THIS PAGE NOT FOR PUBLICATION

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 13-02-27-A, Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Alternative and Augmentative Communication Devices Benefit Coverage Standard, Section 8.590.2.S
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.590.2.S, 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 new text provided at §8.590.2.S immediately following current text at §8.590.2.R and immediately before §8.590.3. All text indicated in blue is for clarification purposes only and should not be amended. This change is effective 09/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Alternative and Augmentative Communication Devices Benefit Coverage Standard, Section 8.590.2.S
Rule Number:	MSB 13-02-27-A
Division / Contact / Phone:	Pharmacy Unit, Office of Clinical Services / Andrea Skubal / 303-866-2113

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 purpose of this rule is to incorporate by reference the Alternative and Augmentative Communication Device Benefit Coverage Standard, developed through the Benefits Collaborative, into the Durable Medical Equipment section of the Volume 8 rules. The Benefit Coverage Standards were drafted to comply with federal regulations that mandate the Department define sufficient, amount, duration, and scope of the Colorado Medicaid covered services. The purpose of this benefit coverage standard is to achieve the goal of ensuring appropriate utilization as well as statewide equity and consistency in the delivery of services.

   "Incorporation by reference" means that the Benefit Coverage Standards themselves will not be repeated in rule, but are a part of the rule. The incorporation of the Benefit Coverage Standards excludes later amendments to, or editions of, the referenced material, and all referenced materials are available on Colorado Medicaid's Benefits Collaborative Web site. Whenever there is a change to a Benefit Coverage Standard, it must be presented to and adopted by the Medical Services Board before the change is implemented just as the Department must do for any other rule.

   The Benefits Collaborative process does not replace the rule-making process. The Benefits Collaborative process ensures stakeholder engagement and involvement in defining Colorado Medicaid covered services before the policies are presented to the Medical Services Board. All Benefit Coverage Standards developed through the Benefits Collaborative must go before the Medical Services Board, individually, for incorporation by reference.

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.

Initial Review	**07/12/2013**	Final Adoption	**08/09/2013**
Proposed Effective Date	**09/30/2013**	Emergency Adoption	

DOCUMENT #11

Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   and House Bill 12-1184.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Alternative and Augmentative Communication Devices Benefit Coverage Standard, Section 8.590.2.S
Rule Number:	MSB 13-02-27-A
Division / Contact / Phone:	Pharmacy Unit, Office of Clinical Services / Andrea Skubal / 303-866-2113

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 and eligible providers will benefit from defined scope of coverage for alternative and augmentative communication devices where none previously existed. With the anticipated utilization of an alternative option to the AACDs that are currently covered, clients gain increased access to care and the Department estimates cost savings with the addition for coverage. Additional costs are not anticipated as a result of 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.

   Any changes experienced by clients as a result of this rule are a result of clearer coverage standards. Clearly defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria, guidance for service providers, and assurance to the Department that public funds are responsibly allocated. Clarity of available benefits based on individual need using evidence based criteria will ensure that people know what services are appropriate for their needs, simplify access to authorized supports, and will also ensure that that providers are paid for appropriate services. Well defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Additionally, clearly defined benefits will simplify the appeal process for all participants.

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.

   No probable costs are anticipated for the Department or any other state agency as a result of this rule revision. However, total fund cost savings potential has been estimated at $492,000 annually.

   Speech communication devices are a significant cost to the Department. About 13 clients per month receive a communication device, which the Department reimburses at an approximate $6,200 per device. However, tablet computers can be integrated with specialized applications or software to provide similar function at a much lower cost of approximately $800 per client. Although this alternative option will not meet the medical needs for all clients with a

communication-inhibiting condition, input from speech language clinicians suggests up to 80% of the clients who qualify for a communication device will utilize the tablet computer alternative. Cost analysis was adjusted to reflect the adjusted utilization rate for tablet computers and a three-year trend in durable medical equipment expenditures was used in the analysis, which indicated an estimated annual savings of $492,000 in total funds. Further, the Joint Budget Committee approved the addition of the tablet computers as a budget reduction item based on the cost analysis estimates and the Department received legislative authority for implementation in the approval of HB 12-1184.

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

   Inaction or denial of implementation will be consistent with the general trend of increase in DME expenditures unnecessarily. Cost saving could be immediately realized upon approval for implementation. The addition of table computers has been highly anticipated by providers and stakeholders, so the impact of inaction would detrimental to the productivity of the collaborative process.

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

   The approval and implementation of the rule update is not anticipated to be costly or intrusive.

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.

   The Benefit Coverage Standard was developed in a purposeful and targeted manner in response to input from various stakeholder groups and Department staff. Alternative methods would not achieve the goal of this rule.

8.590.2.R. Rental Policy.

1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the Medicaid bulletin. The provider is responsible for all maintenance and repairs as described at 8.590.4.P-Q, until the cap is reached.

2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the client. The provider shall give the client and/or caregiver all applicable information regarding the equipment as described at 8.590.4.C.4. The equipment shall not be under warranty after the rental period ends.

3. The rental period may be interrupted, for a maximum of sixty consecutive days.

4. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a physician, and maintained in the provider file.

5. If the client changes providers, the current rental cap remains in force.

8.590.2.S. DME and Supply Benefit Coverage Standards Incorporated by Reference

All eligible providers of Durable Medical Equipment and Disposable Medical Supplies enrolled in the Colorado Medicaid program shall be in compliance with the following Colorado Medicaid Benefit Coverage Standards, which are hereby incorporated by reference:

1. Alternative and Augmentative Communication Devices (AACD) (approved June 28, 2013). The incorporation of the AACD Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

These Benefit Coverage Standards are available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.590.3 PRIOR AUTHORIZATION

THIS PAGE NOT FOR PUBLICATION

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 13-03-18-A, Revision to the Medical Assistance Rule Concerning Nursing Facility Provider Fees, non-Medicare Patient Days Review, Section 8.443.17.A.4.f
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.443, 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 replace current text at §8.443.17.A.4.f with the new text provided. All text indicated in blue is for clarification purposes only and should not be amended. This change is effective 09/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Provider Fees, non-Medicare Patient Days Review, Section 8.443.17.A.4.f
Rule Number:	MSB 13-03-18-A
Division / Contact / Phone:	Safety Net Section / Matt Haynes / 6305

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).

   8.443.17.A.4.f addresses the review of non-Medicare patient days used in the calculation of the provider fee to be assessed to facilities. The rule currently allows all providers to request a review if their actual days in the fiscal year (FY) differ by more than 5% from the calendar year (CY) days used to calculate the fee. This rule was in conjunction with monthly days reporting at 8.443.17.A.4.e when the program was established. In the first year of the provider fee program, providers were submitting data monthly and the fees and payments were being set contemporaneously. With the passage of Senate Bill (SB) 09-263, the program shifted to a prospective payment system based on historical rather than contemporaneous estimates. With the program now being based on historical data, the data used is actual data. For example, in FY 2013-14 the fee will be calculated using actual non-Medicare days from CY 2012. In FY 2014-15, the fee will be calculated using actual non-Medicare days from CY 2013. Because of this, a provider's actual experience will be captured by the program. The environment that this rule was created to address no longer exists, and as such, the original need that the rule was intended to satisfy is not present. For new facilities, the Department must still use estimated non-Medicare days, and, therefore, the need to review those days still exists. The Department has revised the rule from requiring a provider to request the review to stating that the days will be reviewed for facilities that have estimated non-Medicare days.

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.

3. Federal authority for the Rule, if any:

   42 CFR Section 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   25.5 -6-203, C.R.S. (2012)

Initial Review	**07/12/2013**	Final Adoption	**08/09/2013**
Proposed Effective Date	**09/30/2013**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Provider Fees, non-Medicare Patient Days Review, Section 8.443.17.A.4.f
Rule Number:	MSB 13-03-18-A
Division / Contact / Phone:	Safety Net Section / Matt Haynes / 6305

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.

   Class I Nursing Facilities

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Class I Nursing Facilities that would have previously requested and won approval for reconsideration would now have higher fee amounts in a particular year. However, since fees are matched with federal dollars, overall reimbursement to the class of providers will increase by reducing reconsiderations. New facilities with estimated days that would be subject to review could see either increases or decreases to their fees owed depending on the nature of the variance.

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 are no additional costs to the Department or any anticipated significant effect on state revenues.

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

   The proposed rule will eliminate a significant cause of delay in finalizing the provider fee model.

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

   There are no other methods for achieving the purpose of the proposed rule

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.

   The only method for achieving the purpose of the proposed rule is to make a change to the rule.

8.443.17 PROVIDER FEES

8.443.17.A The state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

1. Each class I nursing facility that is licensed in this State shall pay a fee assessed by the state department.

2. The following nursing facility providers are excluded from the provider fee:

   a. A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services and skilled nursing care on a single, contiguous campus. Assisted living services include assisted living residences as defined in Section 25-27-102 (1.3), C.R.S., or that provide assisted living services on-site, twenty-four hours per day, seven days per week;

   b. A skilled nursing facility owned and operated by the state;

   c. A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and

   d. A facility that has forty-five or fewer licensed beds.

3. To determine the amount of the fee to assess pursuant to this section, the state department shall establish a rate per non-Medicare patient day that is equivalent to a percentage of accrual basis gross revenue (net of contractual allowances) for services provided to patients of all class I nursing facilities licensed in this State. The percentage used to establish the rate must not exceed that allowed by federal law. For the purposes of this section, total annual accrual basis gross revenue does not include charitable contributions or revenues received by a nursing facility that are not related to services provided to nursing facility residents (for example, outpatient revenue).

4. The state department shall calculate the fee to collect from each nursing facility during the July 1 rate-setting process.

   a. Each July 1, the state department will determine the aggregate dollar amount of provider fee funds necessary to pay for the following:

      (i) State department's administrative cost pursuant to 8.443.17.B.1

      (ii) CPS pursuant to 8.443.10.A

      (iii) PASRR pursuant to 8.443.10.B

(iv) Pay for Performance pursuant to 8.443.12

(v) Provider Fee Offset Payment pursuant to 8.443.10.C

(vi) Excess of the statutory limited growth in the general fund pursuant to 8.443.11

(vii) Acuity or case-mix of residents pursuant to 8.443.7.D

b. This calculation will be based on the most current information available at the time of the July 1 rate-setting process.

c. The aggregate dollar amount of provider fee funds necessary will be divided by non-Medicare patient days for all class I nursing facilities to obtain a per day provider fee assessment amount for each of the two following categories:

(i) nursing facilities with 55,000 total patient days or more;

(ii) nursing facilities with less than 55,000 total patient days.

The state department will lower the amount of the provider fee charged to nursing facility providers with 55,000 total patient days or more to meet the requirements of 42 CFR 433.68 (e). In addition, the 55,000 total patient day threshold can be modified to meet the requirements of 42 CFR 433.68 (e).

d. Each facility's annual provider fee amount will be determined by taking the per day provider fee calculated above times the facility's reported annual non-Medicare patient days.

e. Each nursing facility will report annually its total number of days of care provided to non-Medicare residents to the Department of Health Care Policy & Financing. The non-Medicare patient days reported will be from the calendar year prior to the July 1 rate setting process. Providers with less than a full year of non-Medicare patient days data will have their non-Medicare days annualized. New providers with no non-Medicare patient days data will have their non-Medicare days estimated by the Department. The non-Medicare patient days will be used for the provider fee calculation.

f. A facility's non-Medicare patient days will be estimated in order to determine the provider's fee payment if and only if one of the following conditions exist:

A new facility

A facility that will close during the rate year

A facility that has had a change of certification or licensure

The facility will have their non-Medicare patient days estimated for each model year until the facility has 12 months of data for the calendar year preceding the rate year.

If a facility's ~~actual~~ non-Medicare patient days are estimated, and the facility's actual non-Medicare days differ by more than 5% from the prior year estimated~~reported~~ non-Medicare patient days used to determine the provider's fee payment, ~~the facility can request~~ the state department will~~, in writing, to~~ review the facility's provider fee calculation~~. If the state department determines that the facility's actual non-Medicare patient days differ by more than 5% from the facility's non-Medicare patient days used to determine the facility's provider fee~~, and an adjustment to the facility's annual provider fee payment will be made ~~. The facility's annual provider fee will be based on actual non-Medicare patient days rather than reported days in the prior year.~~in the subsequent year.

g. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.

h. The state department shall assess the provider fee on a monthly basis.

i. The fee assessed pursuant to this section is due 30 days after the end of the month for which the fee was assessed.

THIS PAGE NOT FOR PUBLICATION

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 13-05-22-A, Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs/IID) Provider Fee, Section 8.443
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) 8.443.17 and 8.443.20, 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 replace the current title text at §8.443.17 **"Provider Fees"** with the new text provided. Please add a new subsection from §8.443.20 "Class II and Class IV Nursing Facility Provider Fee" through §8.443.20.3.b.iii with new text provided. All text indicated in blue is for clarification purposes only and should not be amended. This change is effective 09/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs/IID) Provider Fee, Section 8.443
Rule Number:	MSB 13-05-22-A
Division / Contact / Phone:	Finance Office / Weston Lander / x.3467

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 (S.B.) 13-167 authorized the Colorado Department of Health Care Policy and Financing (the Department) to assess a service fee on Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The fee is used to generate increased federal matching funds that are used to maintain the continuity and quality of care at these facilities. The fee program was initially established in House Bill 03-1292, which gave the Department of Human Services (DHS) the authority to administer the fee program. Due to the Department's expertise in federal financing programs and role as the State's Medicaid agency, the General Assembly determined that the administration of the fee program would be more appropriately housed within the Department.

   The proposed rule change establishes the fee program as described in S.B. 13-167. The administrative rules change first establishes the fee rate calculation methodology pursuant to S.B. 13-167. The rule change then describes the process for collecting the fee from ICFs/IID. The rule change also delineates the class I nursing facility provider fee from the class II and class IV nursing facility service fee.

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 C.F.R. sections 433.55 and 433.68 (2012)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   S.B. 13-167, 25.5-6-204, C.R.S. (2012)

Initial Review	**07/12/2013**	Final Adoption	**08/09/2013**
Proposed Effective Date	**09/30/2013**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs/IID) Provider Fee, Section 8.443
Rule Number:	MSB 13-05-22-A
Division / Contact / Phone:	Finance Office / Weston Lander / x.3467

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 three ICFs/IID operating in the state will be impacted by this rule change. The rule change will establish the provider fee program under the Department's administration.

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 qualitative impact of the rule change will ensure that ICFs/IID are able to maintain reimbursement rates, which in turn ensures the financial viability of the ICFs/IID, and the ability to provide essential services to some of Colorado's most vulnerable populations.

   Quantitatively, the rule changes will allow the Department to collect approximately $2 million in fees from this class of providers. The fee revenue, in turn, allows the Department to generate $2 million in additional federal matching funds. The cost of the fee is currently an allowable cost for providers, so the cost of the fee is offset by an increase in reimbursement for the facilities. Ultimately the net reimbursement on the facilities is unchanged by the fee.

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 rule changes proposed will allow for the administration of the fee program. The federal matching funds generated by the fee provide approximately $1 million in General Fund savings per year.

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

   The Department must comply with statute. S.B. 13-167 stated that the state board shall adopt rules rule for this program; therefore, rules must be established.

   The benefit of the proposed rule change is to establish the ICF/IID fee program. The fee program saves the state General Fund $1 million per fiscal year by increasing federal matching funds.

If the rule changes are not made, the Department would not be able to collect fees from ICFs/IID. Without the fee, ICF/IID reimbursement would be reduced and the state General Fund would lose the savings it obtains from the increased FFP.

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

   This rule change is the only method through which the provider fee program can be established in compliance with state law.

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.

   The purpose of this rule change can only be achieved by defining the procedures for fee calculation and collection in rule.

8.443.16 STATE-OPERATED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (CLASS IV)

8.443.16.A State-operated intermediate care facilities for the mentally retarded (class IV) shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services. Actual costs will be determined on the basis of information on the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

1. These costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period.

2. Reimbursement to state-operated intermediate care facilities for the mentally retarded shall be adjusted retrospectively at the close of each twelve-month period.

3. The retrospective per diem rate will be calculated as total allowable costs divided by total resident days.

8.443.17 CLASS I NURSING FACILITY PROVIDER FEES

8.443.17.A The state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

8.443.19 PAYMENT FOR OUT OF STATE NURSING FACILITY CARE

8.443.19.A. Payments for out-of-state nursing facility care shall be made to providers when:

1. The nursing facility services are needed because of a medical emergency.

2. The nursing facility services are needed because the resident's health would be endangered if he/she were required to travel to Colorado and the attending physician has certified to such in the resident's medical records.

3. The Department determines, on the notification from the client's primary care physician, the needed medical services or necessary supplementary resources, are not available in Colorado but are available in another state;

    a. The Department's State Utilization Review Contractor may review the appropriateness of care plan and documentation that the resident will demonstrate significant improvement.

8.443.19.B. Where the resident needs rehabilitation services, the resident shall meet all of the following criteria:

1. The resident's medical condition, as documented by the physician, shall be stable to the extent that the resident's primary need is no longer for acute medical care but for intensive, multi-disciplinary rehabilitation care.

2. The resident's disability shall be within 12 months of admission.

8.443.19.C. The out-of-state nursing facility shall send the following to the Department monthly:

1. Problem list and rehabilitation goals;

    a. Treatment plan relative to each rehabilitation goal;

    b. Time frame for goal achievement; and

2. Statement of expected discharge status (e.g., timing and the resident's condition on discharge).

8.443.19.D. Those residents without need for rehabilitation services shall be expected to meet Colorado nursing facility admission requirements as described in 10 C.C.R. 2505-10, Sections 8.402.01-8.402.10 and can be admitted if:

1. It is general practice for residents in a particular locality to use nursing facility services in another state; or

2. The resident of an out-of-state nursing facility has been determined to be eligible for Colorado Medicaid due to his inability to indicate his/her intended state of residence.

8.443.19.E. The out-of-state nursing facility shall:

1. Enroll as a provider in the Colorado Medicaid Program;

2. Submit a copy of the re-certification survey yearly upon completion done by the survey and certification and/or licensure agency in their state;

3. Submit a copy of the following documentation with the claims:

   a. The current Medicaid provider agreement with the state where it is located;

   b. The provider number in the state where it is located; and

   c. Their Medicaid rate, at the time services were rendered, in the state where it is located.

8.443.19.F. Payment shall not exceed 100 percent of audited Medicaid costs as determined by the Department or its designee. Audited costs shall be based on Medicaid costs in the state where the facility is located.

8.443.19.G. If the facility is not a Medicaid participant in the state where it is located, it shall submit to the Department an audited Medicare cost report. The payment shall not exceed 100 percent of audited Medicare costs.

8.443.20 CLASS II AND CLASS IV NURSING FACILITY PROVIDER FEE

8.443.20. A. The Department shall charge and collect provider fees on services provided by all class II and class IV nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees and federal matching funds shall be used to sustain reimbursement for providing medical care under the state's medical assistance program for class II and class IV nursing facility providers.

1. Each class II and class IV nursing facility that is licensed in Colorado shall pay a fee assessed by the Department.

2. To determine the amount of the fee to assess pursuant to this section, the Department shall establish a fee rate on a per patient day basis.

   a. The total annual fees due for class II and class IV nursing facilities will be calculated such that they do not exceed the federal limits as established in with 42 C.F.R. § 433.68(f)(3)(i)(A), or five percent of the total costs for all class II and class IV nursing facilities, whichever is lower.

~~42 C.F.R. § 433.68(f)(3)(i)(A) [2013] is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203-1818. Any material that has been incorporated by~~

~~reference in this rule may be examined in any state publications repository library.~~

42 C.F.R. § 433.68(f)(3)(i)(A) [2013] is hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of incorporated tests for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203-1818.

b. The total annual fees will be divided by annual patient days for class II and class IV facilities from the most recently available MED-13 cost reports to establish the per patient day fee.

c. The Department may use estimated patient days in the per patient day fee calculation to adjust for expected changes in utilization.

d. When final audited MED-13 cost reports are available, the Department will review the fees charged during each state fiscal year to ensure that the fee amount was less than five percent of the total costs for all class II and class IV nursing facilities five percent statutory limit. If the fees were greater than five percent of the total costs for all class II and class IV nursing facilities, the Department will retroactively adjust the fees.

3. The Department shall calculate the fee to collect from each class II and class IV nursing facility by August 1 for the state fiscal year.

a. The Department shall notify the providers of their fee obligation in writing at least 30 days prior to due date of the fee.

b. The Department shall assess the provider fee on a ~~quarterly~~ monthly ~~-~~basis.

i. Each facility's annual provider fee amount will be divided by ~~four~~twelve to determine the facility's ~~quarterly~~monthly amount owed to the Department.

ii. The ~~quarterly~~monthly fee is due by last day of the ~~quarter~~month for which the fee was assessed.

iii. Fees may be paid through intragovernmental transfer, Automated Clearing House, or check.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Rules pursuant to changes set forth in the Patient Protection and Affordable Care Act of 2010, affecting Sections 8.100.1-8.100.6
Rule Number:	MSB 13-04-10-A
Division / Contact / Phone:	Eligibility / Chad Anderson / 3805

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 13-04-10-A , Revisions to the Medicaid Eligibility Rules pursuant to changes set forth in the Patient Protection and Affordable Care Act of 2010, affecting Sections 8.100.1-8.100.6
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.1 through 8.100.6, 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)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please delete all current text at §8.100.1, 8.100.2, 8.100.3, 8.100.4, 8.100.5 and 8.100.6 replace with the new text provided. This change is effective 11/01/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Rules pursuant to changes set forth in the Patient Protection and Affordable Care Act of 2010, affecting Sections 8.100.1-8.100.6
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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 CCR 2505-10 Sections 8.100.1, 8.100.2, 8.100.3, 8.100.4, 8.100.5 and 8.100.6 to incorporate eligibility rule changes pursuant to the passage and implementation of the Affordable Care Act (ACA). The ACA introduced several new regulations that did not previously exist for determining financial eligibility and household composition, especially within the former Family and Children's Medical Assistance at Section 8.100.4. New regulations based around the IRS calculation for Modified Adjusted Gross Income include significant changes, deletions and rewritten paragraphs and subsections in 8.100.4. Section 8.100.1 has had several deletions of obsolete definitions and also includes new additions pursuant to the law. The legal basis at 8.100.2 was augmented by adding reference to the ACA; some of the requirements in 8.100.3 were moved to 8.100.5 as some no longer generally apply to the new MAGI coverage groups.

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:

   The Patient Protection and Affordable Care Act of 2010, Public Law 111-148, Sections 2001, 2002 and 2201; Public Law 111-148, Patient Protection and Affordable Care Act, Sections 2001, 2002 and 2201; 1902(a)(10)(E)(iii) of the Social Securty Act, and 42 CFR 435.110, 435.116, 435.118, 435.119, 435.4, 435.603, 435.949, 435.956 and 435.1200.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   Language for Colorado State Statutes is pending.

Initial Review	**06/14/2013**	Final Adoption	**08/09/2013**
Proposed Effective Date	**09/30/2013**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Rules pursuant to changes set forth in the Patient Protection and Affordable Care Act of 2010, affecting Sections 8.100.1-8.100.6
Rule Number:	MSB 13-04-10-A
Division / Contact / Phone:	Eligibility / Chad Anderson / 3805

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 rule will affect new and current recipients of what has been known as Family and Children's Medicaid, as well as affecting non-disabled Adults without dependent children whose income is under 133% FPL, as these are the groups with the biggest changes to their eligibility policy. Some of the changes in household income and household composition may affect the eligibility of some current Family Medicaid recipients, but the ACA outlines coordination efforts between Medicaid and the Health Benefit Exchange to ensure continuity of coverage.

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 expansion of categorical and financial eligibility will increase Medicaid program case loads, providing access to care for many Coloradans not currently insured. This will drive both operational and financial impacts. Increased access to health care is associated with improved health outcomes for clients as well as lower levels of uncompensated services for providers. Coverage under the Medicaid Program will allow clients to satisfy personal coverage mandates required by the Affordable Care Act. Also, there will be a number of cases whose household members are split between Medicaid and the state health insurance exchange, so cooperation between the Department and the exchange will be essential.

   The Department estimates 61,368 clients in FY 2013-14 and an additional 100,065 clients in FY 2014-15 will be eligible under the expansion.

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 estimates a total funds impact of approximately $303 million in FY 2013-14 and $893 million in FY 2014-15 for physical and mental health service costs for clients gaining eligibility through the expansion of eligibility under the Affordable Care Act. All but approximately $2 million of these totals is federal funding.

Additional administrative expenditures are anticipated for implementation of SB 13-200. However, while related to the proposed eligibility changes, these expenditures are not limited to the scope of the MSB 13-04-10-A. Refer to the SB 13-200 fiscal note for further detail.

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

   The Department is implementing these rule changes pursuant to the Patient Protection and Affordable Care Act, Public Law 111-148. The proposed rule changes are necessary to comply with federal and pending state statutory requirements; inaction is not an option.

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

   The proposed rule changes are necessary for compliance with the Affordable Care Act and pending state statutory requirements. There are no less costly or less intrusive methods for implementing the federal law.

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 achieving implementation of the federal law. While the federal government has provided some state options with regard to the Medicaid expansion, Colorado is moving forward to implement the full rule using guidance from the Centers for Medicaid and Medicare Services.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.100

10 CCR 2505-10 8.100

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1. Definitions

300% Institutionalized Special Income Group is a Medical Assistance category that provides Long-Term Care Services to aged or disabled individuals.

1619b is section 1619b of the Social Security Act which allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medical Assistance coverage after they return to work.

~~1931 Medical Assistance is a Medical Assistance category for families, qualified pregnant women and children with limited income provided under section 1931 of Title XIX of the Social Security Act.~~

AB - Aid to the Blind is a program which provides financial assistance to low-income blind persons.

ABD - Aged, Blind and Disabled Medical Assistance is a group of Medical Assistance categories for individuals that have been deemed to be aged, blind, or disabled by the Social Security Administration or the Department.

Adult MAGI Medical Assistance group provides Medical Assistance to eligible adults from the age of 19 through the end of the month that the individual turns 65, who do not receive or who are ineligible for Medicare.

AND - Aid to Needy Disabled is a program which provides financial assistance to low-income persons over age 18 who have a total disability which is expected to last six months or longer and prevents them from working.

AFDC - Aid to Families with Dependent Children is the Title IV federal assistance program in effect from 1935 to 1997 which was administered by the United States Department of Health and Human Services. This program provided financial assistance to children whose families had low or no income.

AP-5615 is the form used to determine the patient payment for clients in nursing facilities receiving Long Term Care.

Alien is a person who was not born in the United States and who is not a naturalized citizen.

Ambulatory Services is any medical care delivered on an outpatient basis.

Annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years.

Applicant is ~~a person~~an individual who ~~has submitted~~is seeking an eligibility determination for Medical Assistance through the submission of an application ~~for public benefits~~.

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

Application for Public Assistance is the designated application used to determine eligibility for financial assistance. It can also be used to determine eligibility for ~~medical assistance~~Medical Assistance.

~~AwDC - Adults without Dependent Children is a category of Medical Assistance for adults who are at least age 19 but less than 65 years without Medicaid eligible dependent children living in the client's household.~~

~~AwDC Randomized Member Selection Process is the process to randomly select clients on the AwDC waitlist to be enrolled within the AwDC program.~~

~~AwDC Waitlist - Adults without Dependent Children Waitlist is a list of persons who have been determined eligible for the Adults without Dependent Children category of Medical Assistance but who cannot be approved for the category as the maximum limit for enrollment has been reached.~~

Blindness is defined in this volume as the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

Burial Trusts are irrevocable pre-need funeral agreements with a funeral director or other entity to meet the expenses associated with burial for Medical Assistance applicants/recipients. The agreement can include burial spaces as well as the services of the funeral director.

Caretaker Relative is any relation by blood, marriage or adoption who is within the fifth degree of kinship to the dependent child, such as: a parent; a brother, sister, uncle, aunt, first cousin, first cousin once removed, nephew, niece, or persons of preceding generations denoted by prefixes of grand, great, great great, or great-great-great; a spouse of any person included in the above groups even after the marriage is terminated by death or divorce; or stepparent, stepbrother, stepsister, step-aunt, etc.

Case management services are services provided by community mental health centers, clinics, community centered boards, and EPSDT case managers to assist in providing services to Medical Assistance clients in gaining access to needed medical, social, educational and other services.

Cash surrender value is the amount the insurer will pay to the owner upon cancellation of the policy before the death of the insured or before maturity of the policy.

Categorically eligible means persons who are eligible for Medical Assistance due to their eligibility for one or more Federal categories of public assistance.

CBMS - Colorado Benefits Management System is the computer system that determines an applicant's eligibility for public assistance in the state of Colorado.

CDHS -Colorado Department of Human Services is the state department responsible for administering the social service and financial assistance programs for Colorado.

Children MAGI Medical Assistance group provides Medical Assistance coverage to tax dependents or otherwise eligible applicants through the end of the month that the individual turns 19 years old.

Child Support Services is a CDHS program that assures that all children receive financial and medical support from each parent. This is accomplished by locating each parent, establishing paternity and support obligations, and enforcing those obligations.

Citizen is a person who was born in the United States or who has been naturalized.

Client is a person who is eligible for the Medical Assistance Program. "Client" is used interchangeably with "recipient" when the person is eligible for the program.

CMS - Centers for Medicare and Medicaid Services is the Federal agency within the US Department of Health and Human Services that partners with the states to administer Medicaid and CHP+ via State Plans in effect for each State. Colorado is in Region VIII.

CHP+ - Child Health Plan Plus is low-cost health insurance for Colorado's uninsured children and pregnant women. CHP+ is public health insurance for children and pregnant women who earn too much to qualify for The Medical Assistance Program, but cannot afford private health insurance.

~~Colorado Medical Assistance application is the designated application for Medical Assistance Programs and the CHP+ Program.~~

COLA - Cost of Living Adjustment is an annual increase in the dollar value of benefits made automatically by the United States Department of Health and Human Services or the state in OASDI, SSI and OAP cases to account for rises in the cost of living due to inflation.

Colorado State Plan is a written statement which describes the purpose, nature, and scope of the Colorado's Medical Assistance Program. The Plan is submitted to the CMS and assures that the program is administered consistently within specific requirements set forth in both the Social Security Act and the Code of Federal Regulations (CFR) in order for a state to be eligible for Federal Financial Participation (FFP).

Common Law Marriage is legally recognized as a marriage in the State of Colorado under certain circumstances even though no legally recognized marriage ceremony is performed or civil marriage contract is executed. Individuals declaring or publicly holding themselves out as a married couple through verbal or written methods may be recognized as legally married under state law. C.R.S. § 14-2-104(3~~)~~).

Community Centered Boards are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Community Spouse is the spouse of an institutionalized spouse.

Community Spouse Resource Allowance is the amount of resources that the Medical Assistance regulations permit the spouse staying at home to retain.

Complete application means an application in which all questions have been answered, which is signed, and for which all required verifications have been submitted.

The Department is defined in this volume as the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Child Health Plan Plus programs as well as other State-funded health care programs.

Dependent child is defined in this volume as a child under the age of 19 residing in the home ~~under the age of 18~~ or between the ages of 18 and 19 who is a full time student in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19.

Dependent relative for purposes of this rule is defined as one who is claimed as a dependent by an applicant for federal income tax purposes.

Disability means the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of l2 months or more.

Dual eligible clients are Medicare beneficiaries who are also eligible for Medical Assistance.

Earned Income is defined for purposes of this volume as any compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

Earned Income Disregards are the allowable deductions and exclusions subtracted from the gross earnings. Income disregards vary in amount and type, depending on the category of assistance.

Electronic data source is an interface established with a federal or state agency, commercial entity, or other data sources obtained through data sharing agreements to verify data used in determining eligibility. The active interfaces are identified in the Department's verification plan submitted to CMS.

Eligibility site is defined in this volume as a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

Employed means that an individual has earned income and is working part time, full time or is self-employed, and has proof of employment. Volunteer or in-kind work is not considered employment.

EPSDT- Early Periodic Screening, Diagnosis and Treatment is the child health component of the Medical Assistance Program. It is required in every state and is designed to improve the health of low-income children by financing appropriate, medically necessary services and providing outreach and case management services for all eligible individuals.

Equity value is the fair market value of land or other asset less any encumbrances.

Ex Parte Review is an administrative review of eligibility during a redetermination period in lieu of performing a redetermination from the client. This administrative review is performed by verifying current information obtained from another current aid program.

Face value of a life insurance policy is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or other special provisions.

Fair market value is the average price a similar property will sell for on the open market to a private individual in the particular geographic area involved. Also, the price at which the property would change hands between a willing buyer and a willing seller, neither being under any pressure to buy or to sell and both having reasonable knowledge of relevant facts.

~~Family and Children's Medical Assistance is a group of Medical Assistance categories that provides medical coverage for children, adults with dependent children, and pregnant women.~~

FBR - The Federal Benefit Rate is the monthly Supplemental Security Income payment amount for a single individual or a couple. The FBR is used by the Aged, Blind and Disabled Medical Assistance Programs as the eligibility income limits.

FFP - Federal Financial Participation as defined in this volume is the amount or percentage of funds provided by the Federal Government to administer the Colorado Medical Assistance Program.

FPL - Federal Poverty Level is a simplified version of the federal poverty thresholds used to determine financial eligibility for assistance programs. The thresholds are issued each year in the Federal Register by the Department of Health and Human Services (HHS).

Good Cause is the client's justification for needing additional time due to extenuating circumstances, usually used when extending deadlines for submittal of required documentation.

Good Cause for child support is the specific process and criteria that can be applied when a client is refusing to cooperate in the establishment of paternity or establishment and enforcement of a child support order due to extenuating circumstances.

HCBS are Home and Community Based Services are also referred to as "waiver programs". HCBS provides services beyond those covered by the Medical Assistance Program that enable individuals to remain in a community setting rather than being admitted to a Long-Term Care institution.

~~Immediate family includes the individual's spouse, minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those persons, regardless of dependency or whether they are living in the applicant's/client's household.~~

Inpatient is an individual who has been admitted to a medical institution on recommendation of a physician or dentist and who receives room, board and professional services for 24 hours or longer, or is expected to receive these services for 24 hours or longer.

Institution is an establishment that furnishes, in single or multiple facilities, food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

Institutionalization is the commitment of a patient to a health care facility for treatment.

An institutionalized individual is one who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Institutionalized Spouse is a Medicaid eligible client who begins a stay in a medical institution or nursing facility on or after September 30, 1989, or is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or receives Home and Community Based Services (HCBS) on or after July 1, 1999; and is married to a spouse who is not in a medical institution or nursing facility. An institutionalized spouse does not include any such individual who is not likely to be in a medical institution or nursing facility or to receive HCBS or PACE for at least 30 consecutive days. Irrevocable means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than outlined in the document.

Insurance Affordability Program (IAP) refers to Medicaid, Child Health Plan *Plus* (CHP+), and premium and cost-sharing assistance for purchasing private health insurance through state insurance marketplace.

Legal Immigrant is an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the immigration and naturalization service as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the immigration and naturalization service.

Legal Immigrant Prenatal is a medical program that provides medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.

Limited Disability for the Medicaid Buy-In Program for Working Adults with Disabilities means that an individual has a disability that would meet the definition of disability under SSA without regard to Substantial Gainful Activity (SGA).

Long-Term Care is Medical Assistance services that provides nursing-home care, home-health care, personal or adult day care for individuals aged at least 65 years or with a chronic or disabling condition.

Long-Term Care institution means class I nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR) and swing bed facilities. Long-Term Care institutions can include hospitals.

Managed care system is a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care.

Medical Assistance is defined as all medical programs administered by the Department of Health Care Policy and Financing. Medical Assistance/Medicaid joint state/federal health benefits program for individuals and families with low income and resources. It is an entitlement program that is jointly funded by the states and federal government and administered by the state. This program provides for payment of all or part of the cost of care for medical services.

Medical Assistance Required Household is defined for purposes of this volume as all parents or caretaker relatives, spouses, and dependent children residing in the same home.

Minimal verification is defined in this volume as the minimum amount of information needed to process an application for benefits. No other verification can be requested from clients unless the information provided is questionable or inconsistent.

MMMNA - Minimum Monthly Maintenance Needs Allowance is the calculation used to determine the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

Modified Adjusted Gross Income (MAGI) refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act. These MAGI groups include Parents and Caretaker Relatives, Pregnant

Women, Children, and Adults. For a more complete description of the MAGI categories and pursuant rules, please refer to section 8.100.4.

MIA - Monthly Income Allowance is the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MSP - Medicare Savings Program is a Medical Assistance Program to assist in the payment of Medicare premium, coinsurance and deductible amounts. There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLIMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals – 1 (QI-1s).

Non-Filer is an individual who neither files a tax return nor is claimed as a tax dependent. For a more complete description of how household composition is determined for the MAGI Medical Assistance groups, please refer to the MAGI household composition section at 8.100.4.E.

Nursing Facility is a facility or distinct part of a facility which is maintained primarily for the care and treatment of inpatients under the direction of a physician. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour basis.

OAP - Old Age Pension is a financial assistance program for low income adults age 60 or older.

OASDI - Old Age, Survivors and Disability insurance is the official term Social Security uses for Social Security Act Title II benefits including retirement, survivors, and disability. This does not include SSI payments.

Outpatient is a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment. Is a patient who does not require admittance to a facility to receive medical services.

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Parent and Caretaker Relative is a MAGI Medical Assistance group that provides Medical Assistance to adults who are parents or Caretaker Relatives of dependent children.

Patient is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

PEAK – the Colorado Program Eligibility and Application Kit is a web-based portal used to apply for public assistance benefits in the State of Colorado, including Medical Assistance.

PNA - Personal Needs Allowance means moneys received by any person admitted to a nursing care facility or Long-Term Care Institution which are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by a Federal or state program.

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 185% FPL, including women who are 60 days post-partum.

Premium means the monthly amount an individual pays to participate in a Medicaid Buy-In Program.

~~Proportionate Share is the income attributed to or counted for each individual member of a household based on the individual's own income plus the equal share of income from the biological or adoptive parent or spouse as defined by the legal or biological relationship between members of a Family Medical Assistance household.~~

Provider is any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding a current valid license or certificate to provide such services or to dispense such goods.

Psychiatric facility is a facility that is licensed as a residential care facility or hospital and that provides inpatient psychiatric services for individuals under the direction of a licensed physician.

Public Institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Questionable is defined as inconsistent or contradictory tangible information, statements, documents, or file records.

Reasonable Compatibility refers to an allowable difference or discrepancy between the income an applicant self attests and the amount of income reported by an electronic data source. For a more complete description of how reasonable compatibility is used to determine an applicant's financial eligibility for Medical Assistance, please refer to the MAGI Income section at 8.100.4.C

Reasonable Explanation refers to the opportunity afforded an applicant to explain a discrepancy between self-attested income and income as reported by an electronic data source, when the difference is above the threshold percentage for reasonable compatibility.

Recipient is any person who has been determined eligible to receive benefits.

Resident is any individual who is living within the state and considers the state as their place of residence. Residents include any unempancipated child whose parent or other person exercising custody lives within the state.

RRB - Railroad Retirement Benefits is a benefit program under Federal law 45 U.S.C.A. § 231 et seq that became effective in 1935. It provides retirement benefits to retired railroad workers and families from a special fund, which is separate from the social security fund.

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a GED.

SGA – Substantial Gainful Activity is defined by the Social Security Administration. SGA is the term used to describe a level of work activity and earnings. Work is "substantial" if it involves performance of significant physical or mental activities or a combination of both, which are productive in nature. For work activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be substantial gainful activity. "Gainful" work activity is work performed for pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

Single Entry Point Agency means the organization selected to provide case management functions for persons in need of Long-Term Care services within a Single Entry Point District.

Single Streamlined Application or "SSAp" is the general application for health assistance benefits through which applicants will be screened for Medical Assistance programs including Medicaid, CHP+, or premium and cost-sharing assistance for purchasing private health insurance through a state insurance marketplace.

SISC- Supplemental Income Status Codes are system codes used to distinguish the different types of state supplementary benefits (such as OAP) a recipient may receive. Supplemental Income Status Codes determine the FFP for benefits paid on behalf of groups covered under the Medical Assistance program.

SSA - Social Security Administration is an agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits.

SSI - Supplemental Security Income is a Federal income supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind or disabled individuals with little or no income and resources.

SSI eligible means eligible to receive Supplemental Security Income under Title XVI of the Social Security Act, and may or may not be receiving the monetary payment.

TANF - Temporary assistance to needy families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. The program began on July 1, 1997, and succeeded the Aid to Families with Dependent Children program. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

Tax Dependent is anyone expected to be claimed as a dependent by a Tax Filer.

Tax-Filer is an individual, head of household or married couple who is required to and who files a personal income tax return.

Third Party is an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of ~~medical assistance~~Medical Assistance.

Title XIX is the portion of the federal Social Security Act which authorizes a joint federal/state Medicaid program. Title XIX contains federal regulations governing the Medicaid program.

TMA - Transitional Medical Assistance is a Medical Assistance category for families that lost ~~1931~~ Medical Assistance coverage due to increased earned income or loss of earned income disregards.

ULTC 100.2 is an assessment tool used to determine level of functional limitation and eligibility for Long-Term Care services in Colorado.

Unearned ~~Income is defined for purposes of this volume as any~~ income is the gross amount received in cash or kind that is not earned from ~~sources other than~~ employment or self-employment.

VA - Veterans Affairs is The Department of Veterans Affairs which provides patient care and Federal benefits to veterans and their dependents.

8.100.2 Legal Basis

Constitution of Colorado, Article XXIV, Old Age Pensions, section 7, established a health and medical care fund for persons who qualify to receive old age pensions.

Colorado Revised Statutes, Title ~~26~~25.5, Article 4, Colorado Medical Assistance Act, section 102, provides for a program of ~~medical assistance~~Medical Assistance for individuals and families, whose income and resources are insufficient to meet the costs of necessary medical care and services, to be administered in cooperation with the federal government.

The Social Security Act, Title XIX, Grants to States for Medical Assistance Programs, and the consequent Federal regulations, Title 42, CFR (Code of Federal Regulations), Chapter IV, Subchapter C, set forth the conditions for states to obtain Federal Financial Participation in ~~medical assistance~~Medical Assistance expenditures.

Under the Colorado Medical Assistance Program, the Medicaid program provides coverage of certain groups specified in Title XIX of the Social Security Act. The OAP State Only Medical Assistance Program provides coverage to certain old age pension clients entitled to health and medical care under the Colorado Constitution.

The Department of Health Care Policy and Financing is the single State agency designated to administer the Colorado Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes. The Office of Medical Assistance of the Department is delegated the duties and responsibilities for administration of the Colorado Medical Assistance Program.

8.100.3.- Medical Assistance General Eligibility Requirements [Eff. 03/30/2009]

8.100.3.A. Application Requirements

1. The eligibility site shall advise individuals concerning the benefits of the Medical Assistance Program and determine and redetermine eligibility for Medical Assistance in accordance with rules and regulations of the Department. A person who is applying for the Medical Assistance Program or a client who is determined ineligible for the Medical Assistance Program in one category shall be evaluated under all other categories of eligibility. There is no time limit for Medical Assistance coverage as long as the client remains categorically eligible.

2. If the applicant applied for Medical Assistance on the Single Streamlined Application and was found ineligible, this application shall be reviewed for all other Medical Assistance eligibility programs, the Child Health Plan Plus (CHP+) program and premium and cost-sharing assistance for purchasing private health insurance through the state insurance marketplace.

    a. The application data and verifications shall be automatically transferred to the state insurance marketplace through a system interface when applicants are found ineligible for Medical Assistance eligibility programs.

3. The applicant must sign the application form, give declaration in lieu of a signature by telephone, or may opt to use an electronic signature in order to receive Medical Assistance.

4. Persons applying to the eligibility site for assistance need complete only one application form to apply for both Medical Assistance and Financial Assistance under the Federal or State Financial Assistance Programs administered in the county. The application will be the Application for Public Assistance.

5. If an applicant is found to be ineligible for a particular program, the Application for Public Assistance shall be reviewed and processed for other financial programs the household has requested on the Application for Public Assistance and all other Medical Assistance Programs. ~~3. The applicant must sign the application form in order to receive Medical Assistance.~~

~~4~~Referrals to other community agencies and organizations shall be made for the applicant whenever available or requested.

6. If the applicant is not able to participate in the completion of the application forms due to physical or mental incapacity, the spouse, other relative, friend, or representative may complete the forms. When no such person is available to assist in these situations, the eligibility site shall assist the applicant in the completion of the necessary forms. This type of situation should be identified clearly in the case record ~~and CBMS case comments~~.

~~5~~7. For the purpose of Medical Assistance, when an applicant is incompetent or incapacitated and unable to sign an application, or in case of death of the applicant, the application shall be signed by someone acting responsibly on behalf of the applicant either:

a. A parent, or other specified relative, or legally appointed guardian or conservator, or

b. For a person in a medical institution for whom none of the above in A are available, an authorized official of the institution may sign the application.

~~6. The eligibility site has the responsibility to assure that the specified relative or representative receives information regarding program benefits and requirements applicable to the family member(s), but the eligibility site can make no restrictions regarding which family member(s) on whose behalf the specified relative or representative may request assistance.~~

~~7~~8. Any family member or specified representative may submit an application and request assistance on behalf of an applicant.

9. Application interviews or requested visits to the eligibility site for Medical Assistance shall not be required. All correspondence may ~~be done~~occur by mail, email or telephone.

10. ~~8. Eligibility~~During normal business hours, eligibility sites shall not restrict the hours in which applicants may file an application. ~~An applicant may file an application at any time during normal business hours.~~ The eligibility site must afford any individual wishing to do so the opportunity to apply for Medical Assistance without delay.

11. ~~9. If an applicant is found to be ineligible for a particular program, the Application for Assistance shall be reviewed and processed for other financial programs the household has requested on the Application for Assistance and all other Medical Assistance Programs.~~ Each person's household composition shall be calculated separately under the MAGI category rules. Each MAGI Medical Assistance~~Referrals to other community agencies and organizations shall be made for the applicant whenever available or requested. 10. If the applicant applied for the Medical Assistance Program on the Colorado Medical Assistance application and was found ineligible, this application shall be reviewed for all other Medical Assistance eligibility programs and the Child Health Plan Plus (CHP+) program.~~

~~11. Persons required to be in the same Medical Assistance required household shall file for the Medical Assistance Program as one assistance unit. Each Medical Assistance Required~~Household shall be budgeted using the appropriate need standard/income level for that unit. See section 8.100.4.~~C~~E for more information on ~~required~~MAGI household ~~members~~composition.

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.

a. 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.

8.100.3.D. Processing Requirements

1. The eligibility site shall process ~~an~~a single streamlined application for Medical Assistance Program benefits within the following deadlines:

   a. 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.

   b. 45 days for all other Medical Assistance Program applicants.

   c. The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.

   d. In unusual circumstances, documented in the case record and in CBMS case comments, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or an administrative or other emergency beyond the agency's control.

2. Upon request, applicants will be given an extension of time within the application processing timeframe to submit requested verification. Applicants may request an extension of time

beyond the application processing timeframe to obtain necessary verification. The extension may be granted at the eligibility site's discretion. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

3. The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.

4. For clients who apply for the Medical Assistance Program and a disability determination is required, the eligibility site shall send a notice informing the applicant of the reason for a delay beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay. The eligibility site shall send this notice no later than 91 days following the application for the Medical Assistance Program.

5. For information regarding continuation of benefits during the pendency of an appeal to the Social Security Administration (SSA) based upon termination of disability benefits see section 8.057.5.C.

6. Effective July 1, 1997, as a condition of eligibility for the Medical Assistance Program, any legal immigrant who is applying for or receiving Medical Assistance shall agree in writing that, during the time period the client is receiving Medical Assistance, he or she will not sign an affidavit of support for the purpose of sponsoring an alien who is seeking permission from the United States Immigration and Citizenship Services to enter or remain in the United States. A legal immigrant's eligibility for Medical Assistance shall not be affected by the fact that he or she has signed an affidavit of support for an alien before July 1, 1997.

7. Eligibility sites at which an individual is able to apply for Medical Assistance benefits shall also provide the applicant the opportunity to register to vote.

    a. The eligibility site shall provide to the applicant the prescribed voter registration application.

    b. The eligibility site shall not:

        i) Seek to influence the applicant's political preference or party registration;

        ii) Display any political preference or party allegiance;

        iii) Make any statement to the applicant or take any action, the purpose or effect of which is to discourage the applicant from registering to vote; and

        iv) Make any statement to an applicant which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

    c. The eligibility site shall ensure the confidentiality of individuals registering and declining to register to vote.

d. Records concerning registration and declination to register to vote shall be maintained for two years by the eligibility site. These records shall not be part of the public assistance case record.

e. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the eligibility site is located not later than ten (10) days after the date of acceptance; except that if a registration application is accepted within five (5) days before the last day for registration to vote in an election, the application shall be transmitted to the county clerk and recorder for the county not later than five (5) days after the date of acceptance.

8. Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote in the new county of residence. The new county of residence shall follow the above procedure. The new county of residence shall notify its county clerk and recorder of the client's change in address within five (5) days of receiving the information from the client.

8.100.3.E. Retroactive Medical Assistance Coverage

1. An applicant for Medical Assistance shall be provided such assistance any time during the three months preceding the date of application, or as of the date the person became eligible for Medical Assistance, whichever is later. That person shall have received medical services at any time during that period and met all applicable eligibility requirements.

2. An explanation of the conditions for retroactive Medical Assistance shall be given to all applicants. Those applicants who within the three months period prior to the date of application or as of the date the person became eligible for Medical Assistance, whichever is later, have received medical services which would be a benefit under the Colorado State Plan, can request retroactive coverage on the application form. The determination of eligibility for retroactive Medical Assistance shall be made as part of the application process. An applicant does not have to be eligible in the month of application to be eligible for retroactive Medical Assistance. The applicant or client may verbally request retroactive coverage at any time following the completion of an application. Verification required to determine Medical Assistance Program eligibility for the retroactive period shall be secured by the eligibility site to determine retroactive eligibility. Proof of the declared medical service shall not be required.

8.100.3.F. Groups Assisted Under the Program

1. The Medical Assistance Program provides benefits to the following persons who meet the federal definition of categorically needy at the time they apply for benefits:

    a. ~~Families~~Parents and ~~children~~Caretaker Relatives, Pregnant Women, Children, and Adults as defined under the ~~Family and Children's~~ Modified Adjusted Gross Income (MAGI)Medical Assistance section 8.100.4.

b. Persons who meet legal immigrant requirements as outlined in this volume, who were or would have been eligible for SSI but for their alien status, if such persons meet the resource, income and disability requirements for SSI eligibility.

c. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B. See section 8.100.3.~~N~~M for more information on SISC Codes.

d. Persons who are eligible for financial assistance under Old Age Pension (OAP) and SSI, but are not receiving the money payment.

e. Persons who would be eligible for financial assistance from OAP or SSI, except for the receipt of Social Security Cost of Living Adjustment (COLA) increases, or other retirement, survivors, or disability benefit increases to their own or a spouse's income. This group also includes persons who lost OAP or SSI due to the receipt of Social Security Benefits and who would still be eligible for the Medical Assistance Program except for the cost of living adjustments (COLA's) received. These populations are referenced as Pickle and Disabled Widow(er)s.

f. Persons who are blind, disabled, or aged individuals residing in the medical institution or Long Term Care Institution whose income does not exceed 300% of SSI.

g. Persons who are blind, disabled or aged receiving HCBS whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.

h. A disabled adult child who is at least 18 years of age and who was receiving SSI as a disabled child prior to the age of 22, and for whom SSI was discontinued on or after May 1, 1987, due to having received of OASDI drawn from a parent(s) Social Security Number, and who would continue to be eligible for SSI if the above OASDI and all subsequent cost of living adjustments were disregarded. This population is referenced as Disabled Adult Child (DAC).

i. Children age 18 and under who would otherwise require institutionalization in an Long Term Care Institution, Nursing Facility (NF), or a hospital but for which it is appropriate to provide care outside of an institution as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).

j. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility criteria but do meet the state eligibility criteria for the OAP State Only Medical Assistance Program. These persons qualify for a SISC Code C.

k. Persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergencies only.

l. Persons with a disability or limited disability who are at least 16 but less than 65 years of age, with income less than or equal to 450% of FPL after income disregards, regardless of resources, and who are employed.

m. ~~Persons who are at least age 19 but less than 65 years without Medicaid eligible dependent children living in the person's household regardless of resources and with income at or below 10% of the Federal Poverty Level (FPL) adjusted for the person's household size.~~

~~n.~~ Children with a disability who are age 18 and under, with household income less than or equal to 300% of FPL after income disregards, regardless of resources.

8.100.3.G. General and Citizenship Eligibility Requirements

1. To be eligible to receive Medical Assistance, an eligible person shall:

a. Be a resident of Colorado;

b. Not be an inmate of a public institution, except as a patient in a public medical institution or as a resident of an Long Term Care Institution or as a resident of a publicly operated community residence which serves no more than 16 residents;

c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;

e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;

f. Meet all other requirements of the Medical Assistance Program for which application is being made; and

g. Fall into one of the following categories:

i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or

ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:

1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");

2) paroled into the United States for at least one year under section 212(d)(5) of the INA; or

3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. sec. 1641, has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or

5) lawfully admitted for permanent residence under the INA with 40 qualifying quarters as defined under Title II of the Social Security Act. The 40 quarters is counted based on a combination of the quarters worked by the individual, the individual's spouse as long as they remain married or spouse is deceased, and/or the individual's parent while the individual is under age 18; or

6) The statutes and acts listed at 8.100.3.G.1.g.iii.1 through 8.100.3.G.1.g.iii.5 are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

7) Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

a) lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children); or

b) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse,

unremarried surviving spouse and unmarried, dependent children); or

c) granted asylum under section 208 of the INA for seven years after the date of entry into the United States; or

d) refugee under section 207 of the INA for seven years after the date of entry into the United States; or

e) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA for seven years after the date of entry into the United States; or

f) Cuban or Haitian entrant, as defined in section 501(e)(2) of the Refugee Education Assistance Act of 1980 for seven years after the date of entry into the United States; or

g) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 450b(e); or

h) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461) for seven years after the date of entry into the United States; or

i) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict; or

j) a victim of a severe form of trafficking in persons, as defined in section 103 of the Trafficking Victims Act of 2000, 22 U.S.C. 7102; or

k) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA for seven years after the date of entry into the United States; or

l) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA for seven years after the date of entry into the United States.

m) The statutes and acts listed at 8.100.3.G.1.g.iii.7.c through 8.100.3.G.1.g.iii.7.l are incorporated herein by reference. No amendments or later editions are incorporated. Copies

are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

iv) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergency medical care only. The rules on confidentiality prevent the Department or eligibility site from reporting to the United States Citizenship and Immigration Services persons who have applied for or are receiving assistance. These persons need not select a primary care physician as they are eligible only for emergency medical services.

For non-qualified aliens receiving Medical Assistance emergency only benefits, the following medical conditions will be covered:

An emergency medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1) placing the patient's health in serious jeopardy;

2) serious impairment of bodily function; or

3) serious dysfunction of any bodily organ or part.

A physician shall make a written statement certifying the presence of an emergency medical condition when services are provided and shall indicate that services were for a medical emergency on the claim form. Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care.

8.100.3.H. Citizenship and Identity Documentation Requirements

1. For determinations of initial eligibility and redeterminations of eligibility for Medical Assistance made on or after July 1, 2006, citizenship or nationality and identity status must be verified unless such satisfactory documentary evidence has already been provided, as described in 8.100.3.H.4.b. This requirement applies to an individual who declares or who has previously declared that he or she is a citizen or national of the United States.

a. The following electronic interfaces shall be accepted as proof of citizenship and/or identity as listed and should be used prior to requesting documentary evidence from applicants/clients:

i) SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.

ii) Department of Motor Vehicles (DMV) Interface is an acceptable interface to verify identity. An automated response from DMV confirms that the data submitted is consistent with DMV data for identity verification requirements. No further action is required for the individual and no additional documentation of identity is required.

b. This requirement does not apply to the following groups:

i~~).~~) Individuals who are entitled to or who are enrolled in any part of Medicare.

ii~~).~~) Individuals who receive Supplemental Security Income (SSI).

iii~~).~~) Individuals who receive child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care.

~~iv).~~iv) Individuals who receive adoption or foster care assistance under Title IV-E of the Social Security Act.

v~~).~~) Individuals who receive Social Security Disability Insurance (SSDI).

vi~~).~~) Children born to a woman who has applied for, has been determined eligible, and is receiving Medical Assistance on the date of the child's birth, as described in 8.100.4.G.5. This includes instances where the labor and delivery services were provided before the date of application and were covered by the Medical Assistance Program as an emergency service based on retroactive eligibility.

1) A child meeting the criteria described in 8.100.3.H.1.f. shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence at any time in the future, regardless of any subsequent changes in the child's eligibility for Medical Assistance.

2) Special Provisions for Retroactive Reversal of a Previous Denial

a) If a child described at 8.100.3.H.1.f. was previously determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial shall be reversed. Eligibility shall be effective retroactively to the date of the child's birth provided all of the following criteria are met:

(1) The child was determined to be ineligible for Medical Assistance during the period between July 1, 2006 and October 1, 2009 solely for failure to meet the citizenship and identity documentation requirements as they existed during that period;

(2) The child would have been determined to be eligible for Medical Assistance had 8.100.3.H.1.f. and/or 8.100.3.H.1.f.ii.1) been in effect during the period from July 1, 2006 through October 1, 2009; and

(3) The child's parent, caretaker relative, or legally appointed guardian or conservator requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.~~Q~~P.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

~~(~~c) A child granted retroactive eligibility for Medical Assistance shall be subject to the requirements described at 8.100.4.G.~~5~~2. for continued eligibility.

vii~~).~~) Individuals receiving Medical Assistance during a period of presumptive eligibility.

2. Satisfactory documentary evidence of citizenship or nationality includes the following:

a. Primary Evidence of Citizenship and Identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:

i) A U.S. passport issued by the U.S. Department of State that:

1) includes the applicant or recipient, and

2) was issued without limitation. A passport issued with a limitation may be used as proof of identity, as outlined in 8.100.3.H.3.

ii) A Certificate of Naturalization (DHS Forms N-550 or N-570) issued by the Department of Homeland Security (DHS) for naturalized citizens.

iii) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) issued by the Department of Homeland Security for individuals who derive citizenship through a parent.

iv) A document issued by a federally recognized Indian tribe, evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

1) Special Provisions for Retroactive Reversal of a Previous Denial

a) For a member of a federally recognized Indian tribe who was determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial of eligibility shall be reversed and eligibility shall be effective as of the date on which the individual was determined to be ineligible provided all of the following criteria are met:

(1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity documentation requirements as they existed during that period;

(2) The individual would have been determined to be eligible for Medical Assistance had 8.100.3.H.2.a.iv) been in effect on or after July 1, 2006; and

(3) The individual or a legally appointed guardian or conservator of the individual requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A member of a federally recognized Indian tribe for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.~~Q~~P.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed as provided in this subsection 2.

b. Secondary Evidence of Citizenship. If primary evidence from the list in 8.100.3.H.2.a. is unavailable, an applicant or recipient shall provide satisfactory documentary

evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H. 3. to establish identity. Secondary evidence of citizenship includes:

i) A U.S. public birth certificate.

1) The birth certificate shall show birth in any one of the following:

a) One of the 50 States,

b) The District of Columbia,

c) Puerto Rico (if born on or after January 13, 1941),

d) Guam (if born on or after April 10, 1899),

e) The Virgin Islands of the U.S. (if born on or after January 17, 1917),

f) American Samoa,

g) Swain's Island, or

h) The Northern Mariana Islands (NMI) (if born after November 4, 1986 (NMI local time)).

2) The birth record document shall have been issued by the State, Commonwealth, Territory or local jurisdiction.

3) The birth record document shall have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship, as described in 8.100.3.H.2.d.

ii) A Certification of Report of Birth (DS-1350) issued by the U.S. Department of State to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.

iii) A Report of Birth Abroad of a U.S. Citizen (Form FS-240) issued by the U.S. Department of State consular office overseas for children under age 18 at the time of issuance. Children born outside the U.S. to U.S. military personnel usually have one of these.

iv) A Certification of birth issued by the U.S. Department of State (Form FS-545 or DS-1350) before November 1,1990.

v) A U.S. Citizen I.D. card issued by the U.S. Immigration and Naturalization Services (INS):

1) Form I-179 issued from 1960 until 1973, or

2) Form I-197 issued from 1973 until April 7, 1983.

vi) A Northern Mariana Identification Card (I-873) issued by INS to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986.

vii) An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC."

viii) A final adoption decree that:

1) shows the child's name and U.S. place of birth, or

2) a statement from a State approved adoption agency that shows the child's name and U.S. place of birth. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

ix) Evidence of U.S. Civil Service employment before June 1, 1976. The document shall show employment by the U.S. government before June 1, 1976.

x) U.S. Military Record that shows a U.S. place of birth such as a DD-214 or similar official document showing a U.S. place of birth.

xi) Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.

xii) Child Citizenship Act. Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Documentary evidence must be provided at any time on or after February 27, 2001, if the following conditions have been met:

1) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this part);

2) The child is under the age of 18;

3) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

4) The child was admitted to the United States for lawful permanent residence (as verified through the Systematic Alien Verification for Entitlements (SAVE) Program); and

5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States ~~)),~~), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

c. Third Level Evidence of U.S. Citizenship. Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence is available. Third level evidence shall be used only when primary evidence cannot be obtained within 10 business days, secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the U.S. A second document from the list in 8.100.3.H.3. to establish identity shall also be presented.

i) Extract of a hospital record on hospital letterhead.

1) The record shall have been established at the time of the person's birth;

2) The record shall have been created at least 5 years before the initial application date; and

3) The record shall indicate a U.S. place of birth;

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

5) Souvenir "birth certificates" issued by a hospital are not acceptable.

ii) Life, health, or other insurance record.

1) The record shall show a U.S. place of birth; and

2) The record shall have been created at least 5 years before the initial application date.

3) For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

iii) Religious record.

1) The record shall have been recorded in the U.S. within 3 months of the date of the individual's birth;

2) The record shall show that the birth occurred in the U.S.;

3) The record shall show either the date of birth or the individual's age at the time the record was made; and

4) The record shall be an official record recorded with the religious organization.

iv) Early school record that meets the following criteria:

1) The school record shows the name of the child;

2) The school record shows the child's date of admission to the school;

3) The school record shows the child's date of birth;

4) The school record shows a U.S. place of birth for the child; and

5) The school record shows the name(s) and place(s) of birth of the applicant's parents.

d. Fourth Level Evidence of Citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence shall only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained within 10 business days, and the applicant alleges U.S. citizenship. The affidavit process described in 8.100.3.H.2.d.ii.5. may be used by U.S. citizens or nationals born inside or outside the U.S. In addition, a second document establishing identity shall be presented as described in 8.100.3.H.3.

i) Federal or State census record showing U.S. citizenship or a U.S. place of birth and the applicant's age.

ii) One of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for The Medical Assistance Program. For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

1) Seneca Indian tribal census record;

2) Bureau of Indian Affairs tribal census records of the Navajo Indians;

3) U.S. State Vital Statistics official notification of birth registration;

4) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth;

5) Statement signed by the physician or midwife who was in attendance at the time of birth; or

6) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

iii) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicate a U.S. place of birth.

iv) Medical (clinic, doctor, or hospital) record.

1) The record shall have been created at least 5 years before the initial application date; and

2) The record shall indicate a U.S. place of birth.

3) An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

v) Written affidavit. Affidavits shall only be used in rare circumstances. They may be used by U.S. citizens or nationals born inside or outside the U.S. If documentation is by affidavit, the following rules apply:

1) There shall be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit);

2) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient;

3) In order for the affidavit to be acceptable the persons making them shall provide proof of their own U.S. citizenship and identity.

4) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit shall contain this information as well;

5) The applicant/recipient or other knowledgeable individual (guardian or representative) shall provide a separate affidavit explaining why the evidence does not exist or cannot be obtained; and

6) The affidavits shall be signed under penalty of perjury pursuant to 18 U.S.C. §1641 and Title 18 of the Criminal Code article 8 part 5 and need not be notarized.

e. Evidence of Citizenship for Collectively Naturalized Individuals. If a document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. A second document from 8.100.3.H.3~~.~~. to establish identity shall also be presented.

i) Puerto Rico:

1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; OR

2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

ii) US Virgin Islands:

1) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; OR

2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

3) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

iii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

4) If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile, and the individual is not a U.S. citizen.

f) Referrals for Colorado Birth Certificates

i) An applicant or client who was born in the State of Colorado who does not possess a Colorado birth certificate shall receive a referral to the Department of Public Health and Environment by the county department to obtain a birth certificate at no charge, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C~~), C.R.S.~~).

ii) The referral shall be provided on county department letterhead and shall include the following:

1) The name and address of the applicant or client;

2) A statement that the county department requests that the Department of Public Health and Environment waive the birth certificate fee, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C~~), C.R.S.;~~); and

3) The name and contact telephone number for the county caseworker responsible for the referral.

iii) An applicant or client who has been referred to the Department of Public Health and Environment to obtain a birth certificate shall not be required to present a birth certificate to satisfy the citizenship documentation requirement at 8.100.3.H.2. The applicant or client shall have the right to

use any of the documents listed under 8.100.3.H.2. to satisfy the citizenship documentation requirement.

3. The following documents shall be accepted as proof of identity and shall accompany a document establishing citizenship from the groups of documentary evidence outlined in 8.100.3.H.2.b. through e.

   a) A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

   b) School identification card with a photograph of the individual;

   c) U.S. military card or draft record;

   d) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses;

   e) Military dependent's identification card;

   f) U.S. Coast Guard Merchant Mariner card;

   g) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. The document is acceptable if it carries a photograph of the individual or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color; or

   h) Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted evidence of citizenship listed under 8.100.3.H.2.b. or 8.100.3.H.2.c. The following requirements must be met:

      i) No other evidence of identity is available to the individual;

      ii) The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity; and

      iii) All documents used must contain consistent identifying information.

      iv) These documents include, but are not limited to, employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds/titles.

   i) Special identity rules for children. For children under 16, the following records are acceptable:

      i) Clinic, doctor, or hospital records; or

ii) School records.

1) The school record may include nursery or daycare records and report cards; and

2) The school, nursery, or daycare record must be verified with the issuing school, nursery, or daycare.

3) If clinic, doctor, hospital, or school records are not available, an affidavit may be used if it meets the following requirements:

a) It shall be signed under penalty of perjury by a parent or guardian;

b) It shall state the date and place of birth of the child; and

c) It cannot be used if an affidavit for citizenship was provided.

d) The affidavit is not required to be notarized.

e) An affidavit may be accepted on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual until that age.

j) Special identity rules for disabled individuals in institutional care facilities.

i) An affidavit may be used for disabled individuals in institutional care facilities if the following requirements are met:

1) It shall be signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility; and

2) No other evidence of identity is available to the individual.

3) The affidavit is not required to be notarized.

k) Expired identity documents.

i) Identity documents do not need to be current to be acceptable. An expired identity document shall be accepted as long as there is no reason to believe that the document does not match the individual.

l) Referrals for Colorado Identification Cards

i) An applicant or client who does not possess a Colorado driver’s license or identification card shall be referred to the Department of Revenue Division of Motor Vehicles by the county department to obtain an

identification card at no charge, pursuant to C.R.S. § 42-2-306(1)(a)(II~~), C.R.S.~~

).

ii) The referral shall be provided on county department letterhead and shall include the following:

1) The name and address of the applicant or client;

2) A statement that the county department requests that the Department of Revenue Division of Motor Vehicles waive the identification card fee, pursuant to C.R.S § 42-2-306(1)(a)(II~~), C.R.S.;~~). ; and

3) The name and contact telephone number for the county caseworker responsible for the referral.

iii) An applicant or client who has been referred to the Division of Motor Vehicles to obtain an identification card shall not be required to present a Colorado identification card to satisfy the identity documentation requirement at 8.100.3.H.3. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.3. to satisfy the identity documentation requirement.

4. Documentation Requirements

a. Effective January 1, 2008, all citizenship and identity documents must either be originals or copies certified by the issuing agency, except as provided in 8.100.3.H.4.b. Uncertified copies, including notarized copies, are not acceptable.

b. Individuals who submitted notarized copies of citizenship and identity documents as part of an application or redetermination before January 1, 2008 shall not be required to submit originals or copies certified by the issuing agency for any application or redetermination processed on or after January 1, 2008.

c. All citizenship and identity documents shall be presumed to be genuine unless the authenticity of the document is questionable.

d. Individuals shall not be required to submit citizenship and identity documentation in person. Documents shall be accepted from a Medical Assistance applicant or client or from his or her guardian or authorized representative in person or by mail.

i) Individuals are strongly encouraged to use alternatives to mailing original documents to counties, such as those described in 8.100.3.H.4.e.

e. Individuals may present original citizenship and identity documents or copies certified by the issuing agency to Medical Assistance (MA) sites, School-based Medical

Assistance sites, Presumptive Eligibility (PE) sites, Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), or any other location designated by the Department by published agency letter.

i) Staff at these locations shall make a copy of the original documents and shall complete a "Citizenship and Identity Documentation Received" form, stamp the copy, or provide other verification that identifies that the documents presented were originals. The verification shall include the name, telephone number, organization name and address, and signature of the individual who reviewed the document(s). This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) Upon request by the client or eligibility site, the copy of the original document with the "Citizenship and Identity Documentation Received" form, stamp, or other verification as described in 8.100.3.H.4.e. i) shall be mailed or delivered directly to the eligibility site within five business days.

f. Counties shall accept photocopies of citizenship and identity documents from any location described in 8.100.3.H.4.e provided the photocopies include the form, stamp, or verification described in 8.100.3.H.4.e.i).

g. Counties shall develop procedures for handling original citizenship and identity documents to ensure that these documents are not lost, damaged, or destroyed.

i) Upon receiving the original documents, eligibility site staff shall make a copy of the original documents and shall complete a "Citizenship and Identity Documentation Received" form, stamp the copy, or provide other verification that identifies that the documents presented were originals, as described in 8.100.3.H.4.e. i~~) .~~). This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) The original documents shall be sent by mail or returned to the individual in person within five business days of the date on which they were received.

iii) To limit the risk of original documents being lost, damaged, or destroyed, counties are strongly encouraged to make copies of documents immediately upon receipt and to return original documents to the individual while he or she is present.

h. Once an individual has provided the required citizenship and identity documentation, he or she shall not be required to submit the documentation again unless:

i) Later evidence raises a question about the individual's citizenship or identity; or

ii) There is a gap of more than five years between the ending date of the individual's last period of eligibility and a subsequent application for The

Medical Assistance Program and the eligibility site has not retained the citizenship and identity documentation the individual previously provided.

5. Record Retention Requirements

    a. The eligibility site shall retain a paper or electronically scanned copy of an individual's citizenship and identity documentation, including any verification described in 8.100.3.H.4.e.i), for at least five years from the ending date of the individual's last period of Medical Assistance eligibility.

6. Name Change Provisions

    a. An individual who has changed his or her last name for reasons including, but not limited to, marriage, divorce, or court order shall not be required to produce any additional documentation concerning the name change unless:

        i) With the exception of the last name, the personal information in the citizenship and identity documentation provided by the individual does not match in every way;

        ii) In addition to changing his or her last name, the individual also changed his or her first name and/or middle name; or

        iii) There is a reasonable basis for questioning whether the citizenship and identity documents belong to the same individual.

7. Reasonable Level of Assistance

    a. The eligibility site shall provide a reasonable level of assistance to applicants and clients in obtaining the required citizenship and identity documentation.

    b. Examples of a reasonable level of assistance include, but are not limited to:

        i) Providing contact information for the appropriate agencies that issue the required documents;

        ii) Explaining the documentation requirements and how the client or applicant may provide the documentation; or

        iii) Referring the applicant or client to other agencies or organizations which may be able to provide further assistance.

    c. The eligibility site shall not be required to pay for the cost of obtaining required documentation.

8. Individuals Requiring Additional Assistance

a. The eligibility site shall provide additional assistance beyond the level described in 8.100.3.H.7 to applicants and clients in obtaining the required citizenship and identity documentation if the client or applicant:

i) Is unable to comply with the requirements due to physical or mental impairments or homelessness; and

ii) The individual lacks a guardian or representative who can provide assistance.

b. Examples of additional assistance include, but are not limited to:

i) Contacting any known family members who may have the required documentation;

ii) Contacting any known current or past health care providers who may have the required documentation; or

iii) Contacting other social services agencies that are known to have provided assistance to the individual.

c. The eligibility site shall document its efforts to provide additional assistance to the client or applicant. Such documentation shall be subject to the record retention requirements described in 8.100.3.H.5.a.

9. Reasonable Opportunity Period

a. If a Medical Assistance applicant or recipient does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. If the applicant or recipient does not provide the required documentation within the reasonable opportunity period, then:

i) the applicant's Medical Assistance application shall be denied, or

ii) the recipient's Medical Assistance benefits shall be terminated.

b. The reasonable opportunity period for ~~Family~~ MAGI Programs covered under 8.100.3.H is 14 calendar days. For the purpose of this section, ~~Family~~MAGI Programs are defined as the following:

Commonly Used Program Name	Rule Citation
~~1931~~Parent and Caretaker Relative Medical Assistance	8.100.4.G.~~2~~3
Transitional Medical Assistance	8.100.4.I.1-7
~~Four Month Extended~~Children's	8.100.4.~~I.8~~G.2

Medical Assistance	
~~Institutionalized under age 21~~	~~8.100.4.H.1.a~~
~~Parents Plus Program~~	~~8.100.4.G.8~~
~~Qualified Child~~	~~8.100.4.G.6~~
~~Expanded Child~~	~~8.100.4.G.6~~
~~Ribicoff Child~~	~~8.100.4.G.7~~
~~Qualified~~ Pregnant Women Medical Assistance	8.100.4.G.~~9~~5
~~Expanded Pregnant~~Adult Medical Assistance	8.100.4.G.~~9~~4

c. The reasonable opportunity period for Adult Programs covered under 8.100.3.F. is 70 calendar days. For the purpose of this rule, Adult Programs are defined as the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Breast and Cervical Cancer Program (BCCP)	8.715
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.O
~~Adults without Dependent Children (AwDC)~~	~~8.100.6.P~~
Medicaid Buy-In Program for Children with Disabilities	8.100.6.Q

10. Good Faith Effort

a. In some cases, a Medical Assistance client or applicant may not be able to obtain the required documentation within the applicable reasonable opportunity period. If the client or applicant is making a good faith effort to obtain the required documentation, then the reasonable opportunity period should be extended. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

Examples of good faith effort include, but are not limited to:

i) Providing verbal or written statements describing the individual's effort at obtaining the required documentation;

ii) Providing copies of emails, letters, applications, checks, receipts, or other materials sent or received in connection with a request for documentation; or

iii) Providing verbal or written statements of the individuals' efforts at identifying people who could attest to the individual's citizenship or identity, if citizenship and/or identity are included in missing documentation.

An individual's verbal statement describing his or her efforts at securing the required documentation should be accepted without further verification unless the accuracy or truthfulness of the statement is questionable. The individual's good faith efforts should be documented in the case file and are subject to all record retention requirements.

8.100.3.I. Additional General Eligibility Requirements

1. Each person for whom Medical Assistance is being requested shall furnish a Social Security Number (SSN); or, if one has not been issued or is unknown, shall apply for the number and submit verification of the application. The application for an SSN shall be documented in the case record by the eligibility site. Upon receipt of the assigned SSN, the client shall provide the number to the eligibility site. This requirement does not apply to those individuals who are not requesting Medical Assistance yet appear on the application, nor does it apply to individuals applying for emergency medical services or eligible newborns born to a Medical Assistance eligible mother.

a. An applicant's or client's refusal to furnish or apply for a Social Security Number affects the family's eligibility for assistance as follows:

i) that person cannot be determined eligible for the Medical Assistance Program; and/or

ii) if the person with no SSN or proof of application for SSN is the only dependent child on whose behalf assistance is requested or received, assistance shall be denied or terminated.

2. A person who is applying for or receiving Medical Assistance shall assign to the State all rights against any other person (including but not limited to the sponsor of an alien) for medical support or payments for medical expenses paid on the applicant's or client's behalf or on the behalf of any other person for whom application is made or assistance is received.

   All appropriate clients of the Medical Assistance Program shall have the option to be referred for child support enforcement services using the form as specified by the Department.

3. A person who is applying for or receiving Medical Assistance shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources are any health coverage or insurance other than the Medical Assistance Program. A client's refusal to supply information regarding third party resources may result in loss of Medical Assistance Program eligibility.

4. A person who is eligible for Medical Assistance shall be free to choose any qualified and approved participating institution, agency, or person offering care and services which are benefits of the program unless that person is enrolled in a managed care program operating under Federal waiver authority.

8.100.3.J. Supplemental Security Income (SSI) And Aid To The Needy Disabled (AND) Recipients

1. Persons who may be eligible for benefits under either ~~Family and Children's~~MAGI Medical Assistance or SSI:

   a. shall be advised of the benefits available under each program;

   b. may apply for a determination of eligibility under either or both programs, and

   c. have the option to receive benefits under the program of their choice, but may not receive benefits under both programs at the same time;

   d. may change their selection if their circumstances change or if they decide later that it would be more advantageous to receive benefits from the other program.

2. Any family member who is receiving financial assistance from SSI or OAP-A is not considered a member of the Medical Assistance required household, is not counted as a member of the household, and the individual's income and resources are disregarded in making the determination of need for Medical Assistance.

3. An individual receiving AND may also receive ~~Family and Children's~~MAGI Medical Assistance. An AND recipient shall be eligible for ~~Family and Children's~~MAGI Medical Assistance, if the recipient meets all the requirements of ~~Family and Children's~~MAGI Medical Assistance. For these individuals, eligibility sites shall include the applicant's AND payment as unearned income to the Medical Assistance required household along with all other income. If the AND individual's AND payment and other income makes the Medical Assistance required household ineligible, eligibility sites shall disregard the AND

individual and give the remaining members ~~Family and Children's~~MAGI Medical Assistance as long as they meet the income requirements for the appropriate ~~Family and Children's~~MAGI Medical Assistance category.

~~4. An individual receiving AND may also receive assistance under the AwDC program. An AND recipient shall be eligible for AwDC, if the recipient meets all the requirements of AwDC. For these individuals, the applicant's AND payment shall not be included as income for determining eligibility.~~

8.100.3.K. Consideration of Income

~~1. In determining eligibility for Medical Assistance for household members, financial responsibility is limited to spouse being responsible for spouse, and parent being responsible for a dependent child. Financial responsibility of parents for a dependent child is not changed by the fact that the child may be pregnant or that she is a mother and caretaker of her own child.~~

~~2. Income of parents of minor parents under the age of 18 living in the same household shall be attributed to the minor parent unless the minor parent is married or legally separated from marriage.~~

~~3. A declared common law spouse retains the same financial responsibility as a legally married spouse. Once declared as~~1. ~~common law, financial responsibility remains unless legal separation or divorce occurs. If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other. This is not changed by the fact that the unmarried individuals may share a common child.4. Income for the Medical Assistance Program eligibility is income which is received by an individual or family in the month in which they are applying for or receiving Medical Assistance or the previous month if income for the current month is not yet available to determine eligibility.~~

~~5.~~ Income or resources of an alien sponsor or an alien sponsor's spouse shall be countable to the sponsored alien effective December 19, 1997. Forms used prior to December 19, 1997, including but not limited to forms I-134 or I-136 are legally unenforceable affidavits of support. The attribution of the income and resources of the sponsor and the sponsor's spouse to the alien will continue until the alien becomes a U.S. citizen or has worked or can be credited with 40 qualifying quarters of work, provided that an alien crediting the quarters to the applicant/client has not received any public benefit during any creditable quarter for any period after December 31, 1996.

~~6~~2. Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.

~~7~~3. Earned income is payment in cash or in kind for services performed as an employee or from self-employment.

~~8~~4. Earned in kind income shall be income produced as a result of the performance of services by the applicant/client, for which he/she is compensated in shelter or other items in lieu of wages.

~~9~~5. Received means "actually" received or legally becomes available, whichever occurs first; the point at which the income first is available to the individual for use. For example, interest income on a savings account is counted when it is credited to the account.

~~10. Compensation received from the Crime Victims Compensation Act shall be considered as income to the extent that it exceeds the expenses for which it was designated, i.e., medical and/or burial expenses.~~

~~11~~6. All Home Care Allowance (HCA) income paid to a Medical Assistance applicant/client by the HCA recipient to provide home care services is countable earned income.

~~12~~7. Participation in the Workforce Investment Act (WIA) affects eligibility for Medical Assistance as follows:

a. Wages derived from participation in a program carried out under WIA (work experience or on-the-job training) and paid to a caretaker relative is considered countable earned income.

b. Training allowances granted by WIA to a dependent child or a caretaker relative of a dependent child to participate in a training program is exempt.

c. Wages derived from participation in a program carried out the under Workforce Investment Act (WIA) and paid to any dependent child who is applying for or receiving Medical Assistance are exempt in determining eligibility for a period not to exceed six months in each calendar year.

~~13~~8. An individual involved in a profit making activity as a sole proprietor, partner in a partnership, independent contractor, or consultant shall be classified as self-employed.

a. To determine the net profit of a self-employed applicant/client deduct the cost of doing business from the gross income. These business expenses include, but are not limited to:

i) the rent of business premises,

ii) wholesale cost of merchandise,

iii) utilities,

iv) taxes,

v) labor, and

vi) upkeep of necessary equipment.

b. The following are not allowed as business expenses:

i) Depreciation of equipment;

ii) The cost of and payment on the principal of loans for capital asset or durable goods;

iii) Personal expenses such as personal income tax payments, lunches, and transportation to and from work.

c. Appropriate allowances for cost of doing business for Medical Assistance clients who are licensed, certified or approved day care providers are (1) $ 55 for the first child for whom day care is provided, and (2) $ 22 for each additional child. If the client can document a cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.

d. When determining self employment expenses and distinguishing personal expenses from business expenses it is a requirement to only allow the percentage of the expense that is business related.

~~14~~9. Self-employment income includes, but is not limited to, the following:

a. Farm income - shall be considered as income in the month it is received. When an individual ceases to farm the land, the self-employment deductions are no longer allowable.

b. Rental income - shall be considered as self-employment income only if the Medical Assistance client actively manages the property at least an average of 20 hours per week.

c. Board (to provide a person with regular meals only) payment shall be considered earned income in the month received to the extent that the board payment exceeds the maximum food stamp allotment for one-person household per boarder and other documentable expenses directly related to the provision of board.

d. Room (to provide a person with lodging only) payments shall be considered earned income in the month received to the extent that the room payment exceeds documentable expenses directly related to the provision of the room.

e. Room and board payments shall be considered earned income in the month received to the extent that the payment for room and board exceeds the food stamp allotment for a one-person household per room and boarder and documentable expenses directly related to the provision of room and board.

~~15~~10. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes, but is not limited to, the following:

a. Pensions and other period payments, such as:

i) Private pensions or disability benefits

ii) Social Security benefits (Retirement, survivors, and disability)

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

vi) Veterans benefits other than Aid and Attendance (A&A) and ~~Unreimbursed~~Unusual Medical Expenses (UME).

vii) Alimony and support payments

viii) Interest, dividends and certain royalties on countable resources

~~ix) Support and maintenance in kind~~

~~The support and maintenance in kind amount should not be greater than 1/3 of the Federal Benefit Rate (FBR). Use the Presumed Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the support and maintenance in kind amount. Use 1/3 of the FBR if an amount is not declared by the client.~~

8.100.3.L.~~d. All earned income that is received by a dependent child who is a full-time student or a part-time student who is not a full-time employee shall be disregarded for the eligibility determination as long as they remain a student.~~

~~e. All earned income of dependent children who are not students (except income from WIA for up to six months in each calendar year) shall be considered in determining eligibility for Medical Assistance. All disregards from the earned income shall apply as listed in the Family and Children's Medical Assistance Program portion of this volume.~~

~~8.100.3.M.~~ Consideration of Resources

1. Resources are counted in determining eligibility for the Aged, Blind and Disabled, and Long-Term Care institutionalized and Home and Community Based Services categories of Medical Assistance. ~~—~~Resources are not counted in determining eligibility for the ~~Family and Children's~~MAGI Medical Assistance programs, the Medicaid Buy-in Program for Working Adults with Disabilities, or the Medicaid Buy-In Program for Children with Disabilities, ~~or AwDC.~~ See section 8.100.5 for rules regarding consideration of resources.

8.100.3.~~N~~M. Federal Financial Participation (FFP)

1. The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medical Assistance Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons.

2. The SISC codes are as follows:

    a. Code A - for institutionalized persons whose income is under 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; and non-institutionalized persons receiving Home and Community Based Services, whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; code A signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments;

    b. Code B - for persons eligible to receive financial assistance under SSI; persons eligible to receive financial assistance under OAP "A" who, except for the level of their income, would be eligible for an SSI payment; persons who are receiving mandatory State supplementary payments; and persons who continue to be eligible for Medical Assistance after disregarding certain Social Security increases; code B signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program and also for SMIB premium payments;

    c. Code C - for persons eligible to receive assistance under OAP "A", OAP "B", or OAP Refugee Assistance for financial assistance only; who do not receive SSI payment and do not otherwise qualify under SISC code B as described in item B. above; code C signifies that no FFP is available in Medical Assistance program expenditures.

    d. Code D1 – for persons eligible to receive assistance under AwDC from program implementation through 12/31/2013; Code D1 signifies 50% FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program.

    e. Code E1 - for persons eligible to receive assistance under the Medicaid Buy-In Program for Working Adults with Disabilities and whose annual adjusted gross income, as defined under IRS statute, is less than or equal to 450% of FPL – after SSI earned income deductions; as well as for children eligible to receive assistance under the Medicaid Buy-In Program for Children with Disabilities and whose household income is less than or equal to 300% of FPL after income disregards. Code E1 signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments.

3. Recipients of financial assistance under State AND, State AB, or OAP "C" are not automatically eligible for Medical Assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.3.~~O.~~N. Confidentiality

1. All information obtained by the eligibility site concerning an applicant for or a recipient of Medical Assistance is confidential information.

2. A signature on the ~~Colorado Medical Assistance application~~ Single Streamlined Application and the Application for Public Assistance allows an eligibility site worker to consult banks, employers, or any other agency or person to obtain information or verification to determine eligibility. The identification of the worker as an eligibility site employee will, in itself, disclose that an application for the Medical Assistance Program has been made by an individual. In this type of contact, as well as other community contacts, the eligibility site should strive to maintain confidentiality. The signature on the ~~Colorado Medical Assistance application~~ Single Streamlined Application and the Application for Public Assistance also provides permission for the release of the client's medical information to be provided by health care providers to the State and its agents for purpose of administration of the Medical Assistance Program.

3. Eligibility site staff may release a client's Medical Assistance state identification number and approval eligibility spans to a Medical Assistance provider for billing purposes.

   Eligibility site staff may inform a Medical Assistance provider that an application has been denied but may not inform them of the reason why.

4. Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State and the eligibility site.

5. The eligibility site must obtain permission from a family, individual, or authorized representative, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of Medical Assistance payment. This permission must be obtained unless the request is from State authorities, federal authorities, or State contractors acting within the scope of their contract. If, because of an emergency situation, time does not permit obtaining consent before release, the eligibility site must notify the family or individual immediately after supplying the information.

6. The eligibility site policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials. If a court issues a subpoena for a case record or for any eligibility site representative to testify concerning an applicant or recipient, the eligibility site must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

7. The following types of information are confidential and shall be safeguarded:

a. Names and addresses of applicants for and recipients of the Medical Assistance Program;

b. Medical services provided;

c. Social and economic conditions or circumstances;

d. Agency evaluation of personal information;

e. Medical data, including diagnosis and past history of disease or disability;

f. All information obtained through the Income and Eligibility Verification System (IEVS), Colorado Department of Labor and Employment, SSA or Internal Revenue Service;

g. Any information received in connection with third party resources;

h. Any information received for verifying income and resources if applicable, or other eligibility and the amount of Medical Assistance payments.

8. The confidential information listed above may be released to persons outside the eligibility site only as follows:

a. In response to a valid subpoena or court order;

b. To State or Federal auditors, investigators or others designated by the Federal or State departments on a need-to-know basis;

c. To individuals executing Income and Eligibility Verification System;

d. Child Support enforcement officials;

e. To a recipient or applicant themselves or their designated representative.

f. To a Long Term Care institution on the AP-5615 form.

9. The applicant/recipient may give a formal written release for disclosure of information to other agencies, such as hospitals, or the permission may be implied by the action of the other agency in rendering service to the client. Before information is released, the eligibility site should be reasonably certain the confidential nature of information will be preserved, the information will be used only for purposes related to the function of the inquiring agency, and the standards of protection established by the inquiring agency are equal to those established by the State Department. If the standards for protection of information are unknown, a written consent from the recipient shall be obtained.

8.100.3.~~P~~O. Protection Against Discrimination

1. Eligibility sites are to administer the Medical Assistance Program in such a manner that no person will, on the basis of race, color, sex, age, religion, political belief, national origin,

or handicap, be excluded from participation, be denied any aid, care, services, or other benefits of, or be otherwise subjected to discrimination in such program.

2. The eligibility site shall not, directly or through contractual or other arrangements, on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap:

   a. Provide aid, care, services, or other benefits to an individual which is different, or provided in a different manner, from that of others;

   b. Subject an individual to segregation barriers or separate treatment in any manner related to access to or receipt of assistance, care services, or other benefits;

   c. Restrict an individual in any way in the enjoyment or any advantage or privilege enjoyed by others receiving aid, care, services, or other benefits provided under the Medical Assistance Program;

   d. Treat an individual differently from others in determining whether he/she satisfies any eligibility or other requirements or conditions which individuals shall meet in order to receive aid, care, services, or other benefits provided under the Medical Assistance Programs;

   e. Deny an individual an opportunity to participate in programs of assistance through the provision of services or otherwise, or afford him/her an opportunity to do so which is different from that afforded others under the Medical Assistance Program.

3. No distinction on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap is permitted in relation to the use of physical facilities, intake and application procedures, caseload assignments, determination of eligibility, and the amount and type of benefits extended by the eligibility site to Medical Assistance recipients.

4. An individual who believes he/she is being discriminated against may file a complaint with the eligibility site, the Department, or directly with the Federal government. When a complaint is filed with the eligibility site, the county director is responsible for an immediate investigation of the matter and taking necessary corrective action to eliminate any discriminatory activities found. If such activities are not found, the individual is given an explanation. If the person is not satisfied, he/she is requested to direct his/her complaint, in writing, to the State Department, Complaint Section, which will be responsible for further investigation and other necessary action consistent with the provisions of Title VI of the 1963 Civil Rights Act, as amended 42 U.S.C. §2000e et seq. and section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. §791.

8.100.3.~~Q~~P. Redetermination of Eligibility

1. A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medical Assistance Program client continues to be eligible to receive Medical Assistance. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months for Title XIX Medical Assistance only cases. An

eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

2. The eligibility site shall promptly redetermine eligibility when:

    a. it receives and verifies information which indicates a change in a client's circumstances which may affect continued eligibility for Medical Assistance; or

    b. it receives direction to do so from the Department.

    The eligibility site shall redetermine eligibility according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes.

3. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program, verification system, and/or CBMS. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the findings of the review will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

4. A redetermination form, approved by the Department, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself cannot be required to be returned. The only verification that can be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

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

    The following procedures relate to mail-out redetermination:

    a. A Redetermination Form shall be mailed to the client together with any other forms to be completed;

    b. Required verification shall be returned by the client to the eligibility site no later than ten working days after receipt of request;

    c. When the individual is unable to complete the forms due to physical, mental or emotional disabilities, or other good cause, and has no one to help him/her, the eligibility site shall either assist the client or refer him/her to a legal or other resource. When initial arrangements or a change in arrangements are being

made, an extension of up to thirty days shall be allowed. The action of the eligibility site in assistance or referral shall be recorded in the case record and CBMS case comments.

d. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the individual.

e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the individual. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.

5. When the redetermination verification information is received by the eligibility site, it shall be date stamped. Within ten working days, the verification information shall be thoroughly reviewed for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility at that time. Verifications shall be documented in the case file and CBMS case comments. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

   a. due to incomplete information, the request form shall be mailed back to the client with a letter specifying the items that require completion;

   b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance client shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes.

8.100.4 ~~Family and Children's~~MAGI Medical Assistance Eligibility [Eff. ~~03/30/2009~~01/01/2014]

8.100.4.A. ~~Family and Children's~~MAGI Application Requirements

1. Persons requesting ~~Family and Children's~~a MAGI Medical Assistance category need only to complete the ~~Colorado Medical Assistance application~~Single Streamlined Application.

2. Parents and Caretaker Relatives, Pregnant ~~women~~Women, Children, and ~~children~~Adults may apply for ~~Family and Children's~~ Medical Assistance at eligibility sites other than the County Department of Social Services. ~~These sites shall be approved by the~~The Department shall approve these sites to receive and initially process these applications. The application used shall be the ~~Colorado Medical Assistance application.~~Single Streamlined Application. The eligibility site shall determine eligibility.

3. The eligibility sites shall refer Medical Assistance clients who are pregnant and/or age 20 and under to EPSDT offices by copying the page of the ~~Colorado Medical Assistance application~~Single Streamlined Application that includes the EPSDT benefit questions. The eligibility site will then forward this page to the EPSDT office within five working days from the date of application approval.

8.100.4.B. ~~Family and Children's Minimal~~MAGI Category 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~~1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:

a. Social Security Number ~~shall be provided for each~~ : Each individual requesting assistance on the application ~~for whom Medical Assistance is being requested, or~~shall provide a Social Security Number, or each shall submit proof ~~shall be submitted that~~ of an application ~~for~~to obtain 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.H under Citizenship and Identity Documentation Requirements.

c. ~~Earned income may~~Income: Income shall be self-~~declared~~attested by an ~~individual~~applicant and verified ~~by the Income and Eligibility Verification System~~

~~(IEVS).~~through an electronic data source. Individuals who provide self-~~declaration~~attestation of ~~earned~~ income must also provide a Social Security Number for wage verification purposes.

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~~an 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 Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual~~ cannot provide verification through self-~~declaration~~attestation, income shall be verified by wage stubs, written documentation from the employer stating the ~~employees'~~employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

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. Verification of Legal Immigrant Status: Immigrant registration cards or papers, if applicable, shall be provided for an applicant applying for Medical Assistance to determine if the ~~client is~~household members are 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~~2. Additional Verification ~~-~~: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

~~4~~3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

~~5~~4. 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~~5. 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~~6. 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.

8.100.4.C. ~~Family and Children's Household Requirements~~MAGI Methodology for Income Calculation

1. ~~Only certain family members residing in~~ The Modified Adjusted Gross Income calculation for the ~~same household shall be included in the same~~purposes of determining a household's financial eligibility for Medical Assistance ~~required household~~shall consist of the following:

~~a. dependent children;~~

a. Gross Income: Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income ~~b. parent(s) or caretaker relative;~~

~~2. Par~~means ~~only a natural (~~all income from whatever source derived, including (but not limited to) the following items:

i) Compensation for services, including fees, commissions, fringe benefits and similar items;

ii) Gross income derived from business;

iii) Gains derived from dealings in property;

iv) Interest;

v) Rents;

vi) Royalties;

vii) Dividends;

viii) Alimony and separate maintenance payments;

ix) Annuities;

x) Income from life insurance and endowment contracts;

xi) Pensions;

xii) Income from discharge of indebtedness;

xiii) Distributive share of partnership gross income;

xiv) Income in respect of a decedent; and

xv) Income from an interest in an estate or trust.

b. Additional Income: In addition to the gross income identified in section 8.100.4.C.1.a., the following income is included if applicable:

i) Any tax exempt interest income

ii) Untaxed foreign wages and salaries

iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits)

c. ~~expectant)~~Income exceptions: There are three exceptions to gross income in the MAGI income calculation:

i) An amount received as a lump sum is counted as income only in the month received.

ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses.

iii) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e). 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during

regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

d. Allowable Deductions The following allowable deductions, among others, are subtracted in order to calculate Adjusted Gross Income: Standard deductions, IRA and qualified retirement plan contributions, business expenses, student loan interest, mortgage interest payments, one half of the self-employment tax, contributions to pre-tax healthcare and other flexible spending accounts, etc. For a more in-depth treatment of allowable deductions to gross income, please refer to 26 U.S.C. Subtitle A, Chapter 1, Subchapter B Parts V, VI, VII and IX 26 U.S.C Subtitle A, Chapter 1, Subchapter B Parts V, VI, VII and IX are hereby incorporated by reference. The incorporation of 26 U.S.C Subtitle A, Chapter 1, Subchapter B Parts V, VI, VII and IX (2013) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

2. When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section.

a. Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 10%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall be determined ineligible due to income.

b. If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy shall be requested. If the applicant is unable to provide a reasonable explanation, paper documentation shall be requested.

i) The Department may request paper documentation only if the Department does not find income to be reasonably compatible and if the applicant does not provide a reasonable explanation or if electronic data are not available.

3. Self-Employment – If the applicant is self-employed the ledger included in the Medical Assistance application shall be sufficient verification of earnings, unless questionable.

4. Budget Periods for MAGI-based Income determination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.

8.100.4.D. Income Disregard

1. Household income is calculated by including the MAGI-based income of every individual in the household, minus an amount equivalent to five percentage points of the Federal Poverty Level for the applicable family size. This five percent (5%) disregard is applied for each of the four MAGI programs: Parents and Caretaker Relatives, Pregnant Women, Children and Adults.

8.100.4.E. Determining MAGI Household Composition.

1. MAGI household composition is determined by relationships of tax dependency as declared on the Single Streamlined Application.

a. In the case of an applicant who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and does not expect to be claimed as a tax dependent by anyone else, then the applicant's MAGI household shall consist of the following:

i) The Tax-Filer

ii) The Tax-Filer's spouse if living in the home

iii) All persons whom the Tax-Filer expects to claim as a tax dependent on their personal income tax return

b. In the case of an applicant who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the applicant's MAGI household shall be the household of the taxpayer claiming that applicant as a tax dependent, except in the following circumstances:

i) The applicant expects to be claimed as a tax dependent of someone other than a spouse, biological, adoptive or step parent.

ii) The applicant is a child under 19 who is expected to be claimed by one parent~~.~~ as a tax dependent and is living with both parents, but the parents do not expect to file a joint tax return.

iii) The applicant is a child under 19 and who expects to be claimed by a non-custodial parent.

c. ~~3~~If the applicant meets one of the exceptions above or is a Non-Filer, household composition shall be determined using the Non-Filer rules and the applicant's household shall consist of the following:

i) The applicant;

ii) The applicant's spouse, if not living separately;

iii) The applicant's natural, adopted, and step children under the age of 19, if not living separately; and

iv) In the case of applicants under the age of 19, the applicant's natural, adoptive, and step parents and natural, adoptive, and step siblings under age 19, if not living separately.

2. Household size for all Medical Assistance categories shall include the unborn child(ren) as a child(ren) living in the home for the purposes of determining eligibility. However, ~~medical assistance~~Medical Assistance is not available to the unborn child, but only to the pregnant mother.

3. ~~4.~~ Medical ~~assistance~~Assistance is ~~not~~ available to the father of an unborn child under the Adult MAGI category when there are no other children in the household.

~~5.~~ 4. Dependent children ~~between the ages of 18 and 19 who are full time students in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19~~ are eligible through the end of the month ~~of completion.~~in which they turn 19 years old.

~~6~~5. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even though:

a. the child is under the jurisdiction of the court (for example, receiving probation services);

b. legal custody is held by an agency that does not have physical possession of the child;

c. the child is in regular attendance at a school away from home;

d. either the child or the relative is away from the home to receive medical treatment;

e. either the child or the relative is temporarily absent from the home;

f. the child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.

~~**8.100.4.D. 1931 Medical Assistance Specific Requirements**~~

~~1. Application for 1931 Medical Assistance shall be made by a caretaker relative with whom the dependent child is~~6. Married couples living~~.~~

~~2. There is no age requirement for the caretaker nor is the status of emancipation a requirement in regard to the caretaker relative. The caretaker relative is a specified relative who exercises responsibility for the care and control of the dependent child.~~

~~3. For 1931 Medical Assistance, include all the family members for whom 1931 Medical Assistance would be considered.~~

together will~~4. 1931 Medical assistance shall be provided to needy families who would have been eligible for Aid to Families with Dependent Children(AFDC) under regulations in effect on July 16, 1996. No other TANF/Colorado Works criterion applies to this group. Eligibility sites shall not require that a Medical Assistance applicant/recipient comply with any TANF/Colorado Works requirements. All references to the 1931 Medical Assistance Program apply to AFDC rules effective on July 16, 1996.~~

~~5. To receive medical assistance under 1931 Medical Assistance, a person shall meet general requirements for Medical Assistance outlined in this volume, and not be receiving Medical Assistance from another category due to financial assistance from AFDC foster care, OAP-A or SSI.~~

~~**8.100.4.E. Family and Children's Income Disregards**~~

~~1. The earned income disregards described in this section shall be applied to the gross wages of~~ each ~~individual who is employed in the following order:~~

~~a. deduct the employment expense disregard of $90; and~~

be ~~b. deduct dependent care disregard.~~

~~For purposes of this section, a dependent is defined as a dependent child or adult~~ included in the ~~Medical Assistance~~other's MAGI household~~. The employed person is allowed a dependent care deduction of the actual amount of the dependent care expenses of up to $175 per month per each dependent two years and older; up to $200 per month per dependent less than two years old.~~

~~In order to receive a dependent care deduction, declaration from the client is acceptable. The declaration, verbal,~~ regardless of whether or not they expect to file taxes jointly, separately or if one or ~~written on the application, shall include the total dependent care costs paid per dependent for the month(s) Medical Assistance eligibility is being determined. The client may also present receipts or other documentation of paid costs for dependent care for these months~~both expect to be claimed as tax dependents.

~~2. The unearned income disregard described in this section shall be applied to the total amount received for each individual:~~

~~a. The first $50 per household per month of any current monthly support obligation shall be disregarded. Monthly support includes child support, and/or maintenance, and/or alimony. The disregard shall be divided among each person that receives the month support.~~

8.100.4.F. ~~Family and Children's~~MAGI Category Presumptive Eligibility

1. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medical Assistance presumptive eligibility sites. A child under the age of nineteen may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites.

2. To be eligible for presumptive eligibility:

   a. ~~an applicant~~a pregnant woman shall have ~~a verified~~an attested pregnancy, declare that her household's income shall not exceed ~~-~~185% of the federal poverty level and declare that she is a United States citizen or a documented immigrant.

   b. a child under the age of 19 shall have a declared household income that does not exceed~~-~~ 133% of federal poverty level and declare that the child is a United States citizen or a documented immigrant of at least five years.

3. Presumptive eligibility sites shall be certified by the Department to make presumptive eligibility determinations. Sites shall be re-certified by the Department every 2 years to remain approved presumptive eligibility sites.

4. The presumptive eligibility sites shall attempt to obtain all necessary documentation to complete the application within fourteen calendar days of application.

5. The presumptive eligibility site shall forward the application to the county within five business days of being completed. If the application is not completed within fourteen calendar days, on the fifteenth calendar day following application, the presumptive eligibility sites shall forward the application to the appropriate county.

6. The presumptive eligibility period shall be no less than 45 days. The presumptive eligibility period ends on the last day of the month following the completion of the 45 day Presumptive Eligibility period. The county department shall make a Medical Assistance

eligibility determination within 45 days from receipt of the application. The effective date of Medical Assistance eligibility shall be the date of application.

7. A ~~Presumptive~~presumptive eligible client may not appeal the end of a presumptive eligibility period.

8. Presumptively eligible women and Medical Assistance clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in the State Hearings section of this volume.

8.100.4.G. ~~Family and Children's~~MAGI Covered Groups

1. For ~~Family and Children's~~MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. ~~Families~~Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 100% of the federal poverty level shall be determined financially eligible for Medical Assistance. Parents or ~~caretaker relatives~~Caretaker Relatives eligible for this category shall have a dependent child in the household receiving Medical Assistance.

   a. Effective January 1, 2014, Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance

4. Effective January 1, 2014, Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage must be provided regardless of changes in the woman's financial circumstances.

6. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for Medical Assistance if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.3. This population is referenced as ~~1931 Medical Assistance~~Legal Immigrant Prenatal.

~~3. Medical assistance shall be furnished to any person who is residing in a participating Medicaid facility and who would be eligible for section 1931 Medical assistance if that person resided outside a facility.~~

~~4. Persons who would be eligible for 1931 Medical Assistance except for the inclusion in the assistance unit of a relative not included as financially responsible whose income makes the unit ineligible. This procedure is referenced as the 113 rule.~~

~~5~~7. A child born to a woman receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This provision also applies in instances when the woman received Medical Assistance to cover the child's birth through retroactive Medical Assistance. ~~as long as the child remains a member of the mother's household. This provision also applies in instances when the woman received Medical Assistance to cover the child's birth through retroactive Medical Assistance.~~ To receive Medical Assistance under this category, the ~~family~~individual need not file an application nor provide a social security number or proof of application for a social security number for the newborn. Anyone can report the birth of the baby verbally or in writing. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time. Once reported, a newborn meeting the above criteria shall be added to the Medical Assistance case according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes. This population is referenced as Eligible Needy Newborn.~~b. whose income does not exceed her proportionate share of 185% of the federal poverty level or whose total family income does not exceed 185% of federal poverty level~~

~~c. For a period beginning with the date of application for medical assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage must be provided regardless of changes in the woman's financial circumstances. This population is referenced as Expanded Pregnant.~~

~~9. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for medical care if she meets the eligibility requirements for expectant mothers listed in~~8.100.4.~~G.9. This population is referenced as Legal Immigrant Prenatal.~~

~~10. If an individual is found ineligible because their income exceeds their proportionate share of the federal poverty level, a recalculation shall be performed to look at the Medical Assistance required household as a whole. The household's total income, after the allowable Medical Assistance deductions, shall be compared to the maximum federal poverty level. If the individual is then eligible under this process, they shall be eligible under the same category for which they originally were determined ineligible. This procedure is referenced as the Boatwright rule.~~

~~8.100.4.~~H. Needy Persons Under 21

1. Medical ~~assistance~~Assistance shall be provided to certain needy persons under 21 years of age, including the following:

   a. Those receiving care in a Long Term Care Institution eligible for Medical Assistance reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement and whose ~~family~~household income is less than the ~~AFDC~~MAGI needs standard for his/her family size when the client applies for assistance. Clients that are receiving benefits under this category and are still receiving active inpatient treatment in the facility at age 21 shall be eligible to age 22. This population is referenced as Psych ~~-~~< 21.

   b. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. ~~See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR 2599).~~ A child shall be the responsibility of the county, even if the child may be in a medical institution at that time. See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR § 2509-1). 12 CCR § 2509-1 (2013) is hereby incorporated by reference. The incorporation of 12 CCR § 2509-1 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

   c. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.

   d. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose ~~family~~household income is less than the ~~AFDC~~MAGI needs standard for his/her family size.

   e. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.

   f. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medical Assistance for the child.

g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the date the individual attained 18 years of age or was emancipated. Eligibility ~~will~~shall be extended until the individual's 21st birthday~~.~~ for these individuals with the exception of those receiving subsidized adoption payments.

i) Eligibility shall be extended until the individual's 26th birthday for individuals receiving subsidized adoption payments.

8.100.4.I. Transitional Medical Assistance and 4 Month Extended Medical Assistance

1. Eligibility for Transitional Medical Assistance shall be granted for twelve months (beginning with the first month of ineligibility) to families who would otherwise become ineligible for Medical Assistance ~~under 1931 Medical Assistance.~~due to a change in income. The extension shall be applied ~~for~~to a family who ~~is~~:

   a. Is eligible and receiving assistance ~~under 1931 Medical Assistance~~ in at least 3 of the 6 months immediately preceding the month in which the family would have become ineligible ~~for 1931~~ Medical Assistance, and

   b. ~~a. who becomes~~Becomes ineligible for ~~1931~~ Medical Assistance solely because of new or increased income from employment, or hours of employment, provided an employed member of the family continues to be employed.

2. Required members of the Medical Assistance ~~required~~ household who come into the household after the unit is receiving transitional Medical Assistance are eligible for the remaining months of Transitional Medical Assistance. Transitional Medical Assistance applies to the members of the Medical Assistance required household.

3. To remain eligible for Transitional Medical Assistance:

   a. The employed member of the Assistance Unit cannot terminate employment without good cause.

   b. The household must include a dependent child. If it is determined that the household no longer has a child living in the home, Transitional Medicaid Assistance shall discontinue at the end of the month in which the household does not include a dependent child.

   c. If health insurance is available from the employer to the employee, at no cost to the ~~1931~~ Medical Assistance recipient, the client shall enroll in the insurance program.

4. When Transitional Medical Assistance ends, the eligibility site shall review the file for all other categories of Medical Assistance for which the family members may be eligible. A new application shall not be required for this process.

5. Eligibility for ~~medical assistance~~Medical Assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for ~~1931~~ Medical Assistance due solely or partially to the receipt of support income. Support income may be ~~child support,~~ maintenance~~,~~ or alimony. The extension shall be applied for a family which receives assistance under ~~1931~~ Medical Assistance in at least three of the six months immediately preceding the month in which the family becomes ineligible for assistance. To be eligible for the four month Medical Assistance extension, the family shall be eligible for ~~1931~~ Medical Assistance in all respects before the support income is applied. The support recipient shall be included in the ~~1931~~ Medical Assistance calculation for the extension to apply.

8.100.4.J. Express Lane Eligibility

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

1. Free/Reduced Lunch Program

    a. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district-

        i~~.~~) Families ~~will~~shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

        ii~~.~~) Children who meet all necessary eligibility requirements as outlined in this volume ~~will~~shall be automatically enrolled.

        iii~~.~~) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity ~~will~~shall receive ~~30 days~~30days of eligibility while awaiting this verification.

        iv~~.~~) Any additionally required verification ~~will~~shall be requested from the client through CBMS prior to being automatically enrolled.

        v~~.~~) Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in this volume.

        vi~~.~~) If it would be found that a child does not satisfy an eligibility requirement for ~~medical assistance~~Medical Assistance, the child's eligibility will be evaluated using the ~~application~~Single Streamlined Application for Medical Assistance.

    b. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district-

i.) Families who are automatically enrolled Free/Reduced Lunch recipient children willshall not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

ii.) These families must apply for Medical Assistance in order to give consent for request of benefits.

2. Direct Certification

a. Individuals who have submitted a Food StampsAssistance or Colorado Works application

i.) Families willshall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

ii.) Children who meet all necessary eligibility requirements as outlined throughout 8.100.4 willshall be automatically enrolled.

iii.) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 30 days of eligibility while awaiting this verification.

iv.) Any additionally required verification willshall be requested from the client through CBMS prior to being automatically enrolled.

v.) Eligibility is based on income declared on the Food StampsAssistance or Colorado Works application as well as eligibility requirements outlined throughout this volume.

vi.) If it would be found that a child does not satisfy an eligibility requirement for medical assistanceMedical Assistance, the child's eligibility willshall be evaluated using the applicationSingle Streamlined Application for Medical Assistance.

vii.) Individuals whose eligibility is not determined through Express Lane Eligibility can also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

8.100.5. ~~-~~Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan Medical Assistance General Eligibility

8.100.5.A. Application Requirements

1. When an individual applies for Medical Assistance on the basis of disability or blindness, the eligibility sites shall take the application and determine whether the individual is eligible for Long Term Care or any of the Aged, Blind, and Disabled categories of assistance described in section 8.100.6~~ under Qualified Disabled and Working Individuals~~. If the applicant does not qualify for Medical Assistance on one of those bases, he/she shall be referred to the local Social Security office to apply for SSI.

    a. Applicants who apply for Long-Term Care Medical Assistance on the basis of disability or blindness, or who apply for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities without a current disability determination, shall complete a Medical Assistance disability determination application in addition to the required ~~Medical Assistance application.~~Single Streamlined Application. The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.

    b. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded to the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated eligibility site representative.

    c. For the Medicaid Buy-In Program for Working Adults with Disabilities, if an individual does not meet the Social Security Administration definition of disability, the state disability determination contractor can review the individual's circumstances to determine if the individual meets limited disability.

2. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the ~~Colorado Medical Assistance application~~Single Streamlined Application.

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals 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 the section 8.100.3.H under Citizenship and Identity ~~Eligibility~~Documentation 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. 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 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. Applicants may request that communication with their employers be made in writing.

   As of CBMS implementation, 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. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. 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. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.

e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

f. 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.

g. ~~Pregnancy~~Additional verification~~, if applicable, and if~~ If the ~~pregnancy~~ requested verification is ~~not observable. The~~submitted by the applicant, no other additional verification shall be ~~documented according~~required unless the submitted verification is found to ~~8.100.4.G.9.a~~be questionable on the basis of fact.

~~h. Additional verification If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.~~

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

8.100.5.C. Effective Date ~~O~~of Eligibility

1. ~~Medical Assistance~~Eligibility for the Aged, Blind and Disabled categories shall be approved effective ~~as~~on the later of ~~the date~~ :

   a. The first day of ~~application for Medical Assistance, or as~~the month of the Single Streamlined Application for Medical Assistance; or

   b. ~~date~~The first day of the month the person becomes eligible for Medical Assistance.

2. ~~, whichever~~The date that eligibility begins for Long-Term Care Medical Assistance is ~~later.~~defined in section 8.100.7.A and B.

3. For the Medicaid Buy-In Program for Children with Disabilities, any child who is determined to be eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits during the entire month. ~~Individuals held in correctional facilities or who are held in community corrections programs that are determined eligible for Medical Assistance shall be approved effective as of the individual's date of release.~~

~~2~~4. Clients applying for Medical Assistance under the Aged, Blind and Disabled category shall be reviewed for retroactive eligibility as described at 8.100.3.E. When reviewing for retroactive eligibility for an individual who is SSI eligible or applied and became SSI eligible in each of the retroactive months, the applicant must:

   a. Be aged at least 65 years~~,~~; or~~;~~

   b. Meet the Social Security Administration definition of disability by~~:~~;

      i~~.~~) Being approved as eligible to receive either SSI or SSDI, on or prior to the date of a medical service~~,~~; or

      ii~~. having~~) Having a disability onset date determined on or prior to the date of a medical service~~,~~; and

   c. ~~and meet~~Meet the financial requirements as described at 8.100.5.E.

5. Individuals held in correctional facilities or who are held in community corrections programs that are determined eligible for Medical Assistance shall be approved effective as of the individual's date of release. Individuals participating in a Community Corrections program who are residing at their home, such as house arrest, or another location that is not a Community Corrections facility that are determined eligible for Medical Assistance shall be approved effective as of the date the individual meets all financial eligibility requirements. All individuals on Parole who are determined eligible for Medical Assistance shall be approved effective as of the date the individual meets all financial eligibility requirements

8.100.5.D. Medical Assistance Estate Recovery Program

1. The eligibility site shall provide written information from the Department to the following people explaining the provisions of the Medical Assistance Estate Recovery Program and how those provisions may pertain to the applicant/client:

    a. Applicants age 55 and older who are institutionalized.

    b. Applicants/clients who will turn age 55 before their next eligibility re-determination who are institutionalized.

    c. Clients age 55 and older~~, and~~ who are approved for admittance to an institution

8.100.5.E. Availability of Resources and Income

Consistent with the legislative declaration outlined at C.R.S. § 25.5-4-300.4, ~~C.R.S.,~~ Medicaid should be the payer of last resort for payment of medically necessary goods and services furnished to clients. All other sources of payment, including an individual's own countable income and resources, should be utilized to the fullest extent possible before Medicaid is accessed.

1. Income, which includes earned and unearned income, shall be calculated on a monthly basis regardless of whether it is received annually, semi-annually, quarterly or weekly.

2. For married couples, the income and resources of both spouses are counted in determining eligibility for either or both spouses. Refer to section 8.100.7.C for exceptions.

3. Resources and income shall be considered available when actually available; or, shall be deemed available when all of the following apply to the resources or income of the individual or individual's spouse:

    a. has any ownership interest in income or resources or equity value of a resource;

    b. has the right, authority, or power to convert the resource or income to cash or to cause the resource or income to be converted to cash; and

    c. is not legally restricted from using the resource or income for his or her support and maintenance.

4. Resources and income shall not be considered unavailable merely because the ~~Individual~~individual or individual's spouse may need to initiate legal proceedings to access the resources or income.

5. If the applicant or client demonstrates with clear and convincing evidence that appropriate steps are being taken to secure the resources, Medical Assistance shall not be delayed or terminated. Verification of efforts to secure the resources must be provided at regular intervals as requested by the Eligibility Site.

6. Resources will be considered available and Medical Assistance shall be denied or terminated if the applicant or client refuses or fails to make a reasonable effort to secure ~~a~~ potential resources or income.

7. Timely and adequate notice must be given regarding a proposed action to deny, reduce, or terminate assistance due to failure to make reasonable efforts to secure resources or income. If upon receipt of the prior notice, the individual acts to secure the potential resource, the proposed action to deny, reduce, or terminate assistance must be withdrawn, and assistance must be approved or continued until the resource or income is, in fact, available.

8. If the resources or income has been transferred to a trust, the trust shall be submitted for review to the Department to determine the effect of the trust on eligibility in accordance with section 8.100.7.E.

9. A resource may not necessarily be unavailable by virtue that an individual may be unaware of his or her ownership of an asset. The Department will not treat the unknown asset as a resource during the period in which the individual was unaware of his/her ownership. However, the value of the previously unknown asset, including any monies such as interest that have accumulated on the asset through the month of discovery, is evaluated under regular income-counting rules in the month of discovery, and the asset is a resource subject to the resource-counting rules following the month of discovery.

    a. The burden is on the individual to prove by clear and convincing evidence that the asset was unavailable by virtue of being unknown by the recipient.

    b. Unknown assets shall not be deemed an overpayment pursuant to Section 8.065 of the Department's regulations where the asset was unknown through no fault of the individual.

    c. If the previously unknown asset causes the individual to be ineligible, the individual may repay the Department from the excess resources to retain Medicaid eligibility.

8.100.5.F. Income Requirements

1. This section reviews how income is looked at for the ABD and Long Term Care Medical Programs and determining premiums for the Medicaid Buy-In Program for Working

Adults with Disabilities. For more general income information and income types refer to the ~~General~~ Medical Assistance General Eligibility Requirements section 8.100.3.

~~2.~~ 2. Income for the ABD Medical Programs eligibility is income which is received by an individual or family in the month in which they are applying for or receiving Medical Assistance, or the previous month if income for the current month is not yet available to determine eligibility.

3. A self-declared common law spouse retains the same financial responsibility as a legally married spouse. Once self-declared as married under the common law, financial responsibility remains unless legal separation or divorce occurs. If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other. This is not changed by the fact that the unmarried individuals may share a common child.

4. Earned income is countable as income in the month received and a countable resource the following month. Earned Income includes the following:

a. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment.

b. Net earnings from self-employment

c. Payments for services performed in a sheltered workshop or work activities center

d. Certain Royalties and honoraria

~~3~~5. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment.

Unearned income is countable as income in the month received and any unspent amount is a countable resource the following month. Unearned income includes, but is not limited to, the following:

a. Death benefits, reduced by the cost of last illness and burial

b. Prizes and ~~rewards~~awards

c. Gifts and inheritances

d. Interest payments on promissory notes established on or after March 1, 2007.

e. Interest or dividend payments received from any resources

f. ~~lump~~Lump sum payments from ~~SSA/SSI, workman's~~workers' compensation, insurance settlements, etc.

g. Dividends, royalties or other payments from mineral rights or other resources listed for sale within the resource limits

h. Income from annuities that meet requirements for exclusion as a resource

i. Pensions and other period payments, such as:

i) Private pensions or disability benefits

ii) Social Security benefits (Retirement, survivors, and disability)

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).

vii) Alimony and support payments

j. Support and maintenance in kind - The support and maintenance in kind amount should not be greater than one third of the Federal Benefit Rate (FBR). Use the Presumed Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the support and maintenance in kind amount. Use one third of the FBR if an amount is not declared by the client.

6. For the purpose of determining eligibility for the Long Term Care and Aged, Blind, and Disabled Medical Assistance categories the following shall be exempt from consideration as either income or resources:

a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification.

b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act.

c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive payments (lump sum) for nine months following receipt and the remainder countable as a resource thereafter.

d. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC).

e. Home produce utilized for personal consumption.

f. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner

toward the purchase of a replacement dwelling are considered exempt for up to 6 months.

g. The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

i) Experimental Housing Allowance Program (EHAP) payments made by HUD under section 23 of the U.S. Housing Act.

ii) The United States Housing Act of 1937 (§ 1437 et seq. of 42 U.S.C.)

iii) The National Housing Act (§ 1701 et seq. of 12 U.S.C.)

iv) Section 101 of the Housing and Urban Development Act of 1965 (§ 1701s of 12 U.S.C., § 1451 of 42 U.S.C.);

v) Title V of the Housing Act of 1949 (§ 1471 et seq. of 42 U.S.C.); or

vi) Section 202(h) of the Housing Act of 1959.

h. Payments made from Indian judgment funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458).

i. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed $ 2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to $ 2000, received by a client in one calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to $ 2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s).

j. Assistance from other agencies and organizations.

k. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for Medical Assistance.

l. Payments received for providing foster care.

m. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than

the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act.

n. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program.

o. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program

p. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act.

q. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended.

r. Monies received pursuant to the "Civil Liberties Act of 1988" P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts).

s. Payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y).

t. A child receiving subsidized adoption funds shall be excluded from the Medical Assistance budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household.

u. The Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.

v. Any money received from the Radiation Exposure Compensation Trust Fund, Including the Energy Employees Occupational Illness Compensation Program Act, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.

w. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are actual expenses for food, housing, medical items, clothing, transportation, or personal needs items.

x. Payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.

y. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds.

z. All wages paid by the United States Census Bureau for temporary employment related to the decennial Census.

aa. Any grant or loan to an undergraduate student for educational purposes made or insured under any programs administered by the Commissioner of Education (Basic Education Opportunity Grants, Supplementary Education Opportunity Grants, National Direct Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program, the BYRD Honor Scholarship programs and the College Work Study Program.

bb. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).

cc. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.

dd. The additional unemployment compensation of $25 a week enacted through the American Recovery and Reinvestment Act of 2009.

8.100.5.G. Deeming Of Income And Resources For The OAP Program

1. All aliens who apply for OAP on or after April 16, 1988, for three years after the date of admission into the United States, shall have the income and resources of their sponsors other than relatives deemed for their care. Refer to the Medical Assistance General Eligibility Requirements section 8.100.3.K for specific information on deeming of income and resources.

8.100.5.H. Income Allocations and Disregards

1. The following income allocations and disregards are only applicable to SSI related, OAP, ~~and~~ Medicare Savings Programs (MSP), and the Medicaid Buy-In Program for Working Adults with Disabilities. ~~Only the unearned income disregard is applicable to AwDC. These disregards are not applicable to the HCBS waivers or the LTC programs.~~

   These allocations~~2. The gross amount of earned~~ and ~~unearned~~disregards are not applicable to the HCBS waivers or the LTC programs.

   For the Medicaid Buy-In Program for Working Adults with Disabilities, the applicant's spouse's income ~~is countable~~ does not count toward ~~eligibility with the following exclusions:~~the applicant.

a. ~~the first $20 of total available unearned income (except for SSI income) must be disregarded;~~

Income~~b. an additional $65 plus 1/2 of the remainder of earned income must be disregarded;~~

~~c. income~~ of spouses living together is considered mutually available ~~and must be compared to the current SSI benefit level for a couple; net income of a non recipient spouse must be reduced by an amount up to one half the individual SSI benefit level for unmet needs of each non recipient child in the family. This does not apply to the Medicaid Buy-In Program for Working Adults with Disabilities.~~for SSI related, OAP, and Medicare Savings Programs (MSP).

b. For~~d. income of single persons must be compared to the current SSI benefit level for an individual (a one third reduction applies to~~ a person living in the household of another~~);~~

and not paying shelter costs, one third of the Federal Benefit Rate (FBR) is counted as in-kind income and is added to the countable income. This does not apply to ~~e.~~ unemancipated children ~~are not subject to a one-third reduction, an amount of parental income equal to the individual or couple SSI benefit level must be allowed for the needs of the parent or parents, up to one half the individual SSI benefit level must be allowed for the unmet needs of each non recipient child in the family, and the remainder must be considered as income available to the applicant or recipient child.~~ .

2. For the purposes of this rule, ~~"~~the following definitions apply:

a. unemancipated child~~" means (1)~~ is:

i) a child under age 18 who is living in the same household with a parent or spouse of a parent, or ~~(2)~~

ii) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment~~;~~.

~~f. one third of~~ b. Ineligible child ~~support~~ is a child who is not applying or eligible for SSI.

c. Ineligible parent/spouse is a parent or spouse who is not applying or eligible for SSI.

3. Countable income is calculated by reducing the gross income by the following allocations and disregards.

a. Income allocations are the part of the gross income that is allocated to individuals in the home who are not eligible for Supplemental Security Income or Old Age Pension. The allocation reduces the gross income that is deemed available to the

applicant/client. The allocation is deducted from the gross income prior to applying the other disregards.

The allocations are:

i) An Ineligible Child Allocation is an amount equal to one half the current year's SSI FBR that is disregarded from the ineligible parents' gross income. This allocation is used to meet the needs of ineligible children in the household. This allocation is available for each ineligible child in the home. The amount of the allocation is reduced by any of the ineligible child's own income.

ii) An Ineligible Parent(s) Allocation is an amount equal to the current year's SSI FBR for a single individual or a couple, as applicable. This amount is used to meet the needs of the ineligible parent(s) in the home with an applicant/client child.

iii) No allocations are allowed for applicant/recipient ~~child from an absent parent~~spouses who do not have children in the home.

b. Allocations are applied to the income in the following manner:

i) Allocation disregards are deducted from unearned income before earned income.

ii) Ineligible child allocation disregards are deducted from parents' income before any standard disregards are applied.

iii) Ineligible parent(s) allocation disregards are deducted after any ineligible child allocation disregards and after the standard income disregards.

4. Income disregards

a. $20 Unearned Income Disregard

If there is unearned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied, the first $20 of total available unearned income (except for SSI income) must be disregarded~~;~~.

~~g.~~ b. $65 Plus One Half Remainder Earned Income Disregard

i) If there is earned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied:

1) Deduct the first $65 of all earned income.

2) Divide the remaining income in half.

3) The result is the amount of earned income used for determining eligibility.

c. Child support received by an applicant/recipient child is reduced by one third of the total child support payment. This reduction does not apply to ineligible children when calculating the ineligible child allocation disregard.

d. The first $400 of the gross monthly ~~earnings, not to exceed $1620 in a calendar year, shall be~~earned income is exempt ~~from consideration as earned income of a~~ for a blind or disabled ~~or blind~~ child who is a student that is regularly attending school. The exemption cannot exceed $1,620 in a calendar year.

e. ~~h. any other applicable exemptions in 20 CFR~~Title 20 of the Code of Federal Regulations, § 416.1112~~. 20 CFR 416.1112~~ (2012) is hereby incorporated ~~herein~~ by reference~~. No~~ into this rule. Such incorporation, however, excludes later amendments to or ~~later~~ editions ~~are incorporated. Copies~~of the referenced material. These regulations are available for public inspection ~~from the following person at the following address: Custodian of Records, Colorado~~at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. ~~Any material that has been~~Certified copies of incorporated ~~by reference in this rule may be examined~~materials are provided at ~~any state publications repository library~~cost upon request.

8.100.5.I. Determining Ownership of Income

1. If payment is made solely to one individual, the income shall be considered available income to that individual.

2. If payment is made to more than one individual, the income shall be considered available to each individual in proportion to their interests.

3. In case of a married couple in which there is no document establishing specific ownership interests, one-half of the income shall be considered available to each spouse.

4. Income from the Community Spouse's ~~Resource~~Monthly Income Allowance, as defined in the spousal protection rules in this volume at 8.100.7.R, is income to the community spouse.

8.100.5.J. Income-Producing Property

1. Net rental income from an exempt home or a life estate interest in an exempt home is countable after the following allowable deductions:

   a. Property taxes and insurance

   b. Necessary reasonable routine maintenance expenses

   c. Reasonable management fee for a professional property manager.

2. Non-business property that is necessary to produce goods or services essential to self-support is excluded up to $6,000.

3. Property used in a trade or business which is essential to self-support is excluded up to a limit of $6,000 if it produces 6% return of the $6,000 excluded value.

8.100.5.K. Department of Veterans Affairs (VA) Payments

The portion of the pension payments for ~~aid~~Aid and ~~attendance~~Attendance (A&A) and ~~unreimbursed medical expenses~~Unusual Medical Expenses (UME), as determined by the VA, shall not be considered as income when determining eligibility.

1. The portion of the pension payments for ~~aid~~Aid and ~~attendance~~Attendance (A&A) and ~~unreimbursed medical expenses~~Unusual Medical Expenses (UME), as determined by the VA, shall not be used as patient payment to the medical facility:

   a. for a veteran or surviving spouse of a veteran in a medical facility other than State Veterans Home; or

   b. for a veteran or surviving spouse of a veteran in a State Veterans Home with dependents.

2. For a veteran or surviving spouse of a veteran in a State Veterans Home with no dependents the portion of the pension payments for ~~aid~~Aid and ~~attendance~~Attendance (A&A) and ~~unreimbursed medical expenses~~Unusual Medical Expenses (UME), as determined by the VA, shall be used as patient payment to the medical facility.

8.100.5.L. Reverse Mortgages

1. In accordance with C.R.S. § 11-38-110, reverse mortgages payments made to a borrower shall not be treated as income for eligibility purposes.

2. Funds remaining the following month after the payment is made will be countable as a resource.

3. Any payments from a reverse mortgage that are transferred to another individual without fair consideration shall be analyzed in accordance with the rules on transfers without fair consideration in the Long-Term Care section and may result in a penalty period of ineligibility.

8.100.5.M. Resource Requirements

1. Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is $2,000. For a married couple, the resource limit is $3,000. If one spouse is institutionalized, refer to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses. Effective January 1, 2011, the resource limits for the Qualified Medicare Beneficiaries (QMB~~,~~), Specified Low Income Medicare Beneficiaries (SLMB~~,~~), and Qualified Individuals 1 (QI-1) programs are $8,180 for a single individual and

$13,020 for a married individual living with a spouse and no other dependents. The resource limits for the QMB, SLMB, and QI programs shall be adjusted annually by the Centers for Medicare and Medicaid Services on January 1 of each year. These resource limits are based upon the change in the annual consumer price index (CPI) as of September of the previous year. Resources are not counted for the Medicaid Buy-In Program for Working Adults with Disabilities~~,~~ or the Medicaid Buy-In Program for Children with Disabilities~~, or AwDC.~~.

2. The following resources are exempt in determining eligibility:

   a. A home, which is any property in which an individual or spouse of an individual has an ownership interest and which serves as the individual's principal place of residence. The property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

      i) Only one principal place of residence is excluded for a single individual or a married couple.

      ~~1~~ii) The individual's ownership interest in the home must have an equity value that:

         ~~a~~1) From January 1, 2006 thru December 31, 2010 is $500,000 or less, or;

         ~~b) Beginning January 1, 2011, is~~2) Is less than the amount that results from the year to year percentage increase to the $500,000 limit. The increase is based upon the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

      ~~2~~iii) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual intends to return to that home, then the individual does not meet the residency requirement for Colorado Medicaid eligibility.

      ~~3~~iv) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless the individual's spouse or dependent relative lives in the home.

      ~~4~~v) If an individual or spouse of an individual owns a home located inside Colorado with an equity value lower than the limit ~~that is located inside Colorado~~in subparagraph (1), above, and if the individual intends to return to that home, then the home is considered an exempt resource if:

         ~~a~~1) The individual is institutionalized; and

         ~~b~~2) The intent to return home is documented in writing.

~~5~~vi) If an individual or spouse of an individual owns a home with an equity value greater than the limit that is located inside Colorado, and if the individual intends to return to that home, then the home is considered to be a countable resource unless spouse or dependent relative lives in the home.

~~6~~vii) If an individual or spouse of an individual owns a home of any value located inside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless spouse or dependent relative lives in the home.

~~7~~viii) If an individual or spouse moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence.

~~8~~ix) If an individual leaves his or her home to live in an institution, the home shall still be considered the principal place of residence, irrespective of the individual's intent to return as long as the individual's spouse or dependent relative continues to live there.

~~9~~x) The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

~~10~~xi) The intent to return home applies to the home in which the individual or spouse of the individual was living prior to being institutionalized or to a replacement home as long as the individual's spouse or dependent relative continues to live in the home.

~~11)~~xii). The intent to return home also applies if the individual is living in an assisted living facility or alternative care facility and receives HCBS while in that facility or transfers into a Long-Term Care institution to receive services.

~~12~~xiii) For an ~~institutionalized~~ individual in a Long-Term Care institution, receiving HCBS, or enrolled in PACE, the exemption for the principal place of residence does not apply to a residence which has been transferred to a trust or other entity, such as a partnership or corporation.

~~a~~1) The exemption shall be regained if the residence is transferred back into the name of the individual.

~~b) The treatment of life estates and remainder interests in an individual's principal place of residence that have been transferred into a trust is described at 8.100.7.H.2.E.~~

~~13~~xiv) The principal place of residence, which is subject to estate recovery, becomes a countable resource upon the execution and recording of a beneficiary deed.

The exemption can be regained if a revocation of the beneficiary deed is executed and recorded.

b. Excess property will not be included in countable resources as long as reasonable efforts to sell it have been unsuccessful. Reasonable efforts to sell means:

i~~).~~.) The property is listed with a professional such as a real estate agent, broker, dealer, auction house, etc, at current market value.

ii) If owner listed, the property must be for sale at current market value, advertised and shown to the public.

iii) Any reasonable offer must be accepted.

iv) If an offer is received that is at least two-thirds of the current market value, that offer is presumed reasonable.

v) The client must continue reasonable efforts to sell and must submit verification of these efforts to the Eligibility Site on a quarterly basis. Reasonable effort is at Eligibility Site discretion.

vi) If the exemption is used to become eligible under the Spousal Protection rules, the property shall continue to be viewed according to 8.100.7.L while efforts to sell it are being made.

vii) Eligibility under this exemption is conditional. Once the property sells, the client shall be ineligible until the resources are below the prescribed limit.

c. One automobile is totally excluded regardless of its value if it is used for transportation for the individual or a member of the individual's household. An automobile includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

d. Household goods are not counted as a resource to an individual (and spouse, if any) if they are:

i) Items of personal property, found in or near the home, that are used on a regular basis; or

ii) Items needed by the household for maintenance, use and occupancy of the premises as a home.

iii) Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.

e. Personal effects are not counted as a resource to an individual (and spouse, if any) if they are:

i) Items of personal property ordinarily worn or carried by the individual; or

ii) Articles otherwise having an intimate relation to the individual.

iii) Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments.

iv) Items of cultural or religious significance to the individual and items required because of an individual's impairment are also not counted as a resource.

f. The cash surrender value of all life insurance policies owned by an individual and spouse, if any, is exempt if the total face value of all life insurance policies does not exceed $1,500 on any person. If the total face value of all the life insurance policies exceeds $1,500 on one person, the cash surrender value of those policies will be counted.

g. Term life insurance having no cash surrender value, and burial insurance, the proceeds of which can be used only for burial expenses, are not countable toward the resource limit.

h. The total value of burial spaces for the applicant/recipient, his/her spouse and any other members of his/her immediate family is exempt as a resource. If any interest is earned on the value of an agreement for the purchase of a burial space, such interest is also exempt.

i. An applicant or recipient may own burial funds through an irrevocable trust or other irrevocable arrangement which are available for burial and are held in an irrevocable burial contract, an irrevocable burial trust, or in an irrevocable trust which is specifically identified as available for burial expenses without such funds affecting the person's eligibility for assistance.

j. An applicant or recipient may also own up to $1,500 in burial funds through a revocable account, trust, or other arrangement for burial expenses, without such funds affecting the person's eligibility for assistance. This exclusion only applies if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual or spouse's burial expenses. Interest on the burial funds is also excluded if left to accumulate in the burial fund. For a married couple, a separate $1,500 exemption applies to each spouse.

The $1,500 exemption is reduced by:

i) the amount of any irrevocable burial funds such as are described in the preceding subparagraph, and

ii) the face value of any life insurance policy whose cash surrender value is exempt.

3. Countable resources include the following:

a. Cash;

b. Funds held by a financial institution in a checking or savings account, certificate of deposit or money market account;

c. Current market value of stocks, bonds, and mutual funds;

d. All funds in a joint account are presumed to be a resource of the applicant or client. If there is more than one applicant or client account holder, it is presumed that the funds in the account belong to those individuals in equal shares. To rebut this presumption, evidence must be furnished that proves that some or all of the funds in a jointly held account do not belong to him or her. To rebut the sole ownership presumption, the following procedure must be followed:

i) Submit statements from all of the account holders regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent.

ii) Submit account records showing deposits, withdrawals and interest in the months for which ownership of funds is at issue.

iii) Correct the account title and submit revised account records showing that the applicant or client is no longer an account holder or separate the funds to show they are solely owned by the individual within 45 days.

e. Any real property that is subject to a recorded beneficiary deed and on which an estate recovery claim can be made.

f. For applications filed on or after January 1, 2006, an individual's home if the individual's equity interest in the home exceeds the equity value limit described at 8.100.5.M.2.a.i)1).

g. Real property not exempt as the principal place of residence and not exempt as income producing property with a value of $6,000 or less, as described at 8.100.5.J.

h. When the applicant alleges that the sale of real property would cause undue hardship to the co-owner due to loss of housing, all of the following information must be obtained:

i) The applicant or client's signed statement to that effect.

ii) Verification of joint ownership.

iii) A statement from the co-owner verifying the following:

1) The property is used as his principal place of residence.

2) The co-owner would have to move if the property were sold.

3) The co-owner would be unable to buy the applicant or client's interest in the property.

4) There is no other readily available residence because there is no other affordable housing available or no other housing with the necessary modifications for the co-owner if he is a person with disabilities.

i. Personal property such as a mobile home or trailer or the like, that is not exempt as a principal place of residence or that is not income producing.

j. Personal effects acquired or held for their value or as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.

k. The equity value of all automobiles that are in addition to one exempt vehicle.

l. The cash surrender value of all life insurance policies owned by an individual and spouse is counted if the total face value of all the policies combined exceeds $1,500 on any person.

m. Promissory notes established before April 1, 2006 are treated as follows:

i) The fair market value of a promissory note, mortgage, installment contract or similar instrument is an available countable resource.

ii) In order to determine the fair market value, the applicant shall obtain three estimates of fair market value from a private note broker, who is engaged in the business of purchasing such notes. In order to obtain the estimates and locate willing buyers, the note shall be advertised in a newspaper with state wide circulation under business or investment opportunities.

iii) A note or similar instrument which transferred funds or assets for less than fair consideration shall be considered as a transfer for less than fair consideration and a period of ineligibility shall be imposed.

n. Promissory notes established on or after April 1, 2006 and before March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is an available countable resource unless the note, loan or mortgage:

1) Has a repayment term that is actuarially sound based on the individual's life expectancy, found in the tables at 8.100.7.J, for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

ii) The value of a promissory note, loan or mortgage which does not meet the criteria in outlined in 8.100.5.M.3.n.i)1)-3) is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is subject to the transfer of assets without fair consideration provisions as outlined in section 8.100.7.F.

o. Promissory notes established on or after March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is an available countable resource, and

ii) A promissory note, loan or mortgage which does not meet the following criteria shall be considered to be a transfer without fair consideration and shall be subject to the provisions outlined at 8.100.7.F.

1) Has a repayment term that is actuarially sound based on the individual's life expectancy as found in the tables in section 8.100.7.J for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

p. Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

i) Ownership of land and mineral rights. If the individual owns the land to which the mineral rights pertain, the current market value of the land generally includes the value of the mineral rights.

ii) If the individual does not own the land to which the mineral rights pertain, the individual should obtain a current market value estimate from a knowledgeable source. Such sources may include:

1) any mining company that holds leases;

2) the Bureau of Land Management;

3) the U.S. Geological Survey.

8.100.5.N. Treatment of Self-Funded Retirement Accounts

1. The following regulations apply to self-funded retirement accounts such as an Individual Retirement Account (IRA), Keogh Plan, 401(k), 403(b) and any other self-funded retirement account.

2. Self-funded retirement accounts in the name of the applicant are countable as a resource to the applicant.

3. Self-funded retirement accounts in the name of the applicant's spouse who is living with the applicant are exempt in determining eligibility for the applicant, except as set forth in 4. below.

4. Self-funded retirement accounts in the name of a community spouse who is married to an applicant who is applying for Long Term Care in a Long Term Care institution, HCBS or PACE, are countable as a resource to the applicant and may be included in the Community Spouse Resource Allowance (CSRA) up to the maximum amount allowable. The terms community spouse and CSRA are further defined in the regulations on Spousal Protection in this volume.

5. The value of a self-funded retirement account is determined as follows:

    a. The gross value of the account, less any taxes due, is the amount that is countable as a resource, regardless of whether any monthly income is being received from the account.

    b. If the applicant is not able to provide the amount of taxes that are due, the value shall be determined by deducting 20% from the gross value of the account.

8.100.5.O. Treatment of Inheritances

1. An inheritance is cash, other liquid resources, non-cash items, or any right in real or personal property received at the death of another.

2. If an Individual or individual’s spouse is the beneficiary of a will, the inheritance is presumed to be available at the conclusion of the probate process or within 6 months if the estate is not in probate.

3. If an individual or individual’s spouse is eligible for a family allowance in a probate proceeding, that allowance will be considered available three months after death or when actually available, whichever is sooner.

4. Evidence demonstrating that the inheritance is not available due to probate or other legal restrictions must be provided to rebut the presumption.

8.100.5.P. Treatment of Proceeds from Disposition of Resources

Treatment of proceeds from disposition of resources is determined as follows:

1. The net proceeds from the sale of exempt or non-exempt resources are considered available resources.

2. The net proceeds are the selling price less any valid encumbrances and costs of sale.

3. After deducting any amount necessary to raise the individual's and spouse's resources to the applicable limits, the balance of the net proceeds, in excess of the resource limits, shall be considered available resources. In lieu of terminating eligibility due to excess resources, the client may request that the proceeds be used to reimburse the Medical Assistance Program for previous payments for Medical Assistance.

4. The proceeds from the sale of an exempt home will be excluded to the extent they are intended to be used and are, in fact, used to purchase another home in which the individual, a spouse or dependent child resides, within three months of the date of the sale of the home.

8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility [Eff. 03/30/2009]

8.100.6.A. Aged, Blind, and Disabled (ABD) General Information

1. Medical Assistance for ABD includes SSI eligible individuals, OAP recipients, and the Medicare Savings Program (MSP) individuals. Refer to section 8.100.5 of this volume for income and resource criteria for these categories of assistance.

8.100.6.B. Disability Determinations

1. Beginning on July 1, 2001, the Department or its contractor shall determine whether the client is disabled or blind in accordance with the requirements and procedures set forth elsewhere in this volume and according to Federal regulations regarding disability determinations.

2. A client who disagrees with the decision on disability or blindness shall have the right to appeal that decision to a state-level fair hearing in accordance with the procedures at 8.~~058~~057.

8.100.6.C. SSI Eligibles

1. Benefits of the Colorado Medical Assistance Program must be provided to the following:

    a. persons receiving financial assistance under SSI;

    b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

    c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

2. The Department has entered into an agreement with SSA in which SSA shall determine Medical Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving SSI benefits as determined by SSA to be eligible for Medical Assistance.

3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the eligibility site to authorize Medical Assistance.

4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical Assistance.

6. The SISC Code for this type of assistance is B.

7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later overturned, must be approved from the original SSI eligibility date.

8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive Medical Assistance benefits. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income.

9. If the eligibility site obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.

10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.

    a. Special Provisions for Infants

        ~~1.~~ i) For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:

            ~~a~~1) the infant was born in a hospital;

            ~~b~~2) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and

            ~~c~~3) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI

8.100.6.D. Pickle Amendment

1. Beginning July 1977, ~~medical assistance~~Medical Assistance must be provided to an individual if their countable income is below the current years SSI standard after a cost of living adjustment (COLA) disregard is applied to their OASDI (excluding Railroad Retirement Benefits) and they meet all other eligibility criteria. This is referred to as Pickle Disregard.

2. The Pickle Disregard applies to an individual who:

    a. lost SSI and/or OAP because of a cost of living adjustment to his/her own OASDI benefits.

    b. lost SSI and/or OAP because a cost of living adjustment to OASDI income deemed from a parent or spouse.

    c. lost OAP and/or SSI due to the receipt of, or increase to, OASDI, and would be eligible for OAP and/or SSI if all COLA'S on the amount that caused them to lose eligibility is disregarded from their current OASDI amount.

8.100.6.E. Pickle Determination

1. To determine eligibility of Medical Assistance recipients to whom the Pickle disregards apply, the eligibility site must:

    a. establish whether the person was eligible for SSI or OAP and, for the same month, was entitled to OASDI;

    b. determine the previous amount of the OASDI that caused them to lose SSI and/or OAP;

    c. determine the current OASDI income;

    d. subtract the previous OASDI income from the current OASDI income to find the cumulative OASDI COLAs since SSI and/or OAP was lost. This is the Pickle Disregard amount;

    e. subtract the Pickle Disregard amount from the current OASDI income to get the countable OASDI income.

2. If the countable OASDI income and all other countable income is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria then medical eligibility must continue or be reinstated.

3. This disregard must also be applied to any OASDI cost of living increases paid to any financially responsible individual such as a parent or spouse whose income is considered in determining the person's continued eligibility for Medical Assistance.

4. The cost of living increase disregard specified in the preceding action must continue to be applied at each eligibility redetermination.

5. An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be contacted by the eligibility site to determine if the individual would continue to remain eligible for Medical Assistance under the provisions for SSI related cases. The individual must complete an application for assistance to continue receiving benefits.

8.100.6.F. 1972 Disregard Individuals

1. Medical Assistance must be provided to a person who was receiving financial assistance under AND or Aid to the Blind (AB) for August 1972 and who – except for the October 1972 Social Security (includes RRB) 20% increase amount would currently be eligible for financial assistance. This disregard must also be applied to a person receiving Medical Assistance in August 1972 who was eligible for financial assistance but was not receiving the money payment and to a person receiving Medical Assistance as a resident in a medical institution in August 1972.

2. To redetermine the eligibility of Medical Assistance recipients to whom the 1972 disregard applies, the eligibility site must:

a. review the case against the current applicable program definitions and requirements;

b. apply the resource and income criteria specified in section 8.100.5;

c. subtract the 1972 disregard amount from the income;

d. consider the remainder against the current appropriate SSI benefit level.

8.100.6.G. Individuals Eligible in 1973

1. Medical Assistance must be provided to ABD persons who are receiving mandatory state supplementary payments (SSP). Such persons are those with income below their December 1973 minimum income level (MIL).

2. Medical Assistance must be provided to a person who was eligible for ~~medical assistance~~Medical Assistance in December 1973 as an inpatient of a medical facility, who continues to meet the December 1973 eligibility criteria for institutionalized persons and who remains institutionalized.

3. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an "essential spouse" of an AND or AB financial assistance recipient, and who continues to be in the grant and continues to meet the December 1973 eligibility criteria. Except for such persons who were grandfathered-in for continued assistance, essential spouses included in assistance grants after December 1973 are not eligible for Medical Assistance.

8.100.6.H. Eligibility for Certain Disabled Widow(er)s

1. Medical Assistance shall be provided retroactive to July 1, 1986, to qualified disabled widow(er)s who lost SSI and/or state supplementation due to the 1983 change in the actuarial reduction formula prescribed in section 134 of P.L. No. 98 21.

   In order for these widow(er)s to qualify, these individuals must:

   a. have been continuously entitled to Title II benefits since December 1983;

   b. have been disabled widow(er)s in January 1984;

   c. have established entitlement to Title II benefits prior to age 60;

   d. have been eligible for SSI/SSP benefits prior to application of the revised actuarial reduction formula;

   e. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial table; and

   f~~.~~. reapply for assistance prior to July 1, 1987.

8.100.6.I. Eligibility for Disabled Widow(er)s

1. Effective January 1, 1991, Medical Assistance shall be provided to disabled widow(er)s age 50 through 64 who lost SSI and/or OAP due to the receipt of Social Security benefits as a disabled widow(er). The individual shall remain eligible for Medical Assistance until he/she becomes eligible for Part A of Medicare (hospital insurance).

   To qualify these individuals must:

   a. be a widow(er);

   b. have received SSI in the past;

   c. be at least 50 years old but not 65 years old;

   d. no longer receive SSI payments because of Social Security payments;

   e. not have hospital insurance under Medicare; and,

   f. meet all other Medical Assistance requirements.

8.100.6.J. Disabled Adult Children

1. Medical Assistance shall be provided to an individual aged 18 or older who loses SSI due to the receipt of OASDI drawn from his/her parents' Social Security Number; and:

   a. who was determined disabled prior to the age of 22; and

   b. who is currently receiving OASDI income as a Disabled Adult Child; and

   c. who would continue to be eligible for SSI if:

      i) the current OASDI income of the applicant is disregarded; and

      ii) the resources are below the applicable limit as listed at 8.100.5.M; and

      iii) other countable income is below the current years SSI FBR.

2. Disabled Adult Children are identified by the OASDI Beneficiary Identification Code (BIC) of "C".

8.100.6.K. Old Age Pension (OAP) Eligibles

1. Individuals that are 65 and over are defined as the OAP-A category. Individuals who attain the age of 60 but not yet 65 are defined as the OAP-B category.

2. Medical Assistance must be provided to persons receiving OAP-A or OAP-B and SSI (SISC B).

3. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria but are not receiving a money payment (SISC-B).

4. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria except for the level of their income (SISC-B).

5. Medical Assistance must be provided to persons in a facility eligible for Medical Assistance reimbursement whose income is under 300% of the SSI benefit level and who, but for the level of their income, would be eligible for OAP "A" or OAP "B" and SSI financial assistance. This group includes persons 65 years of age or older receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement (SISC A). This population is referenced as Psych >65.

6. The OAP B individual included in AFDC assistance unit shall receive Medical Assistance as a member of the AFDC household (SISC B).

7. The OAP State Only Medical Assistance Program provides Medical Assistance to OAP-A, OAP-B or OAP Refugees who lost their OAP financial assistance because of a cost of living adjustment other than OASDI. Examples of other sources of income are VA, RRB, PERA, etc. (SISC C).

8. For the purpose of identifying the proper SISC code for persons receiving assistance under OAP "A" or OAP "B", if the person:

   a. receives an SSI payment (SISC B);

   b. does not receive an SSI payment but is receiving assistance under OAP "A", a second evaluation of resources must be made using the same resource criteria as specified in section 8.100.5.M for those who meet this criteria the SISC code is B for money payment and "disregard" case, A for institutional cases;

   c. does not receive an SSI payment and does not otherwise qualify under SISC code B or A as described in item b. above (SISC C).

8.100.6.~~K~~L. Qualified Medicare Beneficiaries (QMB)

1. Medical Assistance coverage for QMB clients is payment of Medicare part B premiums, co-insurance and deductibles.

2. Effective July 1, 1989, a Qualified Medicare Beneficiary is an individual who:

   a. is entitled to Part A Medicare; and

   b. resources may not exceed the standard for an individual~~, who has resources at~~ or ~~below twice the SSI individual resource limit, or for a~~ couple who ~~has~~have resources ~~at or below three times the SSI individual resource limit~~, as described in section 8.100.5.M; and

   c. has income at or below the percentage of the federal poverty level for the size family as mandated for QMB by federal regulations. Poverty level is established by the Executive Office of Management and Budget.

3. For QMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for QMB.

4. For QMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus ~~1/2~~one half remainder earned income disregard shall be applied to the total amount of earned income.

5. Medicare cost sharing expenses must be provided to qualified Medicare beneficiaries. This limited Medical Assistance package of Medicare cost sharing expenses only includes:

   a. payment of Part A Medicare premiums where applicable; ~~and,~~

   b. payment of Part B Medicare premiums; and~~,~~

   c. payment of coinsurance and deductibles for Medicare services whether or not a benefit of Medical Assistance up to the full Medicare rate or reasonable rates as established in the State Plan.

6. Individuals may be QMB recipients only or the individual may be classified as a dual eligible. A dual eligible is a Medicare recipient who is otherwise eligible for Medical Assistance.

7. A QMB-only recipient is an individual who is not eligible for other categorical assistance program due to their income and/or resources but who meets the eligibility criteria for QMB described above.

8. Individuals who apply for QMB assistance have the right to have their eligibility determined under all categories of assistance for which they may qualify.

9. All other general non-financial requirements or conditions of eligibility must also be met such as age, citizenship, residency requirements as well as reporting and redetermination requirements. These criteria are defined in section 8.100.3 of this volume.

10. Eligibility for QMB benefits shall be effective the month following the month of determination. Beneficiaries who submit and complete an application within the 45-day standard shall be eligible for benefits no later than the first of the month following the 45th day of application. Administrative delays shall not postpone the effective date of eligibility.

11. QMB benefits are not retroactive and the three month retroactive Medical Assistance rule does not apply to QMB benefits.

12. Clients who would lose their QMB entitlement due to annual social security COLA will remain eligible for QMB coverage under Medical Assistance, as income disregard cases, until the next year's federal poverty guidelines are published.

8.100.6.~~L. Special~~M. Specified Low Income Medicare Beneficiaries

1. Medical Assistance coverage for SLMB clients is limited to payment of monthly Medicare Part B (Supplemental Medical Insurance Benefits) premiums.

2. Effective January 1, 1993, a ~~Special~~Specified Low Income Medicare Beneficiary (SLMB) is an individual who:

   a. is entitled to Medicare Part A;

   b. resources may not exceed the standard for an individual ~~who has resources at~~ or ~~below twice the SSI individual resource limit, or for a~~ couple who has resources ~~at or below three times the SSI individual resource limit,~~ as described in section 8.100.~~3~~5.M of this volume.

   c. has income at or below a percentage of the federal poverty level for the family size as mandated by federal regulations for SLMB. Income limits have been defined through CY 1995, as follows: CY 1993 and 1994 100-110% of FPL, CY 1995 100-120% of FPL.

3. For SLMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for SLMB.

4. For SLMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus ~~1/2~~one half remainder earned income disregard shall be applied to the total amount of earned income.

5. SLMB eligibility starts on the date of application or up to three month prior to the application date for retroactive Medical Assistance.

6. Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.

7. Clients who would lose their SLMB entitlement due to annual SSA COLA will remain eligible for SLMB coverage, as income disregard cases, through the month following the month in which the annual federal poverty levels (FPL) update is published.

8.100.6.~~M~~ N. Medicare Qualifying Individuals 1 (QI1)

1. Medical Assistance coverage is limited to monthly payment of Medicare Part B premiums. Payment of the premium shall be made by the Department on behalf of the individual.

2. Eligibility for this benefit is limited by the availability of the allocation set by CMS. Once the state allocation is met, no further benefits under this category shall be paid and a waiting list of eligible individuals shall be maintained.

3. Eligibility for QI1 benefits shall be effective the month in which application is made and the individual is eligible for benefits. Eligibility may be retroactive up to three months from the date of application, but not prior to January 1, 1998.

4. In order to qualify as a Medicare Qualifying Individual 1, the individual must meet the following:

    a. be entitled to Part A of Medicare,

    b. income of at least 120%, but less than 135% of the FPL.

    c. resources may not exceed ~~twice~~ the ~~SSI limit~~standard as described in section 8.100.5.M, and

    d. he/she cannot otherwise be eligible for Medical Assistance.

5. For QI1 purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus ~~1/2~~one half remainder earned income disregard shall be applied to the total amount of earned income.

6. Clients who would lose QI-1 entitlement due to annual social security COLA will remain eligible for QI-1 coverage under Medical Assistance, as an income disregard case, until the next year's federal poverty guidelines are published.

8.100.6.~~N~~O. Qualified Disabled And Working Individuals

1. Medical Assistance coverage is limited to monthly payment of Medicare Part A premiums, and any other Medicare cost sharing expenses determined necessary by CMS.

2. Effective July 1, 1990, a Qualified Disabled and Working Individual (QDWI) is an individual who:

    a. was a recipient of federal Social Security Disability Insurance (SSDI) benefits, who continues to be disabled but lost SSDI entitlement due to earned income in excess of the Social Security Administration's Substantial Gainful Activity (SGA) threshold, and;

    b. has exhausted SSA's allowed extension of "premium free" Medicare Part A coverage under SSDI, and;

    c. has resources at or below twice the SSI resource limit as described in section 8.100.5~~.~~., and;

    d. has income less than 200% of FPL.

3. For QDWI purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals

have earned income, the income of all the individuals shall be added together and the $65 plus ~~1/2~~one half remainder earned income disregard shall be applied to the total amount of earned income.

4. An individual may be eligible under this section only if he/she is not otherwise eligible under another Medical Assistance category of eligibility.

5. Eligibility for QDWI benefits shall be effective the month of determination of entitlement.

6. Eligibility may be retroactive only to the date as of which SSA approves an individual's application for coverage as a "Qualified Disabled and Working Individual". However, eligibility may not begin prior to 07/01/90.

8.100.6.~~O~~P. Medicaid Buy-In Program for Working Adults with Disabilities.

1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:

   a. Applicants must be at least age 16 but less than 65 years of age.

   b. Income must be less than or equal to 450% of FPL after income allocations and disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income allocations and disregards. Only the applicant's income will be considered.

   c. Resources are not counted in determining eligibility.

   d. Individuals must have a disability as defined by Social Security Administration medical listing or a limited disability as determined by a state contractor.

   e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.

   f. Individuals will be required to pay monthly premiums on a sliding scale based on income.

      ~~1.~~i) The amount of premiums cannot exceed 7.5% of the individual's income.

      ~~2.~~ii) Premiums are waived for the first month of eligibility and any retroactive period.

      ~~3.~~iii) Premium amounts are as follows:

         ~~a.~~1) There is no monthly premium for individuals with income at or below 40% FPL.

         ~~b.~~2) A monthly premium of $25 is applied to individuals with income above 40% of FPL but at or below 133% of FPL.

         ~~c.~~3) A monthly premium of $90 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.

~~d.~~4) A monthly premium of $130 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.

~~e.~~5) A monthly premium of $200 is applied to individuals with income above 300% of FPL but at or below 450% of FPL.

~~4.~~iv) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

~~5.~~v) A change in client net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation

~~**8.100.6.P Adults without Dependent Children**~~

~~1. To be eligible for Adults without Dependent Children:~~

~~a. Applicants must be at least age 19 but less than 65 years of age.~~

~~b. Income must be at or below 10% Federal Poverty Level for the household size.~~

~~i. Earned income will be calculated according to the rules found at 8.100.3.K Consideration of Income, 8.100.3.L General Income Exemptions, and 8.100.4.E Family and Children's Income Disregards.~~

~~ii. Unearned income will be calculated according to the rules found at 8.100.5.F.3 Income Requirements and 8.100.5.H Income Disregards.~~

~~iii. The income of the head of household and of the spouse in the home will be used in determining eligibility.~~

~~iv. The AND payment to AND recipients shall not be used in determining eligibility.~~

~~c. Household size will be determined according to the rules at 8.100.4.C, with the exception of the following:~~

~~i. Medical Assistance is available to the father of an unborn child.~~

~~d. Resources are not counted in determining eligibility.~~

e. Individuals cannot have a Medicaid eligible dependent child in the household.

f. Individuals cannot be eligible for or enrolled in Medicare Part A or Part B.

g. Individuals cannot be pregnant.

2. Retroactive Medical Assistance coverage is not available for any individuals that are determined eligible and enrolled in AwDC.

3. AwDC Verification Requirements will follow the Family and Children's Minimal Verification Requirements found at 8.100.4.B.

4. All persons determined eligible for AwDC will be placed on the AwDC Waitlist and enrolled in the AwDC program through the AwDC Randomized Member Selection Process. The AwDC Randomized Member Selection Process will randomly select individuals to be enrolled into the AwDC program. Those individuals not selected will continue to be on the waitlist. The AwDC Randomized Member Selection Process will be held every month to fill positions within the AwDC program that may become available. The following rules apply to the AwDC Waitlist:

a. Persons shall be moved from the AwDC Waitlist to the AwDC program as a position becomes available and if they are selected through the Randomized Member Selection Process.

b. Persons must be eligible for AwDC at the time they are moved from the AwDC Waitlist.

c. Eligibility for persons moved from the AwDC Waitlist to AwDC shall begin on the first day of the month that the open position is available and offered to the client.

d. Persons cannot appeal the specific action of being placed on the AwDC Waitlist.

8.100.6.Q. Medicaid Buy-In Program for Children with Disabilities

1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:

   a. Applicants must be age 18 or younger.

   b. Household income will be considered and must be less than or equal to 300% of FPL after income disregards. The following rules apply:

      i) 8.100.4.C - Family and Children's E - MAGI Household Requirements

      ii) 8.100.3.K - Consideration of 5.F - Income Requirements

      iii) 8.100.3.L - General 5.F.6 - Income Exemptions

      iv) 8.100.4.E - Family and Children's Disregards

~~1. An additional~~iv) An earned income of $90 shall be disregarded from the gross wages of each individual who is employed

v) A disregard of a 33% (.3333) reduction will be applied to the household's net income ~~(after the disregards at 8.100.4.E have been applied).~~.

c. Resources are not counted in determining eligibility.

d. Individuals must have a disability as defined by Social Security Administration medical listing.

e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18 shall be determined for eligibility through the Medicaid Buy-In Program for Working Adults with Disabilities.

f. Families will be required to pay monthly premiums on a sliding scale based on household size and income.

i) For families whose income does not exceed 200% of FPL, the amount of premiums and cost-sharing charges cannot exceed 5% of the family's adjusted gross income. For families whose income exceeds 200% of FPL but does not exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot exceed 7.5% of the family's adjusted gross income.

ii) Premiums are waived for the first month of eligibility and any retroactive period.

iii) For households with two or more children eligible for the Medicaid Buy-In Program for Children with Disabilities, the total premium shall be the amount due for one eligible child.

iv) Premium amounts are as follows:

1) There is no monthly premium for households with income at or below 133% of FPL.

2) A monthly premium of $70 is applied to households with income above 133% of FPL but at or below 185% of FPL.

3) A monthly premium of $90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL.

4) A monthly premium of $120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.

v) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause

the premium amount (based on percentage of income) to increase by $10 or more.

vi) A change in household net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.

3. Verification requirements will follow the ~~Family and Children's Minimal~~MAGI Category Verification Requirements found at 8.100.4.B.