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the ~~Long~~ Long-Term Care institution.

4. For living expense purposes, income and resources of spouses living in the same household for a full calendar month or more must be considered as available to each

other, whether or not they are actually contributed, and must be evaluated in accordance with rules contained in 8.100.7.Q.

4. ~~The income limits for eligibility for long-term care~~Long–Term Care ~~in a hospital, Long Term Care institution, Home and Community Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE) are:~~

   a. ~~for an individual who is institutionalized in a hospital or Long Term Care institution or receiving HCBS or PACE for a period of not less than 30 days, the income limit is 300% of the current individual SSI benefit level.~~

   b. ~~for an individual that exceeds 300% of the current individual SSI benefit level but is below the regional average private pay rate for the Long Term Care institution, the individual may become income eligible for Long Term Care by establishing an income trust in accordance with the rules on income trusts in section 8.100.7.E. Income trusts are not valid for establishing income eligibility for hospital care.~~

8.100.7.D. **~~Other groups eligible for Medical Assistance~~ Other Medical Assistance Clients Requesting Long-Term Care in an Institution or through HCBS or PACE**

Clients who need Long-Term Care services who are eligible for the State Only Health Care Program shall submit an application because they are not already Medicaid eligible.

~~Recipients of Supplemental Security Income (SSI) and Old Age Pension (OAP) A or B with a SISC code A or B are eligible for Medical Assistance, not including Long Term Care. For Long Term Care eligibility in a Long Term Care institution or Home and Community Based Services (HCBS), a separate application must be submitted to the eligibility site.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Income Verification §8.100.4.B.
Rule Number:	MSB 10-06-09-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 10-06-09-A, Revision to the Medical Assistance Rule Concerning Medicaid Income Verification §8.100.4.B.
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.4.B., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please revise current text at §8.100.4.B.c with the new text provided. Text at §8.100.4.B.c, unnumbered paragraph three was removed by a vote of the Board and will not be included in the rule text. All other text is provided for clarification purposes only.

This rule change is effective 03/30/2011

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Income Verification §8.100.4.B.
Rule Number:	MSB 10-06-09-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

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).

   Senate Bill 08-161 (25.5-8-109 C.R.S. (2008)) allowed self-declaration of income for families. The Department is now implementing self-declaration of income verified through the Income and Eligibility Verification System (IEVS).

   The proposed language was approved for publication effective October 30, 2010. However, it was subsequently deleted through an administrative error effective November 30, 2010. The proposed rule is being presented in order to reestablish the previously approved language.

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:

3. Federal authority for the Rule, if any:

   42 CFR Part 435.948(a)(1)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-8-101 through 25.5-8-104, C.R.S. (2008);
   Senate Bill 08-161 (25.5-8-109, C.R.S. (2008))

Initial Review	**01/14/2011**	Final Adoption	**02/11/2011**
Proposed Effective Date	**04/01/2011**	Emergency Adoption	

DOCUMENT #

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Income Verification §8.100.4.B.
Rule Number:	MSB 10-06-09-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

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 class of persons that will be affected and benefit from this proposed rule change are Medicaid program clients with work income.

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 population affected by this change will have less burden to provide income documentation. This will also ease administrative burden for eligibility site workers as the process will be automated within CBMS.

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.

There is currently an interface between the Colorado Benefits Management System (CBMS) and the Department of Labor and Employment that runs monthly and returns quarterly wage information for currently eligible Medicaid clients. It did not have the capacity to verify income for Children's Basic Health Plan clients or new applicants that are not currently eligible in CBMS. It also did not have the capacity to automatically interface wage data into CBMS income screens without worker intervention.

CBMS system changes were required to allow wage data updates for all medical assistance clients as well as to automate the process within CBMS. The Department was appropriated $43,901 to implement SB 08-161 for CHP+ and Medicaid.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

This rule is needed to comply with new legislation, Senate Bill 08-161 (25.5-8-109 CRS (2008)).

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

N/A

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.

   N/A

8.100.4.B. Family and Children's Minimal Verification Requirements

1. The particular circumstances of a family will dictate the appropriate documentation needed for a complete application. Documentation to establish that a situational requirement is met is needed only when inadequate or inconsistent information supplied by the caretaker relative warrants securing verification to clarify a question of eligibility.

2. Minimal Verification - The following items shall be verified for all families applying for medical assistance:

   a. A Social Security Number shall be provided for each individual on the application for whom Medical Assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number.

   b. Verification of citizenship and identity as outlined in section 8.100.3 under Citizenship and Identity Requirements.

   c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. ~~shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call.~~If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

      If the applicant is self employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the Colorado Medical Assistance application is sufficient verification of earnings, unless questionable.

      If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer, ~~if the applicant authorizes the telephone call.~~

      Estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

   d. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medical Assistance benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements.

   e. Pregnancy verification, if applicable, and if the pregnancy is not observable. The verification shall be documented according to 8.100.4.G.9.a.

   f. Unearned income may be declared by the client verbally or in writing on the application.

3. Additional Verification - No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

4. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

5. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.

6. The criteria of age, school attendance, and relationship can be declared by the client unless questionable. If questionable, these criteria can be established with information provided from:

    a. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or,

    b. records or statements from sources such as: a court, school, government agency, hospital, or physician.

7. Establishing that a dependent child meets the eligibility criterion of:

    a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;

    b. school attendance, if questionable requires (1) obtaining confirmation from the school by phone or in writing, and (2) documenting the means of verification in the case file and CBMS case comments;

    c. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.