THIS PAGE NOT FOR PUBLICATION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 10 C.C.R. 2505-10 8.493, Revision to the Home and Community Based Services Home Modification Rule for Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493
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) 10 C.C.R. 2505-10 8.493, 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*

Replace the following current text with new text provided:

§8493.3.E,
§8.493.4.B,
§8.493.4.C,
§8.493.4.E, and
§8.493.7.C.

All text indicated in blue is for clarification only and should not be change. This change is effective 09/30/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Home and Community Based Services Home Modification Rule for Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493
Rule Number:	MSB 10 C.C.R. 2505-10 8.493
Division / Contact / Phone:	LTSS / Diane Byrne / 303-866-2873

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).

   Description: The rules set forth at 10 CCR 2505-10 Section 8.493 are being revised to allow the Department to meet a Legislative directive and appropriate to raise the cap for the Home Modification benefit. This appropriation indicated the Department was responsible for bringing forward a rule change to the Medical Services Board that increases the amount of money available to the benefit within the feasible amount available within the approved funding. A change in the dollar threshold at which occupational therapist evaluations are required and case managers may approve without a PAR was also determined within the Home Modification Stakeholder Workgroup. The lifetime cap was increased from $12,500 to $14,000 and the OT evaluation/CM approval threshold was increased from $1,000 to $1,500

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 U.S.C. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   C.R.S. 25.5-6-704, Long Bill (SB-15-234) appropriating $711,238 to increase the lifetime cap on home modifications.

Initial Review	**07/10/2015**	Final Adoption	**08/14/2015**
Proposed Effective Date	**09/30/2015**	Emergency Adoption	

DOCUMENT #01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Home and Community Based Services Home Modification Rule for Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493
Rule Number:	MSB 10 C.C.R. 2505-10 8.493
Division / Contact / Phone:	LTSS / Diane Byrne / 303-866-2873

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.

Persons who utilize the Home Modification benefit in the Elderly, Blind, and Disabled waiver, the Brain Injury waiver, the Community Mental Health Supports waiver, and the Spinal Cord Injury waiver will benefit from an increase in the cap on the Home Modification funds available to them. Budget projections anticipate that the allocation provided by legislation will enable the Department to raise the maximum available amount to $14,000. There is no cost to the Department.

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

This rule will have a positive economic impact on persons who choose to use the additional funds. Persons who have access to the Home Modification benefit but who do not choose to utilize the additional funds will not be impacted. Lower cost home modifications will also be implemented more quickly with the adjustment in the OT evaluation/CM approval threshold.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There is no cost to the Department. The funds are available to the Department via an appropriation and directive from the State Legislature which indicates that the Department is responsible for using the funds to increase the Home Modification benefit cap.

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

The Department is revising the rule to increase the lifetime cap, which will enable the Department to meet the Legislative directive.

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

This rule revision does not increase the cost to the Department for providing the Home Modification benefit, but rather enables the Department to utilize the appropriation granted by the Legislature.

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 increase of the lifetime cap on the Home Modification benefit via the revision to Section 8.493 is necessary for the Department to access and distribute the appropriated funds and meet the Legislative directive.

8.493 HOME MODIFICATION

8.493.1 DEFINTIONS

Eligible Client means a client who is enrolled in the following Home and Community-Based Services (HCBS) waivers: Brain Injury, Spinal Cord Injury, Community Mental Health Supports, or Elderly, Blind and Disabled.

Home Modification means specific modifications, adaptations or improvements in an Eligible Client's existing home setting which, based on the client's medical condition:

1. Are necessary to ensure the health, welfare and safety of the client, and

2. Enable the client to function with greater independence in the home, and

3. Are required because of the client's illness, impairment or disability, as documented on the ULTC-100.2 form and the care plan; and

4. Prevents institutionalization of the client.

Home Modification Provider means a provider agency that has met all the standards for Home Modification described in 10 C.C.R. 2505-10, Section 8.493.5.B and is an enrolled Medicaid provider.

8.493.2 BENEFITS

8.493.2.A. Home Modifications, adaptations or improvements may include but are not limited to the following:

1. Installing or building ramps.

2. Installing grab-bars and installing other durable medical equipment as part of a larger Home Modification project.

3. Widening doorways.

4. Modifying bathrooms.

5. Modifying kitchen facilities.

6. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and su-pplies.

8.493.2.B. Previously completed Home Modifications shall be eligible for maintenance or repair within the client's remaining allotment while remaining subject to 8.493.3, Exceptions and Restrictions.

8.493.3 EXCEPTIONS AND RESTRICTIONS

8.493.3.A. Modifications to an existing home that are not a direct medical or remedial benefit to the client are not a benefit.

8.493.3.B. Duplicate adaptations, improvements, or modifications as a part of new construction costs are not a benefit.

8.493.3.C. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet industry standards.

8.493.3.D. Home Modification projects are not a benefit in any type of certified or non-certified congregate facility, as defined in 10 C.C.R. 2505-10, Sections 8.485.50 F. and G.

8.493.3.E. There shall be a lifetime cap of $~~12,500~~14,000 per client. The increase in the lifetime cap available to a client is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, the lifetime cap shall be $10,000 per client.

8.493.3.F. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider as stated on the bid.

8.493.4 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES

8.493.4.A. The SEP case manager shall consider alternative funding sources to complete the Home Modification. These alternatives shall be documented in the case record.

8.493.4.B. The SEP case manager shall obtain prior approval by submitting a Prior Authorization request form (PAR) to the Department for Home Modification projects estimated at between $~~1,000.00~~ 1,500.00 and $~~12,500.00~~14,000. The increase in the lifetime cap available to a client is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, the lifetime cap shall be $10,000 per client.

8.493.4.C. The SEP case manager may approve Home Modification projects estimated at less than $~~1,000.00~~1,500.00 without prior authorization.

8.493.4.D. The Department may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Modification request.

8.493.4.E. Home Modifications estimated to cost $~~1,000.00~~1,500.00 or more shall be evaluated according to the following procedures:

1. An occupational therapist shall assess the client's needs and the therapeutic value of the requested Home Modification. When an occupational therapist with experience in Home Modification is not available, a Department-approved physical therapist or other qualified individual may be substituted. A report specifying how the Home Modification would contribute to a client's ability to remain in or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

2. The occupational therapist services may be provided by a home health agency and billed to Medicaid Home Health consistent with Home Health rules set forth in 10 C.C.R. 2505-10, Section 8.520, including physician orders and plans of care.

3. The SEP case manager and the occupational therapist shall consider less expensive alternative methods of addressing the client's needs. The case manager shall document these alternatives in the client’s case file.

8.493.4.F. The SEP case manager shall follow a bid process according to the following procedures:

1. The SEP case manager shall solicit and receive bids from at least two Home Modification Providers.

2. The bids shall include a breakdown of the costs of the project including:

   a. Description of the work to be completed.

   b. Estimate of the materials and labor needed to complete the project.

   c. Estimate for building permits, if needed.

   d. Estimated timeline for completing the project.

   e. Name, address and telephone number of the Home Modification Provider.

   f. Signature of the Home Modification Provider.

3. Home Modification Providers have a maximum of 30 days to submit a bid for the Home Modification project after the SEP case manager has solicited the bid.

4. The SEP case manager shall submit copies of the bids and occupational therapist's evaluation with the PAR to the Department. The Department shall authorize payment to the lowest bidder.

5. The SEP case manager may request approval of bid that is not the lowest by submitting a written justification or explanation to the Department with the PAR.

6. If the SEP case manager has made three attempts to obtain a written bid from Home Modification Providers and the Home Modification Providers have not responded within 30 calendar days, the case manager may accept one bid. Documentation of the contacts and an explanation of these attempts shall be attached to the PAR.

7. A revised PAR and bid request shall be submitted according to the procedures outlined in this Section for any changes from the original approved PAR.

8. Home Modification projects shall be initiated within 60 days of signed approval from the Department.

8.493.4.G. If a property to be modified is not owned by the client or the client's family, the SEP case manager shall obtain a letter from the owner of the property authorizing modifications to the property prior to initiation of the project and allowing the client to leave the modification in place if the property is vacated by the client.

8.493.5 PROVIDER RESPONSIBILITIES

8.493.5.A. Home Modification Providers shall conform to all general certification standards and procedures set forth in 10 C.C.R. 2505-10, Section 8.487.11.

8.493.5.B. Home Modification Providers shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.

8.493.5.C. The Home Modification Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work.

8.493.5.D. The Home Modification Provider shall assure that the project complies with local and/or state building codes. In areas where there is no building authority, the Home Modification Provider shall assure that the project complies with the appropriate provisions of the 2003 edition

of the International Residential Code and the accessibility provisions contained within the 2003 edition of the International Building Code. The Home Modification project shall also comply with the Colorado Plumbing Code as adopted by the Colorado Examining Board of Plumbers and the National Electrical Code as adopted by the Colorado Electrical Board, effective July 1, 2005. No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. Copies of the 2003 International Building Code and copies of the rules and regulations of the State Electrical Board and State Examining Board of Plumbers are available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

8.493.5.E. All Home Modification projects shall be inspected and approved by a state, local or county building inspector or a licensed engineer, architect, contractor or any other person as designated by the Department.

8.493.5.F. Copies of building permits and inspection reports shall be submitted to the SEP case manager and all problems noted on inspections shall be corrected before the Home Modification Provider submits a final invoice for the payment. In the event that a permit is not required, the Home Modification Provider shall submit to the SEP case manager a signed statement indicating that a permit is not required.

8.493.6 REIMBURSEMENT

8.493.7 Payment for Home Modification services shall be the lower of the billed charges or the prior authorized amount. Reimbursement shall be made in two payments per Home Modification.

8.493.7.A. The Home Modification Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits and initial labor costs.

8.493.7.B. Final payment shall be made when the Home Modification project has been completed and the SEP agency has in the client's file copies of:

1. Signed lien waivers for all labor and materials, including lien waivers from sub-contractors.

2. Required permits.

3. One year written warranty on parts and labor.

4. Final inspection documentation verified by the SEP case manager and documented in the client's file that the Home Modification has been completed through:

    a. Contact with the building inspector or other inspector as referenced at 10 C.C.R. 2505-10, Section 8.493.5.E; or

    b. Contact with the client; or

    c. Contact with the family member or responsible party; or

    d. By conducting an on-site visit.

8.493.7.C. The Home Modification Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily. If another Home Modification Provider is required to complete the work, the original Home Modification Provider shall be paid only the difference between the amount paid originally to the Home Modification Provider and the amount needed to

complete the Home Modification paid to the second Home Modification Provider, up to the ~~$$12,500.00~~$14,000.00 maximum lifetime cap. The increase in the lifetime cap available to a client is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, the lifetime cap shall be $10,000 per client.

8.493.7.D. The Home Modification Provider shall not be reimbursed for durable medical equipment available as a Medicaid state plan benefit unless the purchase and installation of the equipment is part of a larger Home Modification project.

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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 15-05-27-B, Revision to the Medical Assistance Rule Concerning the Use of Private Disability Income, Section 8.100.4.C.
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) 8.100.4.C, 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*

Replace current text at §8.100.4.C.1.a, §8.100.4.C.1.a.xiv), §8.100.4.C.1.a.xv), and §8.100.4.C.1.a.xvi) with the current text provided. All text indicated in blue is for clarification only and should not be changed. This change is effective 09/30/2015

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Use of Private Disability Income, Section 8.100.4.C.
Rule Number:	MSB 15-05-27-B
Division / Contact / Phone:	Eligibility Division / Geoffrey Oliver / 303-866-2686

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 change amends 10 CCR 2505-10, Section 8.100.4.C, to reflect changes in the use of private disability income in MAGI methodology determination process for all applicants and MAGI-based beneficiaries. The purpose of this rule change is to bring the MAGI methodology for income calculations into alignment with tax law that says taxable private disability income should be counted as a source of gross income. The IRS construes 26 USC § 61(b), 26 USC §104(a)(3)(A), (B) and 26 USC § 105(a), (3) as meaning that disability benefits paid by an employer (either through an insurance policy or state disability fund) is taxable private disability income because the empoyee did not pay taxes on the premiums for the policy or contributions to the fund.

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:

   Section 1902(e)(14) of the Social Security Act, 26 USC § 61 42 CFR § 435.603, 26 USC § 36B, 26 USC § 104, and 26 USC § 105.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   25.5-4-105.

Initial Review	**07/10/2015**	Final Adoption	**08/14/2015**
Proposed Effective Date	**10/01/2015**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Use of Private Disability Income, Section 8.100.4.C.
Rule Number:	MSB 15-05-27-B
Division / Contact / Phone:	Eligibility Division / Geoffrey Oliver / 303-866-2686

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.

   Individuals who reported a taxable private disability income amount that is less than their total private disability and who could be eligible for benefits from MAGI-based programs will be more likely to be found eligible for Medical Assistance because their income will be less than if their total private disability was taken into consideration.

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

   Individuals who have private disability and have reported that a portion of that private disability is not taxable income will be more likely to be approved for MAGI-based programs because the non-taxable portion of their private disability will not be countable income. This should increase the number of approvals for MAGI-based programs. Individuals who are currently beneficiaries of a MAGI or non-MAGI-based programs and have private disability should not lose their eligibility for Medical Assistance. Some individuals who are enrolled in CHP+ and have private disability insurance may be found eligible for Medicaid instead of CHP+ based upon their reported taxable private disability.

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 costs of the proposed changes are indeterminate. The change only affects clients that have private disability income that have been determined eligible for MAGI populations. The majority of clients with a disability should be determined eligible for a non-MAGI population. The Department believes that very few individuals with private disability income would be determined eligible under a MAGI population. For this reason, costs of this change are expected to be nominal.

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

   Implementation is necessary to comply with Federal requirements

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

There are no alternatives to achieve 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.

   There are no alternative methods for the proposed rule that were considered.

8.100.4.C. MAGI Methodology for Income Calculation

1. The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of the following:

   a. Gross Income: For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) 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. Except as otherwise provided ~~, pursuant to 26 U.S.C. § 61~~ gross income means 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; and~~.~~

      xvi) Taxable private disability income.

   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. 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: For an in depth treatment of allowable deductions from gross income, please refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) 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. The following deductions are allowed to be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income including (but not limited to):

i) Student loan interest deductions

ii) Certain Self- employment expenses (SEP, SIMPLE and qualified plans, and health insurance deductions)

iii) Deductible part of self-employment tax

iv) Health savings account deduction

v) Certain Business expenses of reservists, performing artist, and fee-basis government officials

vi) Certain reimbursed expenses of employees

vii) Moving expenses

viii) IRA deduction

ix) Penalty on early withdrawal

x) Domestic production activities deduction

xi) Alimony paid outside the home

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.