THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Information Office Eligibility Rule Concerning Long-Term Care Medical Eligibility, Section 8.100.7
Rule Number:	MSB 15-07-08-D
Division / Contact / Phone:	Eligibility Policy / Eric Stricca / 303-866-4475

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 15-07-08-D, Revision to the Medical Assistance Health Information Office Eligibility Rule Concerning Long-Term Care Medical Eligibility, Section 8.100.7
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) 8.100.7, 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 beginning at §8.100.7.A.2.g through §8.100.7.A.2.k with new text provided beginning at §8.100.7.A.2.f through §8.100.7.A.2.j

Replace current text beginning at §8.100.7.E.2.b through §8.100.7.E.2.k with the new text provided beginning at §8.100.7.E.2.a through §8.100.7E.2.j.

Replace current text beginning at §8.100.7.H.5 through the end of the table with the new text provided.

Replace current text at §8.100.7.I.3.a.iv) through §8.100.7.I.3.b.iv) with new text provided.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Replace current text at §8.100.7.I.5 through §8.100.7.I.5.a.i) with the new text provided.

Replace current text at §8.100.7.I.5.g.v)3)b) with the new text provided

Replace current text at §8.100.7.J. through the end of the 4th table with the new text provided.

Remove current text at §8.100.7.V.3.g.iii).

All text indicated in blue is for clarification purposes only and should not be revised. This change is effective 11/30/2015.

*to be completed by MSB Board Coordinator

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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 change is to incorporate revisions mandated by Executive Order D 2012-002 (EO 2), as codified at Section 24-4-103.3 CRS (2014). The governor has issued an Executive Order which requires state agencies to review state rules every five years to ensure rules are effective, efficient and essential. A regulatory review is solely for the purpose of identifying those rules which are duplicative, overlapping, outdated and inconsistent. The Colorado Benefits Management System (CBMS) does not need to be updated for sections 8.100.7 since all CBMS algorithms are in alignment with our federal regulations.
   The changes address non-substantive issues such as correcting inaccurate rule citations, removing redundant rules, clarifications and removing tables that should be issued as guidance and not set in rule.

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. § 1396a, p and r-5

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   25.5-5-201(g) and 25.5-6-101, 102, 103 C.R.S. (2014).

Initial Review	**09/11/2015**	Final Adoption	**10/09/2015**
Proposed Effective Date	**11/30/2015**	Emergency Adoption	

DOCUMENT #01

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Title of Rule:	Revision to the Medical Assistance Health Information Office Eligibility Rule Concerning Long-Term Care Medical Eligibility, Section 8.100.7
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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 proposed rule will impact the Long-Term Care Medical Assistance covered groups. The benefit to the proposed language is to eliminate duplicative, overlapping, outdated and inconsistent rules.

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

   To achieve regulatory review goals, section 8.100.7 has been revised and updated to assure state rules are current and are in alignment with federal regulations. This will have a positive impact on the Long-Term Care Medical Assistance covered groups by eliminating any confusion on duplicative, overlapping, outdated and inconsistent rules.

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 will be no costs to the Department, any other agency or state revenues.

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

   Since there are no costs involved, there will only be the benefit of eliminating any confusion on duplicative, overlapping, outdated and inconsistent rules.

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

   Since there are no costs, this is the least costly method. Eliminating any confusion on duplicative, overlapping, outdated and inconsistent rules is the least intrusive method.

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.

8.100.7 Long-Term Care Medical Assistance Eligibility

8.100.7.A. Persons in Long-Term Care Institutions or Other Residential Placement

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

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

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

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

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

   a. Have attained the age of 65 years or;

   b. Have met the requirements according to the definition of disability or blindness applicable to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)

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

      Supporting documentation must be provided which verifies the 30 consecutive full days. This documentation shall include the ULTC 100.2 and/or medical records which must be verified by a physician or case manager.

      If a client dies prior to the 30th consecutive full day, the client shall be determined to have met the 30 consecutive full day requirement if:

      i) There is a statement from a physician, or case manager that declares if the client had not died, he/she would have been institutionalized for 30 consecutive full days, and;

      ii) The statement is verified by supporting documentation from the beginning of the institutionalized period, which is the first 15 days, or prior to the death of the client, whichever is earliest.

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

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

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

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

i) This special income standard must be applied for:

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

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

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

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

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

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

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

~~k~~j. Have submitted documents verifying that an annuity conforms to the regulations regarding Annuities at 8.100.7.I.

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

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

1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry Point/Case Management Agency to have met the functional level of care and will remain in the community by receiving HCBS or PACE; and

a. are SSI (including 1619b) or OAP Medicaid eligible; or

b. are eligible under the Institutionalized 300% Special Income category described at 8.100.7.A; or

c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P. For this group, access to HCBS:

i) Is limited to the Elderly, Blind and Disabled and Community Mental Health Supports waivers; and

ii) Is contingent on the Department receiving all necessary federal approval for the waiver amendments that extend access to HCBS to the Working Adults with Disabilities population described at 8.100.6.P.

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

a. All individuals applying for or requesting Long-Term Care services must disclose and provide documentation of:

i) any transfer of assets without fair consideration as described at 8.100.7.F; and

ii) any interest in an annuity as described at 8.100.7.I; and

iii) any interest in a trust as described at 8.100.7.E.

b. Failure to disclose and provide documentation of the assets described at 8.100.7.B.2.a may result in the denial of Long-Term Care services.

c. The requirements at 8.100.7.B.2.a and 8.100.7.B.2.b do not apply to individuals who have been determined eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P.

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

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

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

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

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

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

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

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

4. For living expense purposes, income and resources of spouses living in the same household for a full calendar month or more must be considered as available to each other, whether or not they are actually contributed, and must be evaluated in accordance with rules contained in 8.100.7.Q.

Long-Term Care

8.100.7.D. Other Medical Assistance Clients Requesting Long-Term Care in an Institution or through HCBS or PACE

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

8.100.7.F. Transfers of Assets Without Fair Consideration

1. Definitions. The following definitions apply to transfers of assets without fair considerations:

   a. "Assets" include all income and resources of the individual and such individual's spouse, including any interest in income or a resource as well as all income or resources which the individual or such individual's spouse is entitled to but does not receive because of action by any of the following:

      i) The individual or such individual's spouse,

      ii) A person, a court, or administrative body with legal authority to act on behalf of the individual or such individual's spouse, or

      iii) Any person, court or administrative body acting at the direction of or upon the request of the individual or such individual's spouse.

   b. "Fair market value" is the value of the asset if sold at the prevailing price at the time it was transferred.

   c. "Fair consideration" is the amount the individual receives in exchange for the asset that is transferred, which is equal to or greater than the value of the transferred asset.

   d. "Look-back period" means the number of months prior to the month of application for long-term care services that the Department will consider for transfer of assets.

   e. "Penalty period" means a period of time for which an applicant or client will not be eligible to receive long-term care services.

   f. "Uncompensated value" shall mean the fair market value of an asset at the time of the transfer minus the value of compensation the individual receives in exchange for the asset.

   g. "Valuable consideration" shall mean what an individual receives in exchange for his or her right or interest in an asset which has a tangible and/or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset.

2. General Provisions

   If an institutionalized individual or the spouse of such individual disposes of assets without fair consideration on or after the look-back period, the individual shall be subject to a period of ineligibility for Long-Term Care services, including Long-Term Care institution care, Home and Community Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE).

~~b~~a. For transfers made before February 8, 2006, the look-back period is 36 months prior to the date of application. For transfers made on or after February 8, 2006, the look-back date is 60 months prior to the date of application.

~~c~~b. 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).

~~d~~c. If an institutionalized individual or such individual's spouse transfers assets without fair consideration on or after the look-back period, the transfer shall be evaluated as follows:

i) The fair market value of the transferred asset, less the actual amount received, if any, shall be divided by the average of the regions, defined at 8.100.7.E, monthly private pay cost for Long-Term Care institution care in the state of Colorado at the time of application.

ii) The resulting number is the number of months that the individual shall be ineligible for Medical Assistance. For transfers made before February 8, 2006, the period of ineligibility shall begin with the first day of the month following the month in which the transfer occurred. For transfers made on or after February 8, 2006, the period of ineligibility shall begin on the later of the following dates:

a) The first day of the month following the month in which the transfer occurred or is discovered. For transfers discovered after the date the transfer occurred, the date of transfer shall be the discovery date.~~,~~

~~or~~Or

~~,~~

b) The date on which the individual would initially be eligible for HCBS, PACE or institutional services based on an approved application for such assistance that were it not for the imposition of the penalty period, would be covered by Medical Assistance;

~~AND~~And;

c) ~~which~~ Which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

~~e~~d. The period of ineligibility shall also include partial months, which shall be calculated by multiplying 30 days by the decimal fractional share of the partial month. The result is the number of days of ineligibility. For transfers occurring on or after April 1, 2006, the result shall be rounded up to the nearest whole number.

~~f~~e. There is no maximum period of ineligibility.

~~g~~f. For transfers prior to February 8, 2006, the total amount of all of the transfers are added together and the period of ineligibility begins the first day of the month following the month in which the resources are transferred.

i) If the previous penalty period has completely expired, the transfers are not added together.

ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.

~~h~~g. For transfers on or after February 8, 2006, the total amounts of all of the transfers are added together and the penalty period is assessed as outlined in section 8.100.7.F.2.c-d~~3-4~~ above.

i) If the previous penalty period has completely expired, the transfers are not added together.

ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.

~~i~~h. The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and basic Medical Assistance services, but shall not be eligible for Medical Assistance for Long-Term Care institution services, Home and Community Based Services or the Program of All Inclusive Care for the Elderly due to the transfer without fair consideration.

~~j~~i. If a transfer without fair consideration is made during a period of eligibility, a period of ineligibility shall be assessed in the same manner as stated above.

~~k~~j. Actions that prevent income or resources from being received, or reduce an individual's ownership, right or interest in an asset such that the individual does not receive valuable consideration as set forth on the following list, which is not exclusive, shall create a rebuttable presumption that the transfer was without fair consideration:

i) Waiving pension income.

ii) Waiving a right to receive an inheritance.

iii) Preventing access to assets to which an individual is entitled by diverting them to a trust or similar device. This is not applicable to valid income trusts, disability trusts and pooled trusts for individuals under the age of 65 years.

iv) Failure of a surviving spouse to elect a share of a spouse's estate or failure to open an estate within 6 months after a spouse's death.

v) Failure to obtain a family allowance or exempt property allowance from an estate of a deceased spouse or parent. Such allowances are presumed to be available 3 months after death.

vi) Not accepting or accessing a personal injury settlement.

vii) Transferring assets into an irrevocable private annuity which was not purchased from a commercial company.

viii) Transferring assets into an irrevocable entity such as a Family Limited Partnership which eliminates or restricts the individual's access to the assets.

ix) Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony, if the benefit outweighs the cost.

x) Failure to exercise rights in a Dissolution of Marriage case, which insure an equitable distribution of marital property and income.

xi) Purchasing a single-premium life insurance policy, endowment policy or similar instrument within the look-back period, which has no cash value, and for which the individual receives no valuable consideration shall be considered an

uncompensated transfer. The total amount of the purchase price shall be considered a transfer without fair consideration.

8.100.7.G. Treatment of Certain Assets as Transfers Without Fair Consideration

1. Promissory notes established before April 1, 2006:

   a. The fair market value of promissory notes is a countable resource and must be evaluated in accordance with the regulations on consideration of resources in this volume.

   b. Promissory notes with one or more of the following provisions, indicating they have little or no market value, shall create a rebuttable presumption of a transfer without fair consideration:

      i) An interest rate lower than the prevailing market rate.

      ii) A term for repayment longer than the life expectancy of the holder of the note, as determined by the tables at 8.100.7.J.for annuities purchased on or after February 8, 2006.

      iii) Low payments.

      iv) Cancellation at the death of the note holder.

   c. Promissory notes which have been appraised by a note broker as having little or no value shall create a rebuttable presumption of a transfer without fair consideration.

2. Promissory notes established on or after April 1, 2006 but before March 1, 2007

   a. Subject to the look-back date described in section 8.100.7.F.2.b for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.n. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c .

3. Promissory notes established on or after March 1, 2007

   a. Subject to the look-back date described in section 8.100.7.F.2.b, for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.o. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c..

4. Personal care services

   a. Effective for agreements that were signed and notarized prior to March 1, 2007, family members who provide assistance or services are presumed to do so for love and affection, and compensation for past assistance or services shall create a rebuttable presumption of a transfer without fair consideration unless the compensation is in accordance with the following:

      i) A written agreement must be executed prior to the delivery of services.

      ii) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement.

iii) The agreement must be dated and the signature must be notarized; and

iv) Compensation for services rendered must be comparable to what is received in the open market.

b. Effective for agreements that are signed and notarized on or after March 1, 2007, compensation under personal service agreements will be deemed to be a transfer without fair consideration unless the following requirements are met:

i) A written agreement was executed prior to the delivery of services; and

a) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement; and

b) The legally authorized representative, agent, guardian, conservator, or other representative of the applicant's estate may not be a beneficiary of a care agreement; and

c) The agreement specifies the type, frequency and time to be spent providing the services agreed to in exchange for the payment or transferred item; and

d) The agreement provides for payment of services on a regular basis, no less frequently than monthly, while the services are being provided; and

ii) Compensation for services rendered must be comparable to what is received in the open market. The burden is on the applicant to prove that the compensation is reasonable and comparable; and

iii) A record or log is provided which details the actual services rendered. The services cannot be services that duplicate services that another party is being paid to provide or which another party is responsible to provide.

c. Payment for services, which were rendered previously and for which no compensation was made, shall be considered as a transfer without fair consideration.

d. Assets transferred in exchange for a contract for personal services for future assistance after the date of application are considered available resources.

e. A care agreement must be entered into, signed, and notarized prior to providing any services for which a beneficiary will be compensated.

5. Transfers of real property into joint tenancy without fair consideration

a. If real property is transferred into joint tenancy with right of survivorship with one or more joint tenants, the amount transferred depends on the number of joint tenants to whom the property is transferred. The following are examples:

i) If the transfer is to one joint tenant, the amount transferred is equal to one-half of the value of the property at the time of the transfer.

ii) If the transfer is to two joint tenants, the amount transferred is equal to two-thirds of the value.

iii) If the transfer is to three joint tenants, the amount transferred is equal to three-fourths of the value of the property at the time of the transfer.

b. If the transfer is completed with two deeds or transactions, the first of which transfers a fractional share of the property into tenancy in common, and the second into joint tenancy, the amount transferred shall be determined in the same manner as set forth above.

6. No period of ineligibility will be imposed if the individual transferred the assets under any of following circumstances:

a. The asset transferred was a home and title to the home was transferred to:

i) The spouse of such individual;

ii) A child of such individual who is either

1) Under the age of 21 years, or

2) Is blind or totally and permanently disabled as determined by the Social Security Administration.

iii) A brother or sister

1) Who has an equity interest in the home and

2) Who was residing in such individual's home for at least one year immediately before the date that the individual becomes institutionalized.

iv) A son or a daughter of such individual

1) Who was residing in the home for a period of at least two years immediately before the date the individual becomes institutionalized and

2) Who provided care to such individual by objective evidence, that permitted such individual to reside at home rather than in an institution.

3) Documentation shall be submitted proving that the son or daughter's sole residence was the home of the parent. The parent's attending physician(s) or professional health provider(s) during the past two years must substantiate in writing that the care was provided, and that the care prevented the parent from requiring placement in a Long-Term Care institution.

b. The assets were transferred:

i) To the individual's spouse or to another for the sole benefit of the individual's spouse.

ii) From the individual's spouse to another for the sole benefit of the individual's spouse.

iii) To a trust which is established solely for benefit of the individual's child who is determined to be blind or totally disabled by the Social Security Administration or to that child directly for the sole benefit of the child.

iv) To a trust established solely for the benefit of an individual under 65 years of age who is determined to be blind or totally disabled by the Social Security Administration.

c. Definition of the term “for the sole benefit of,” as used in the preceding exceptions to the transfer penalty rules:

i). A transfer or a trust is considered to be for the sole benefit of the spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

ii). To insure that the asset transferred is for the sole benefit of the spouse, blind or disabled child or disabled individual, the following criteria must be met:

1) The transfer must be accomplished by a written instrument which legally binds the parties to a specified course of action and sets forth:

a) The conditions under which the transfer was made, and

b) A statement as to whom can benefit from the transfer.

2) The written instrument must provide for the spending of funds or use of the transferred assets for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual.

3) Disability trusts and income trusts, which designate the Colorado Department of Health Care Policy and Financing as the remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual, are exempt from this requirement.

4) A community spouse to whom a Community Spouse Resource Allowance has been transferred does not have to provide a written document or comply with the requirement that the transfer is actuarially sound. However, the Community Spouse Resource Allowance must be for the sole benefit of the community spouse to whom it is transferred. Upon the death of the community spouse, those resources shall be made available to the surviving spouse, at least up to the amount of the elective share of the augmented estate, the family allowance and the exempt property allowance.

7. There is a rebuttable presumption the transfer without fair consideration was made for purposes of Medical Assistance eligibility or avoiding the medical assistance estate recovery program.

a. The presumption that an asset was transferred to establish or maintain Medicaid eligibility or to avoid the medical assistance estate recovery program is rebutted only if the individual or individual’s spouse demonstrates by providing convincing evidence that the asset was transferred exclusively for some other purpose and the reason for the transfer did not include Medical Assistance eligibility or avoidance of medical assistance estate recovery..

b. A subjective statement of intent or ignorance of the transfer penalty or verbal assurances that the individual was not considering Medical Assistance eligibility when the transfer was made are not sufficient.

c. There is a rebuttable presumption that transfers without fair consideration were made for the purpose of Medical Assistance eligibility in the following cases:

i) In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer total an amount insufficient to meet all living expenses and medical expenses reasonably expected to be incurred by the

individual or the individual's spouse in the sixty (60) months following the transfer. Medical expenses include the cost of Long-Term Care unless the future necessity of such care could have been absolutely precluded because of the particular circumstances.

ii) In any case where:

1) the transfer was made on behalf of the individual or the individual's spouse;

2) the transfer was made by:

a) the individual or individual's spouse

b) a guardian,

c) a conservator, or

d) agent under a power of attorney; and

3) the transfer was made to:

a) anyone related to the individual or individual's spouse by birth, adoption or marriage, other than between the individual and the individual's spouse; or to

b) anyone related to the guardian, conservator, or agent under a power of attorney by birth, adoption or marriage.

d. Convincing evidence may include, but is not limited to, verification which establishes:

i) That at the time of the transfer the individual could not have anticipated needing long term Medical Assistance due to the existence of other circumstances which would have precluded the need.

ii) Other assets were available at the time of the transfer to meet current and future needs of the individual, including the cost of Long-Term Care institution or other institutionalized care for a period of sixty (60) months.

iii) The specific purpose for which the assets were transferred and the reason the transfer was necessary and the reason there was no alternative but to transfer the assets without fair consideration.

8. Apportionment of penalty period between spouses

a. If a transfer results in a period of ineligibility for an individual, and the individual's spouse becomes institutionalized and is otherwise eligible for Medical Assistance, the period of ineligibility shall be apportioned equally between the spouses.

b. If one spouse dies or is no longer institutionalized, any months remaining in the period of ineligibility shall be assigned to the spouse who remains institutionalized.

9. If the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of a trust, the trust document shall be submitted to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on Medical Assistance eligibility.

10. Notice

a. The Colorado Department of Health Care Policy and Financing is an interested person according to 15-14-406, C.R.S. or a successor statute.

b. As an interested party, the department shall be given notice of a hearing in cases in which Medical Assistance planning or Medical Assistance eligibility is set forth in the petition as a factor for requesting court authority to transfer property.

11. Undue Hardship

a. The period of ineligibility resulting from the imposition of the transfer or the trust provisions may be waived if denial of eligibility would create an undue hardship for an individual who is otherwise eligible. Undue hardship can be established if application of the transfer penalty would:

i) deprive the individual of medical care such that the individual's health or life would be endangered; or

ii) deprive the individual of food, clothing, shelter or other necessities of life.

b. Undue hardship shall not exist when the application of the trust or transfer rules merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

c. Notice of an undue hardship exception shall be given to the applicant or client. The Eligibility Site shall make a determination on the request within 15 working days from when the request is received. The Eligibility Site shall issue a notice of action on the determination of hardship. An adverse determination may be appealed in accordance with the appeal process as described at Section 8.057 of this volume.

d. The facility in which an institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual with the individual's or his or her personal representative's consent. Where the individual is unable to give consent and where the personal representative of the individual has a conflict of interest concerning the particular circumstance giving rise to the period of ineligibility, the facility may request an undue hardship on behalf of the individual. An example of such a conflict of interest would be a situation where the personal representative who is also an agent under a power of attorney transfers property to himself or herself. The facility shall submit the undue hardship request to the Eligibility Site and give sufficient detail of the circumstance surrounding the conflict of interest and the information required below to the Eligibility Site. These provisions are not intended to change the Department's requirements under Section 8.057 of the Department's regulations as to who has standing to file an appeal.

e. An individual or representative may request that the Eligibility Site waive a transfer penalty on the basis of undue hardship. The request shall be made in writing to the applicant's or client's Eligibility Site case worker. The individual making the request has the burden of proof and must provide clear and convincing evidence to substantiate the circumstances surrounding the transfer, attempts to recover the assets, and the impact of the denial of Medicaid payments for Long-Term Care services. The request and documentation shall include all of the following:

i) the reason(s) for the transfer including the individual's participation in the transfer or grant of legal authority to another that gave rise to the transfer, and the relationship between the transferor and transferee;

ii) evidence to prove that the assets have been irretrievably lost and that all reasonable attempts made to recover the asset(s), including any legal actions and the results of the attempts, including but not limited to a request for an adult protection investigation (such as in a case of financial exploitation), filing a police

report, or filing a civil action have been exhausted or have been or are being pursued; and,

iii) documentation such as a notice of discharge or pending discharge from the facility and a physician's statement detailing how the inability to receive nursing facility or community based services would result in the individual's inability to obtain life-sustaining medical care or that the individual would not be able to obtain food, clothing or shelter.

f. To the extent that the transferred assets are recovered pursuant to the attempts in (e)(ii) above, the individual shall reimburse Medicaid for the funds expended as a result of an approved undue hardship request.

g. If the transferee and the transferor of the assets for which the transfer penalty is being imposed are related parties there shall be a rebuttable presumption that the transferred assets are not irretrievably lost as required under (e)(ii) above. Related parties are described in Section 8.100.7.G.7.c.ii of these regulations.

12. No period of ineligibility shall be assessed in any of the following circumstances:

a. Convincing and objective evidence is provided that the individual intended to dispose of the resources either at fair market value or for other fair consideration.

b. Convincing and objective evidence is presented proving that the resources were transferred exclusively for a purpose other than to qualify or remain eligible for Medical Assistance.

c. All of the resources transferred without fair consideration have been returned to the individual.

d. For assets transferred before February 8, 2006, the assets were transferred more than 36 months prior to the date of application.

e. For assets transferred before February 8, 2006, the penalty period has expired based on the following formula: The fair market value of the transferred asset is divided by the average cost of Long Term Care institution care in the state at the time of application and the resulting number of months of ineligibility has ended prior to the date of application.

8.100.7.H. Life Estates

1. Definitions

a. "Fair Market Value" means the amount for which a property or interest in a property could reasonably be expected to sell on the open market.

b. "Life Estate." A life estate conveys upon a grantee certain rights in property measured by the life of the life estate holder or of some other person. The owner of a life estate has the right to possess the property, the right to use the property, the right to obtain profits from the property, and the right to sell the life estate interest in the property. The establishment of a life estate on a property results in the creation of two interests: a life estate interest and a remainder interest.

c. "Remainder Interest" means an interest in property created at the time a life estate is established which gives the holder of the interest the right to ownership of the property upon the death of the life estate holder. An individual holding a remainder interest is free to sell his or her interest in the property unless the sale is restricted by the terms of the instrument which established the remainder interest.

2. General Provisions

a. Life Estates Established before July 1, 1995

i) Transfer without fair consideration Treatment

1) The establishment of a life estate before July 1, 1995 by an individual or individual's spouse shall not be considered a transfer without fair consideration.

ii) Resource Treatment

1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered to be an exempt resource.

2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.

i) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.

3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.

4) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource

i) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.a.

b. Life Estates Established on or after July 1, 1995

i) Transfer without fair consideration Treatment

1) The establishment of a life estate on or after July 1, 1995 on property owned by an individual or individual's spouse shall be considered a transfer ~~transfer~~ without fair consideration if the life estate was established within the look-back period described at 8.100.7.F.2.b.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be based on the value of the remainder interest, as calculated using the methodology described at 8.100.7.H.4.a.

2) The purchase of a life estate interest in a home not owned by an individual or individual's spouse on or after April 1, 2006 within the look-back period described at 8.100.7.F.2.b. shall be considered a transfer without fair consideration unless the purchaser lives in the home for a period of at least twelve (12) consecutive months after the date of the purchase.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be the entire amount used to purchase the life estate.

b) If the payment for the life estate exceeds the value of the life estate, as calculated using the methodology described at 8.100.7.H.3, then the difference between the amount paid and the value of the life estate shall be considered to be a transfer without fair consideration.

ii) Resource Treatment

1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered an exempt resource.

2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.

a) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.a.

3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.

5) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource

a) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.

3. Determining the Value of a Life Estate

a. The value of a life estate interest is calculated using the following method:

i) Determine the fair market value of the property on which the life estate was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the actual value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Life Estate" factor in Column 1 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the life estate interest.

b. If a life estate was established on property held by spouses in joint tenancy, then the age of the youngest individual shall be used to calculate the value of the life estate.

4. Determining the Value of a Remainder Interest

a. The value of a remainder interest is calculated using the following method:

i) Determine the fair market value of the property on which the remainder interest was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the market value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Remainder" factor in Column 2 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the remainder interest.

b. If a life estate was established on property held by spouses in joint tenancy, then the age of the youngest individual shall be used to calculate the value of the remainder interest.

5. Life Estate Table

This rule incorporates by reference the Social Security life estate and remainder interest table ~~s~~effective April 1999 to the present. The incorporation of the tables~~ excludes~~ later amendments, or editions of, the referenced material.
The Social Security life estate and remainder interest tables are available at http://policy.ssa.gov/poms.nsf/lnx/0501140120
Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the 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.

~~Age~~	~~Column 1 Life Estate~~	~~Column 2 Remainder~~
~~0~~	~~.97188~~	~~.02812~~
~~1~~	~~.98988~~	~~.01012~~
~~2~~	~~.99017~~	~~.00983~~
~~3~~	~~.99008~~	~~.00992~~
~~4~~	~~.98981~~	~~.01019~~
~~5~~	~~.98938~~	~~.01062~~
~~6~~	~~.98884~~	~~.01116~~
~~7~~	~~.98822~~	~~.01178~~
~~8~~	~~.98748~~	~~.01252~~
~~9~~	~~.98663~~	~~.01337~~
~~10~~	~~.98565~~	~~.01435~~
~~11~~	~~.98453~~	~~.01547~~
~~12~~	~~.98329~~	~~.01671~~
~~13~~	~~.98198~~	~~.01802~~
~~14~~	~~.98066~~	~~.01934~~
~~15~~	~~.97937~~	~~.02063~~
~~16~~	~~.97815~~	~~.02185~~
~~17~~	~~.97700~~	~~.02300~~
~~18~~	~~.97590~~	~~.02410~~
~~19~~	~~.97480~~	~~.02520~~
~~20~~	~~.97365~~	~~.02635~~
~~21~~	~~.97245~~	~~.02755~~
~~22~~	~~.97120~~	~~.02880~~
~~23~~	~~.96986~~	~~.03014~~
~~24~~	~~.96841~~	~~.03159~~
~~25~~	~~.96678~~	~~.03322~~

26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086

~~72~~	~~.57261~~	~~.42739~~
~~73~~	~~.55571~~	~~.44429~~
~~74~~	~~.53862~~	~~.46138~~
~~75~~	~~.52149~~	~~.47851~~
~~76~~	~~.50441~~	~~.49559~~
~~77~~	~~.48742~~	~~.51258~~
~~78~~	~~.47049~~	~~.52951~~
~~79~~	~~.45357~~	~~.54643~~
~~80~~	~~.43659~~	~~.56341~~
~~81~~	~~.41967~~	~~.58033~~
~~82~~	~~.40295~~	~~.59705~~
~~83~~	~~.38642~~	~~.61358~~
~~84~~	~~.36998~~	~~.63002~~
~~85~~	~~.35359~~	~~.64641~~
~~86~~	~~.33764~~	~~.66236~~
~~87~~	~~.32262~~	~~.67738~~
~~88~~	~~.30859~~	~~.69141~~
~~89~~	~~.29526~~	~~.70474~~
~~90~~	~~.28221~~	~~.71779~~
~~91~~	~~.26955~~	~~.73045~~
~~92~~	~~.25771~~	~~.74229~~
~~93~~	~~.24692~~	~~.75308~~
~~94~~	~~.23728~~	~~.76272~~
~~95~~	~~.22887~~	~~.77113~~
~~96~~	~~.22181~~	~~.77819~~
~~97~~	~~.21550~~	~~.78450~~
~~98~~	~~.21000~~	~~.79000~~
~~99~~	~~.20486~~	~~.79514~~
~~100~~	~~.19975~~	~~.80025~~
~~101~~	~~.19532~~	~~.80468~~
~~102~~	~~.19054~~	~~.80946~~
~~103~~	~~.18437~~	~~.81563~~
~~104~~	~~.17856~~	~~.82144~~
~~105~~	~~.16962~~	~~.83038~~
~~106~~	~~.15488~~	~~.84512~~
~~107~~	~~.13409~~	~~.86591~~
~~108~~	~~.10068~~	~~.89932~~
~~109~~	~~.04545~~	~~.95455~~

8.100.7.I. Annuities

1. DEFINITIONS

   a. “Annuity” means a contract between an individual and a commercial company in which the individual invests funds and in return receives installments for life or for a specified number of years.

   b. “Annuitant” means an individual who is entitled to receive payments from an annuity.

c. “Annuitization Period” means the period of time during which an annuity makes payments to an annuitant.

d. “Annuitized” means an annuity that has become irrevocable and is making payments to an annuitant.

e. “Assignable” means an annuity that can have its owner and/or annuitant changed.

f. “Balloon Payment” means a lump sum equal to the initial annuity premium less any distributions paid out before the end of an annuitization period.

g. “Beneficiary” means an individual or individuals entitled to receive any remaining payments from an annuity upon the death of the annuitant.

h. “Department” means the Department of Health Care Policy and Financing, its successor(s), or its designee(s).

i. “Irrevocable” means an annuity that cannot be canceled, revoked, terminated, or surrendered under any circumstances.

j. “Non-assignable” means an annuity that cannot have its owner and/or annuitant changed under any circumstances.

k. “Owner” means the person who may exercise the rights provided in an annuity contract during the life of the annuitant. An owner can generally name himself or herself or another person as the annuitant.

l. “Revocable” means an annuity that can be canceled, revoked, terminated, or surrendered.

m. “Transaction” means:

i) The purchase of an annuity;

ii) The addition of principal to an annuity;

iii) Elective withdrawals from an annuity;

iv) Requests to change the distributions from an annuity;

v) Elections to annuitize an annuity contract; or

vi) Any other action taken by an individual that changes the course of payments made by an annuity or the treatment of income or principal of an annuity.

2. Annuities purchased on or before June 30, 1995

a. A revocable or irrevocable annuity established on or before June 30, 1995 is not a countable resource if it is annuitized and regular returns are being received by the annuitant.

i) Payments from the annuity to the individual or individual’s spouse are income in the month received.

b. A revocable or irrevocable annuity established on or before June 30, 1995 is a countable resource if it has not been annuitized.

3. Annuities Established on or after July 1, 1995 but before February 8, 2006

a. The purchase of an annuity shall be considered to be a transfer without fair consideration unless the following criteria are met:

i) The annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business;

ii) The annuity is annuitized for the individual or individual's spouse;

iii) The annuity is purchased on the life of the individual or individual's spouse; and

iv) The annuity provides payments for a period not exceeding the annuitant's projected life expectancy based on ~~the~~ life expectancy tables ~~at~~ described at 8.100.7.J.

b. To determine if a transfer without fair consideration has occurred in the purchase of an annuity, the Eligibility Site shall:

i) Determine the date on which the annuity was purchased;

ii) Determine the amount of money used to purchase the annuity and the length of the annuitization period;

iii) Determine the age of the annuitant at the time the annuity was purchased; and

iv) Determine the life expectancy of the annuitant at the time the annuity was purchased using the appropriate life expectancy table described at 8.100.7.J.

1) If the length of the annuitization period exceeds the annuitant's life expectancy, then a transfer without fair consideration exists for the portion of the annuitization period that exceeds the annuitant's life expectancy.

2) If the total value of the annuity's payments during the annuitization period is less than the original purchase price of the annuity, then the difference shall be considered to be a transfer without fair consideration.

3) If the total value of the annuity's payments during the annuitization period is equal to or greater than the original purchase price of the annuity, then the purchase of the annuity shall not be considered to be a transfer without fair consideration. However, any payments made by the annuity shall be considered to be countable income in the month received.

4) If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period. However, any payments made by the annuity shall be considered to be countable income in the month received.

4. Annuities Established on or after April 1, 1998 but before February 8, 2006

a. The Eligibility Site shall determine the Minimum Monthly Maintenance Needs Allowance (MMMNA) of the community spouse, if applicable.

i) If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, then the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered to be a transfer without fair consideration in determining the institutionalized spouse's eligibility.

This applies only to the extent that the transferred amount causes the Community Spouse Resource Allowance to exceed the maximum.

b. The Eligibility Site shall determine if the Individual is receiving substantially equal installments from the annuity for the annuitization period of the annuity.

i) If the annuity is not paid in substantially equal installments, then the original purchase price of the annuity shall be considered to be a transfer without fair consideration.

c. If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period.

i) Any payments made by the annuity shall be considered to be countable income in the month received.

5. Annuities Purchased on or after February 8, 2006

a. As a condition of Medicaid eligibility, at the time of application or redetermination, an applicant or his or her spouse for Medicaid Long-Term Care services shall disclose any interest that the Medicaid applicant or his or her spouse has in an annuity.

i) ~~The applicant shall provide the Eligibility Site with a complete copy of the annuity contract including the most recent beneficiary designation.~~A complete copy of the annuity contract, including the most recent beneficiary designation, shall be provided to the eligibility site.

b. By providing Medicaid Long-Term Care services, the Department shall be a remainder beneficiary of any annuity in which an individual or individual's spouse has an interest. The purchase of the annuity shall not be considered to be a transfer without fair consideration if:

i) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or

ii) The Department is named as the remainder beneficiary in the next position after the community spouse or minor or disabled child.

iii) This provision shall not apply to annuities that are revocable and/or assignable.

c. The Eligibility Site shall notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity for medical assistance provided to the institutionalized individual. This notice shall include a statement requiring the issuer to notify the Eligibility Site of any changes in the amount of income or principal that is being withdrawn from the annuity or any other transactions, as defined at 8.100.7.I.1., regardless of when the annuity was purchased.

d. If the Department is not named on the annuity as a remainder beneficiary, then the value of funds used to purchase the annuity shall be deemed a transfer without fair consideration and shall be subject to the penalty period provisions described at 8.100.7.F.

i) This provision shall not apply to annuities that are revocable and/or assignable.

e. Revocable Annuities

i) A revocable annuity is a countable resource. The value of the annuity is the total value of the annuity principal plus any accumulated interest.

a) If the annuity includes a surrender charge or other financial penalty (other than tax withholding or a tax penalty) for withdrawing funds from the annuity, then the value of the annuity is the net amount the individual would receive upon full surrender of the annuity.

ii) Payments from a revocable annuity are not countable as income.

f. Irrevocable Assignable Annuities

i) An irrevocable assignable annuity is a countable resource. The value of the annuity is presumed to be the total value of the annuity principal plus any accumulated interest.

a) An individual or individual's spouse can rebut the presumption by providing documented offers from at least three companies who are active in the market for buying and selling annuities an annuity income streams. The value of the annuity shall then be the highest of the offers.

b) Any payments from an irrevocable assignable annuity that is considered to be a countable resource are not considered to be countable income.

ii) An individual or individual's spouse can rebut the presumption that an irrevocable assignable annuity is not a countable resource by providing documented offers from at least three companies who are active in the market for buying and selling annuities and annuity income streams stating their unwillingness or inability to purchase the annuity or annuity income stream.

a) Any payments from an irrevocable assignable annuity that is not considered to be a countable resource are considered to be countable income in the month received.

g. Irrevocable Non-Assignable Annuities

i) An irrevocable non-assignable annuity is not considered to be a countable resource.

ii) Payments from an irrevocable non-assignable annuity are considered countable income in the month received.

iii) An irrevocable non-assignable annuity purchased by or for the benefit of a community spouse shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

iv) An irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

v) In addition to the requirements listed at 8.100.7.I.5.g.iv) for naming the Department as remainder beneficiary, an irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if the annuity meets any one of the following conditions:

1) The annuity is considered either:

a) An Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or

b) A deemed Individual Retirement Account under a qualified employer plan described in Section 408(q) of the Internal Revenue Code of 1986; or

2) The annuity is purchased with proceeds from one of the following:

a) An Individual Retirement Account as described in Section 408(a) of the Internal Revenue Code of 1986; or

b) An account established by an employer or association of employers as described in Section 408(c) of the Internal Revenue Code of 1986; or

c) A simple retirement account as described in Section 408(p) of the Internal Revenue Code of 1986; or

d) A simplified employee pension plan as described in Section 408(k) of the Internal Revenue Code of 1986; or

e) A Roth IRA as described in Section 408A of the Internal Revenue Code of 1986; or

3) The annuity meets all of the following requirements:

a) The annuity is irrevocable and non-assignable; and

b) The annuity is actuarially sound based on the life expectancy tables ~~listed~~ described at 8.100.7.J.; and

c) The annuity provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

vi) If an irrevocable non-assignable annuity is considered to be a transfer without fair consideration, then, for the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount of funds used to purchase the annuity.

h. Annuity Transactions

i) If an Individual or individual's spouse undertakes any transaction, as defined at 8.100.7.I.1. which has the effect of changing the course of payments to be made by an annuity or the treatment of income or principal of the annuity, such a transaction shall be deemed to be a transfer without fair consideration, regardless of when the annuity was originally purchased. For the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount used to purchase the annuity.

a) Routine changes such as a notification of an address change or death or divorce of a remainder beneficiary are excluded from treatment as a transfer without fair consideration.

b) Changes which occur based on the terms of the annuity which existed before February 8, 2006 and which do not require a decision, election, or action to take effect are excluded from treatment as a transfer without fair consideration.

c) Changes which are beyond the control of the individual, such as a change in law, a change in the policies of the annuity issuer, or a change in terms based on other factors, such as the annuity issuer's financial condition, are excluded from treatment as a transfer without fair consideration.

8.100.7.J. Life Expectancy Tables

This rule incorporates by reference the Social Security Office of the Chief Actuary Period Life Table 2011 for both males and females. The incorporation of the table excludes later amendments, or editions of, the referenced material.

The Social Security Office of the Chief Actuary Period Life Table 2011 is available at www.ssa.gov/oact/STATS/table4c6.html.

Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the 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.

~~Table 1: LIFE EXPECTANCY TABLE – MALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006~~**~~Age~~**	**~~Life Expectancy~~**	**~~Age~~**	**~~Life Expectancy~~**	**~~Age~~**	**~~Life Expectancy~~**	**~~Age~~**	**~~Life Expectancy~~**
~~0~~	~~71.80~~	~~30~~	~~44.06~~	~~60~~	~~18.42~~	~~90~~	~~3.86~~
~~1~~	~~71.53~~	~~31~~	~~43.15~~	~~61~~	~~17.70~~	~~91~~	~~3.64~~
~~2~~	~~70.58~~	~~32~~	~~42.24~~	~~62~~	~~16.99~~	~~92~~	~~3.43~~
~~3~~	~~69.62~~	~~33~~	~~41.33~~	~~63~~	~~16.30~~	~~93~~	~~3.24~~
~~4~~	~~68.65~~	~~34~~	~~40.23~~	~~64~~	~~15.62~~	~~94~~	~~3.06~~
~~5~~	~~67.67~~	~~35~~	~~39.52~~	~~65~~	~~14.96~~	~~95~~	~~2.90~~
~~6~~	~~66.69~~	~~36~~	~~38.62~~	~~66~~	~~14.32~~	~~96~~	~~2.74~~

7	65.71	37	37.73	67	13.70	97	2.60
8	64.73	38	36.83	68	13.09	98	2.47
9	63.74	39	35.94	69	12.50	99	2.34
10	62.75	40	35.05	70	11.92	100	2.22
11	61.76	41	34.15	71	11.35	101	2.11
12	60.78	42	33.26	72	10.80	102	1.99
13	59.79	43	32.37	73	10.27	103	1.89
14	58.82	44	31.49	74	9.27	104	1.78
15	57.85	45	30.61	75	9.24	105	1.68
16	56.91	46	29.74	76	8.76	106	1.59
17	55.97	47	28.88	77	8.29	107	1.50
18	55.05	48	28.02	78	7.83	108	1.41
19	54.13	49	27.17	79	7.40	109	1.33
20	53.21	50	26.32	80	6.98	110	1.25
21	52.29	51	25.48	81	6.59	111	1.17
22	51.38	52	24.65	82	6.21	112	1.10
23	50.46	53	23.82	83	5.85	113	1.02
24	45.55	54	23.01	84	5.51	114	0.96
25	48.63	55	22.21	85	5.19	115	0.89
26	47.73	56	21.43	86	4.89	116	0.83
27	46.80	57	20.66	87	4.61	117	0.77
28	45.88	58	19.90	88	4.34	118	0.71
29	44.97	59	19.15	89	4.09	119	0.66
Table 2: LIFE EXPECTANCY TABLE MALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8, 2006**Age**	**Life Expectancy**	**Age**	**Life Expectancy**	**Age**	**Life Expectancy**	**Age**	**Life Expectancy**
0	74.14	30	45.90	60	19.72	90	3.70
1	73.70	31	44.96	61	18.96	91	3.45
2	72.74	32	44.03	62	18.21	92	3.22
3	71.77	33	43.09	63	17.48	93	3.01
4	70.79	34	42.16	64	16.76	94	2.82
5	69.81	35	41.23	65	16.05	95	2.64
6	68.82	36	40.30	66	15.36	96	2.49
7	67.83	37	39.38	67	14.68	97	2.35
8	66.84	38	38.46	68	14.02	98	2.22
9	65.85	39	37.55	69	13.38	99	2.11
10	64.86	40	36.64	70	12.75	100	2.00
11	63.87	41	35.73	71	12.13	101	1.89
12	62.88	42	34.83	72	11.53	102	1.79
13	61.89	43	33.94	73	10.95	103	1.69

14	60.91	44	33.05	74	10.38	104	1.59
15	59.93	45	32.16	75	9.83	105	1.50
16	58.97	46	31.29	76	9.29	106	1.41
17	58.02	47	30.42	77	8.77	107	1.33
18	57.07	48	29.56	78	8.27	108	1.25
19	56.14	49	28.70	79	7.78	109	1.17
20	55.20	50	27.85	80	7.31	110	1.10
21	54.27	51	27.00	81	6.85	111	1.03
22	53.35	52	26.16	82	6.42	112	0.96
23	52.42	53	25.32	83	6.00	113	0.89
24	51.50	54	24.50	84	5.61	114	0.83
25	50.57	55	23.68	85	5.24	115	0.77
26	49.64	56	22.86	86	4.89	116	0.71
27	48.71	57	22.06	87	4.56	117	0.66
28	47.77	58	21.27	88	4.25	118	0.61
29	46.84	59	20.49	89	3.97	119	0.56
Table 3: LIFE EXPECTANCY TABLE FEMALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006**Age**	**Life Expectancy**	**Age**	**Life Expectancy**	**Age**	**Life Expectancy**	**Age**	**Life Expectancy**
0	78.79	30	50.15	60	22.86	90	4.71
1	78.42	31	49.19	61	22.06	91	4.40
2	77.48	32	48.23	62	21.27	92	4.11
3	76.51	33	47.27	63	20.49	93	3.84
4	75.54	34	46.31	64	19.72	94	3.59
5	74.56	35	45.35	65	18.96	95	3.36
6	73.57	36	44.40	66	18.21	96	3.16
7	72.59	37	43.45	67	17.48	97	2.97
8	71.60	38	42.50	68	16.76	98	2.80
9	70.61	39	41.55	69	16.04	99	2.64
10	69.62	40	40.61	70	15.35	100	2.48
11	68.63	41	39.66	71	14.66	101	2.34
12	67.64	42	38.72	72	13.99	102	2.20
13	66.65	43	37.78	73	13.33	103	2.06
14	65.67	44	36.85	74	12.68	104	1.93
15	64.68	45	35.92	75	12.05	105	1.81
16	63.71	46	35.00	76	11.43	106	1.69
17	62.74	47	34.08	77	10.83	107	1.58
18	61.77	48	33.17	78	10.24	108	1.48
19	60.80	49	32.27	79	9.67	109	1.38

20	59.83	50	31.37	80	9.11	110	1.28
21	58.86	51	30.48	81	8.58	111	1.19
22	57.89	52	29.60	82	8.06	112	1.10
23	56.92	53	28.72	83	7.56	113	1.02
24	55.95	54	27.86	84	7.08	114	0.96
25	54.98	55	27.00	85	6.63	115	0.89
26	54.02	56	26.15	86	6.20	116	0.83
27	53.05	57	25.31	87	5.79	117	0.77
28	52.08	58	24.48	88	5.41	118	0.71
29	51.12	59	23.67	89	5.05	119	0.66
Table 4: LIFE EXPECTANCY TABLE FEMALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8, 2006**Age**	**Life Expectancy**	**Age**	**Life Expectancy**	**Age**	**Life Expectancy**	**Age**	**Life Expectancy**
0	79.45	30	50.53	60	23.06	90	4.47
1	78.94	31	49.56	61	22.24	91	4.15
2	77.97	32	48.60	62	21.43	92	3.86
3	77.00	33	47.63	63	20.63	93	3.59
4	76.01	34	46.67	64	19.84	94	3.35
5	75.03	35	45.71	65	19.06	95	3.13
6	74.04	36	44.76	66	18.30	96	2.93
7	73.05	37	43.80	67	17.54	97	2.75
8	72.06	38	42.86	68	16.80	98	2.58
9	71.07	39	41.91	69	16.07	99	2.43
10	70.08	40	40.97	70	15.35	100	2.29
11	69.09	41	40.03	71	14.65	101	2.15
12	68.09	42	39.09	72	13.96	102	2.02
13	67.10	43	38.16	73	13.28	103	1.89
14	66.11	44	37.23	74	12.62	104	1.77
15	65.13	45	36.31	75	11.97	105	1.66
16	64.15	46	35.39	76	11.33	106	1.55
17	63.17	47	34.47	77	10.71	107	1.44
18	62.20	48	33.56	78	10.11	108	1.34
19	61.22	49	32.65	79	9.52	109	1.25
20	60.25	50	31.75	80	8.95	110	1.16
21	59.28	51	30.85	81	8.40	111	1.07
22	58.30	52	29.95	82	7.87	112	0.99
23	57.33	53	29.07	83	7.36	113	0.91
24	56.36	54	28.18	84	6.88	114	0.84
25	55.39	55	27.31	85	6.42	115	0.77

~~26~~	~~54.41~~	~~56~~	~~26.44~~	~~86~~	~~5.98~~	~~116~~	~~0.71~~
~~27~~	~~53.44~~	~~57~~	~~25.58~~	~~87~~	~~5.56~~	~~117~~	~~0.66~~
~~28~~	~~52.47~~	~~58~~	~~24.73~~	~~88~~	~~5.17~~	~~118~~	~~0.61~~
~~29~~	~~51.50~~	~~59~~	~~23.89~~	~~89~~	~~4.81~~	~~119~~	~~0.56~~

8.100.7.K. Spousal Protection - Treatment of Income and Resources for Institutionalized Spouses

1. The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community. Being a community spouse does not prohibit Medicaid eligibility if all criteria are met. The community spouse resource allowance does not supersede the Medicaid eligibility criteria.

2. For purposes of spousal protection, an institutionalized spouse is an individual who:

    a. Begins a stay in a medical institution or nursing facility on or after September 30, 1989, or

    b. 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

    c. Receives Home and Community Based Services on or after July 1, 1999; and

    d. Is married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraphs 8.100.7.K.2.a thru c for at least 30 consecutive days.

3. A community spouse is defined as the spouse of an institutionalized spouse.

8.100.7.L. Assessment and Documentation of The Couple's Resources

An assessment of the total value of the couple’s resources shall be completed at the time of initial Medical Assistance application or when requested by either spouse of a married couple. All non-exempt resources owned by a married couple are counted, whether owned jointly or individually. There are no exceptions for legal separation, pre-nuptial, or post-nuptial agreements. Once the applicant is approved, the Community Spouses’ resources are not reviewed again unless the Community Spouse applies for Medical Assistance.

8.100.7.M. Calculation of the Community Spouse Resource Allowance

1. A Community Spouse Resource Allowance (CSRA) shall be allocated based on the total resources owned by the couple as of the time of Medical Assistance application. The CSRA is established at intake only, and; once approved the community spouse’s resources are not considered again until the community spouse applies for Medical Assistance. This is true even if the community spouse becomes institutionalized but does not apply for Medical Assistance. In calculating the amount of the CSRA, resources shall not be attributed to the community spouse based upon state laws relating to community property or the division of marital property.

    For persons whose Medical Assistance application is for an individual who meets the definition of an institutionalized spouse, the CSRA is the largest of the following amounts:

    a. The total resources of the couple but no more than the current maximum allowance which, changes each year beginning January 1st.; or

    b. The increased CSRA calculated pursuant to section 8.100.7.S; or

c. The amount a court has ordered the institutionalized spouse to transfer to the community spouse for monthly support of the community spouse or a dependent family member.

2. The resources allotted to the community spouse as the CSRA shall be transferred into the name of the community spouse and shall not be considered available to the institutionalized spouse. After the transfer of the CSRA to the community spouse, the income from these resources shall be attributed to the community spouse.

3. The transfer of the CSRA shall be completed as soon as possible, but no later than the next redetermination when the community spouse becomes institutionalizes; whichever is earlier. If the transfer is not completed within this time period, the resources shall be attributed to the institutionalized spouse and shall affect his/her Medical Assistance eligibility. Verification of the transfer of assets to the community spouse shall be provided to the eligibility site.

   The institutionalized spouse may transfer the resources allotted to the community spouse as the CSRA to another person for the sole benefit of the community spouse.

4. If the community spouse is in control of resources attributed to the institutionalized spouse, but fails to make such resources available for his/her cost of care, this fact shall not make the institutionalized spouse ineligible for Medical Assistance, where:

   a. The institutionalized spouse has assigned The Department any rights to support from the community spouse; or

   b. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but The Department has the right to bring a support proceeding against the community spouse without such assignment; or

   c. The eligibility site determines that the denial of eligibility would work an undue hardship upon the institutionalized spouse. For the purposes of this subparagraph, undue hardship means that an institutionalized spouse, who meets all the Medical Assistance eligibility criteria except for resource eligibility, has no alternative living arrangement other than the medical institution or Long Term Care institution.

8.100.7.N. Treatment of the Home and Other Exempt Resources

The CSRA shall not include the value of exempt resources including the home. It is not necessary for the home to be transferred to the community spouse. The rules regarding countable and exempt resources can be found in the section 8.100.5. However, for Spousal Protection there is no limit to the value of household goods and personal effects and one automobile.

8.100.7.O. Determination of the Institutionalized Spouse's Income and Resource Eligibility

1. The institutionalized spouse is resource eligible for Medical Assistance when the total resources owned by the couple are at or below the amount of the Community Spouse Resource Allowance plus the Medical Assistance resource allowance for an individual of $2,000.

2. The eligibility site shall determine whether the institutionalized spouse is income eligible for Medical Assistance. The institutionalized spouse shall be income eligible if his/her gross income is at or below the Medical Assistance income limit for recipients of long-term care. If an income trust is used the trust must be established before the MIA is calculated.

8.100.7.P. Attribution of Income

During any month in which a spouse is institutionalized, the income of the community spouse shall not be deemed available to the institutionalized spouse except as follows:

1. If payment of income from resources is made solely in the name of either the institutionalized spouse or the community spouse, the income shall be considered available only to the named spouse.

2. If payment of income from resources is made in the names of both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each spouse.

3. If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.

4. The above regulations of attribution of income are superseded if the institutionalized spouse can establish by a preponderance of the evidence that the ownership interests in the income are other than that provided in the regulations.

8.100.7.Q. Calculating the Community Spouse's Monthly Income Needs

1. The community spouse's total minimum monthly needs shall be determined as follows:

   a. The current minimum monthly maintenance needs allowance (MMMNA), which is equal to 150% of the federal poverty level for a family of two and is adjusted in July of each year;

   b. An excess shelter allowance, in cases where the community spouse's expenses for shelter exceed 30% of the MMMNA. The excess shelter allowance is computed by adding (a) and (b) together:

      i) The community spouse's expenses for rent or mortgage payment including principal and interest, taxes and insurance, and, in the case of a condominium or cooperative, any required maintenance fee, for the community spouse's principal residence; and

      ii) The larger of the following amounts: the standard utility allowance used by Colorado under U.S.C. 2014(e) of Title 7; or the community spouse's actual, verified, utility expenses. A utility allowance shall not be allowed if the utility expenses are included in the rent or maintenance charge, which is paid by the community spouse.

      iii) The excess shelter allowance is the amount, if any, that exceeds 30% of the MMMNA.

2. An additional amount may be approved for the following expenses:

   a. Medical expenses of the community spouse or dependent family member for necessary medical or remedial care. Each medical or remedial care expense claimed for deduction must be documented in a manner that describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider. An expense may be deducted only if it is:

      i) Provided by a medical practitioner licensed to furnish the care;

      ii) Not subject to payment by any third party, including Medical Assistance and Medicare;

   b. The cost of Medicare, Long Term Care insurance, and health insurance premiums. A health insurance premium may be allowed in the month the premium is paid or may be prorated and allowed for the months the premium covers. This allowance does not include payments made for coverage which is:

i) Limited to disability or income protection coverage;

ii) Automobile medical payment coverage;

iii) Supplemental to liability insurance;

iv) Designed solely to provide payments on a per diem basis, daily indemnity or non-expense-incurred basis; or

v) Credit life and/or accident and health insurance.

3. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

4. The total that results from adding the current MMMNA and the excess shelter allowance shall not exceed the current maximum MMMNA which is $2,175.00 for the year 2001 and is adjusted by the Health Care Financing Administration in January of each year.

8.100.7.R. Calculating the Amount of Income to be Contributed by the Institutionalized Spouse for the Community Spouse's Monthly Needs

1. The Monthly Income Allowance (MIA) is the amount of money necessary to raise the community spouse's income to the level of his/her monthly needs, and shall be obtained from the monthly income of the institutionalized spouse. For individuals who become institutionalized on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse must be considered to have been made available to the community spouse before an MIA is allocated to the community spouse.

2. The MIA shall be the amount by which the community spouse's minimum monthly needs, which is the MMMNA, exceed his/her income from sources other than the institutionalized spouse. The community spouse’s income shall be calculated by using the gross income less mandatory deduct ions for FICA and Medicare tax.

3. If a court has entered an order against the institutionalized spouse for monthly support of the community spouse, the MIA shall not be less than the monthly amount ordered by the court.

4. The eligibility site shall make adjustments to the MMMNA and/or the MIA on a monthly basis for any continuing change in circumstances that exceeds $50 a month. Continuing changes of less than $50 in a month, and any infrequent or irregular changes, shall be considered at redetermination.

8.100.7.S. Increasing the Community Spouse Resource Allowance

1. The CSRA shall be increased above the maximum amount if additional resources are needed to raise the community spouse's monthly income to the level of the Minimum Monthly Maintenance Needs Allowance (MMMNA). In making this determination the items listed below are calculated in the following order:

a. The community spouse's MMMNA;

b. The community spouse’s own income; and

c. The Monthly Income Allowance (MIA) contribution that the community spouse is eligible to receive from the institutionalized spouse.

d. If the community spouse's own income, and the Monthly Income Allowance contribution from the institutionalized spouse's income is less than the Minimum Monthly Maintenance Needs Allowance, additional available resources shall be shifted to the community spouse to bring his/her income up to the level of the MMMNA. The additional resources necessary to raise the community spouse's monthly income to the level of the MMMNA shall be based upon the cost of a single-premium lifetime annuity with monthly payments equal to the difference between the MMMNA and the community spouse's income. The following steps shall be followed to determine the amount of resources to be shifted:

i) The applicant shall obtain three estimates of the cost of an annuity that would generate enough income to make up the difference between the MMMNA and the combined community spouse's income as described above.

ii) The amount of the lowest estimate shall be used as the amount of resources to increase the CSRA.

iii) The applicant shall not be required to purchase the annuity in order to have the CSRA increased.

e. The CSRA shall not be increased if the institutionalized spouse refuses to make the monthly income allowance (MIA) available to the community spouse.

8.100.7.T. Deductions from Monthly Income of the Institutionalized Spouse

1. During each month after the institutionalized spouse becomes Medical Assistance eligible, deductions shall be made from the institutionalized spouse's monthly income in the following order.

a. A personal needs allowance or the client maintenance allowance as allowed by program eligibility.

b. A Monthly Income Allowance (MIA) for the community spouse, but only to the extent that income of the institutionalized spouse is actually made available to, or for the benefit of, the community spouse;

c. A family allowance for each dependent family member who lives with the community spouse.

i) The allowance for each dependent family member shall be equal to one third of the amount of the MMMNA and shall be reduced by the monthly income of that family member.

ii) Family member means dependent children (minor or adult), dependent parents or dependent siblings of either spouse that are residing with the community spouse and can be claimed by either the institutionalized or community spouse as a dependent for federal income tax purposes.

d. Allowable deductions identified in section 8.100.7.V.

e. If the institutionalized spouse fails to make his/her income available to the community spouse or eligible dependent family members in accordance with these regulations, that income shall be applied to the cost of care for the institutionalized spouse.

f. No other deductions shall be allowed.

8.100.7.U. Right to Appeal

1. Both spouses shall be informed of the following:

a. The amount and method by which the eligibility site calculated the community spouse resource allowance (CSRA), community spouse monthly income allowance (MIA), and any family allowance;

b. The spouses' right to a fair hearing concerning these calculations;

c. The eligibility site conclusions with respect to the spouses' ownership and availability of income and resources, and the spouses' right to a fair hearing concerning these conclusions.

2. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

3. Appeals from decisions made by the eligibility site shall be governed by the provisions under Recipient Appeals Protocols/Process at 8.058.

8.100.7.V. Long-Term Care Institution Recipient Income

1. Determination of Income and Communication between the Long-Term Care institution and the Eligibility Site Using the AP-5615 Form for Patient Payment

a. Sections I, II and IV of the AP-5615 form are to be completed by the Long-Term Care institution for all admissions, readmissions, transfers to and from another payer source, including private pay and Medicare, discharges, deaths, changes in income and/or patient payment, medical leaves of absence and non-medical/programmatic leave in excess of 42 days combined per calendar year.

b. The initial determination of resident income for patient payment shall be made by the Eligibility Site. The Eligibility Site shall notify the Long-Term Care institution of current resident income.

c. On receipt of AP-5615 form, the Eligibility Site will, within five working days:

i) For an admission, a readmission or a transfer from/to private pay, Medicare, or another payer source:

1) Verify and correct, if necessary, data entered by the Long-Term Care institution.

2) List and/or verify the resident's monthly income adjustments and/or Long-Term Care Insurance benefit payments; and compute patient payment. Provide the completed AP-5615 to the Long-Term Care institution.

3) Correct the automated system to indicate the Long-Term Care institution name and provider number and to reflect the current distribution of income. Submit the AP-5615 form to the Department.

d. For change in patient payment with respect to changes in resident income:

i) Verify changes in resident income, and correct if necessary. All such corrections must be initialed,

ii) Compute patient payment and provide the completed AP-5615 to the Long-Term Care institution.

e. For change in patient payment with respect to the post-eligibility treatment of income, the Eligibility Site shall:

i) Review the AP-5615 form for Medicare part B premium deduction allowances for the first two months of admission.

ii) If client is already on the Medicare Buy-In program for Medicare part B, do not adjust patient payment on AP-5615 form for the Medicare premium deduction. If client is not on the Buy-In program, adjust AP-5615 form for the Medicare premium deduction for the first two months of Long-Term Care institution eligibility.

iii) If the client has a Medicare D premium, the Eligibility Site shall use the amount as an income adjustment/deduction in the patient payment calculation and complete the AP-5615 form.

f. For resident leave of absence:

i) Non-Medical/Programmatic Leave. When combined non-medical/programmatic days in excess of 42 days are reported, verify adherence to the restrictions and conditions of section 8.482.44.

ii) Medical Leave/Hospitalization. Verify that the patient payment is apportioned correctly between the nursing facility and the hospital so that no Medicaid payment is requested for the period. See also section 8.482.43.

iii) The nursing facility may wait until the end of the month to complete the AP-5615 form for an ongoing hospitalization.

g. For change in payer status:

i) If Medicare or insurance is a primary payer during the month, verify the nursing facility's calculation of the patient payment.

ii) Complete and provide the AP-5615 to the nursing facility.

h. For discharge or death of resident:

i) Verify the date of death or discharge, and verify the correct patient payment including the resident's monthly income for the discharged month, and the amount calculated by per diem. All corrections must be initialed.

ii) Note if the resident entered another Long-Term Care institution and, if so, enter the name of the new Long-Term Care institution in the system.

iii) In the event the resident may return to the same facility, the AP-5615 form may be completed at the end of the month for discharges due to hospitalization.

i. For discontinuation of Long-Term Care eligibility:

i) Initiate and send an AP-5615 form to the Long-Term Care institution within 5 working days of the date of determination that the client's eligibility will be discontinued. Indicate the date the discontinuation will be effective.

j. Failure to provide a correct and timely AP-5615 to the Long-Term Care institution may result in the refusal of the Department to reimburse such Long-Term Care institution care. The AP-5615 form is required in order for a Prior Authorization Request (PAR) to be issued for Long-Term Care institution claim reimbursement.

k. General Instructions:

i) The AP-5615 form must be verified and a signed AP-5615 form returned to the Long-Term Care institution.

ii) The AP-5615 form must be signed and dated by the director of the Eligibility Site or by his/her designee.

iii) AP-5615 forms may be initiated by either the Long-Term Care institution or Eligibility Site. If the Eligibility Site is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the Long-Term Care institution, the Eligibility Site may initiate the revision to the AP-5615 form. In such case, one copy of the AP-5615 form showing the changes will be sent to the Long-Term Care institution.

l. The Department may deduct excess payments from the Eligibility Site administrative reimbursement as stated in the Colorado Department of Human Services Finance Staff Manual, Volume 5 if the Eligibility Site fails to:

i) Perform the duties as detailed in this section; or

ii) Adhere to the limitations on a reduced patient payment; as detailed in section 8.100.7.V.4; or

iii) Notify the Long-Term Care institution within 5 working days of any changes in resident income, provided the Long-Term Care institution is not authorized to receive the resident's income; and excessive Medicaid funds are paid to the Long-Term Care institution as a result of this negligence.

2. Collection of Patient Payment

a. It shall be the responsibility of the Long-Term Care institution to collect from the client, or from the client's family, conservator or administrator, the patient payment, which is to be applied to the cost of client care. The Department is not responsible for any deficiency in patient payment accounts, due to failure of the Long-Term Care institution to collect such income.

b. If, however, the Long-Term Care institution is unable to collect such funds, through refusal of the resident or the resident's family, conservator, administrator or responsible party to release such income, the Long-Term Care institution shall immediately notify the Eligibility Site.

c. When notified by the Long-Term Care institution of the refusal of the client or the client's family, conservator administrator or responsible party to pay the patient payment due, the Eligibility Site shall immediately contact the refusing party. If, after such contact, the party still refuses to release such income, the action shall be deemed a failure to cooperate, and the Eligibility Site shall proceed to discontinue Medicaid benefits for the resident.

3. Calculation of Patient Payment

a. Specific instructions for computing the patient payment amount are contained in this volume under The “Status of Long-Term Care institution Care” Form, AP-5615

b. Once an applicant for Nursing Facility Medical Assistance has been determined eligible for Medical Assistance, the Eligibility Site shall determine the patient payment due to the Nursing Facility which is to be applied to the Medicaid reimbursement for the cost of care. That patient payment is calculated by:

i) Determining all applicable income of the recipient

ii) Deducting all applicable allowable monthly income adjustments, which include:

1) Personal Needs Allowance

2) If applicable, Monthly Income Allowance for the community spouse.

3) If applicable, Family Dependent Allowance

4) If applicable, Home Maintenance Allowance

5) If applicable, Trustee/Maintenance Fees: actual fees, with a maximum of $20 per month

6) If applicable, Mandatory Income Tax Withheld

7) Mandatory garnishments repaying Federal assistance overpayment

8) Medical or remedial care expenses that are not subject to payment by a third party:

a) Medicare Part B Premium expenses, if applicable, are deductible only for the first and second month in the Nursing Facility.

b) Medicare Part D Premium expenses, if applicable, are ongoing deductions.

c) Other medical and remedial expenses covered under the Nursing Facility PETI (NF PETI) program are not deductible. NF PETI-approved expenses are allowed only for residents with a patient payment, but do not change the patient payment amount. For NF PETI, see the Section 8.482.33 in this volume “Post Eligibility Treatment of Income”.

c. Long-Term Care Insurance

Long-Term Care insurance payments are not counted as income for eligibility purposes. However, they are income available for a patient payment. The patient payment shall include the client’s income after the allowable deductions and any Long-Term Care insurance payments for the month. In the event that the patient payment is greater than the cost of care, the Long-Term Care insurance payment shall be applied before the client’s income.

i) If Long-Term Care insurance is received for the month, and:

1) If, after all deductions, the client has income available for a patient payment, add this to the amount of the Long-Term Care insurance to determine the total patient payment.

a) If the total amount is greater that the allowable cost of care, the Long-Term Care insurance is applied before the client’s income, or;

b If after all deductions, the client does not have income available for the patient payment, only the Long-Term Care insurance payment is used.

d. Personal Needs Allowances

i) Non-Veteran related personal needs allowance

1) Prior to January 1, 2015 the personal needs allowance base amount is $50 per month.

2) Effective January 1, 2015 the personal needs allowance base amount is $75 per month and will be adjusted annually at the same rate as the statewide average of the nursing facility per diem rate net of patient payment pursuant to C.R.S. § 25.5-6-202(9)(b)(I). Each yearly adjustment will set a new base amount.

a) The first annual rate adjustment to the new $75 base amount will occur on January 1, 2015.

ii) Veterans-related personal needs allowance

Effective 07/01/91, the personal needs allowance shall be $90 per month for a veteran in a Long-Term Care institution who has no spouse or dependent child and who receives a non-service connected disability pension from the U.S. Veterans Administration. The personal needs allowance shall also be $90 per month for the widow(er) of a veteran with no dependent children.

1) Public Law requires that a veteran, without a spouse or dependent child, who enters a Long-Term Care institution have their veteran's pension reduced to $90 which is to be reserved for their personal needs. This reduction in pension is not applicable to veteran's who reside in a State Veteran's Nursing facility. If a veteran, who does not reside in a State Veteran's Nursing facility, receives a pension reduction of $90 he/she is allowed to apply this $90 to his/her personal needs allowance. It is not considered income toward the patient payment. The same regulation applies to a widow of a veteran without any dependent children.

2) To verify if those veterans residing in State Veteran's Nursing facilities are receiving a non-service connected pension you may request their award letter from the Department of Veterans Affairs or call the Department of Veterans Affairs and verify through contact. If they are receiving any amount in a non-service connected pension they are entitled to a $90 personal needs allowance so long as they do not have a spouse or dependent child. The same regulation applies to a widow of a veteran without any dependent children.

iii) For aged, disabled, or blind Long-Term Care institution recipients engaged in income-producing activities, an additional amount of $65 per month plus one-half of the remaining gross income may be retained by the individual.

iv) Effective September 15, 1994, aged, disabled, or blind Long-Term Care institution residents, HCBS or PACE recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included as a deduction from the patient payment. The patient payment deduction must be for a specific accounting period when the taxes are owed and expected to be withheld from income or paid by the individual in the accounting period. The Eligibility Site must verify that the taxes were withheld. If the taxes are not paid, the Eligibility Site must establish a recovery. The deduction is also applicable for any Federal pensions with mandated tax withholdings from unearned income despite the individual earner being institutionalized. All other pensions will discontinue the tax withholding once notified that the recipient is receiving institutionalized care through Medicaid, thus

signifying that the withholding was not mandatory. This deduction does not apply to individuals who have elected to have taxes withheld from their earnings as a means to receiving a greater tax refund.

e. The reserve specified in section 8.100.7.V.3.d.iii. of this volume shall apply to Long-Term Care institution residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:

i) work in a sheltered workshop or work activity center;

ii) “protected employment” which means the employer gives special privileges to the individual;

iii) an activity that produced income in connection with a course of vocational rehabilitation;

iv) employment training sessions;

v) activities within the facility such as crafts products and facility employment.

f. In determining the personal needs reserve amount for Long-Term Care institution residents engaged in income-producing activities:

i) The personal needs allowance is reserved from earned income only when the person has insufficient unearned income to meet this need;

ii) In determining countable earned income of a Long-Term Care institution resident, the following rules shall apply:

1) $65 shall be subtracted from the gross earned income.

2) The result shall be divided in half.

3) The remaining income is the countable earned income and shall be considered in determining the patient payment.

iii) When the personal needs allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.

g. Other Deductions Reserved from Recipient's Income:

i) In the case of a married, long-term care recipient who is institutionalized in a Long-Term Care institution and who has a spouse (and, in some cases, other dependent family members) living in the community, there are “spousal protection” rules which permit the contribution of the institutionalized spouse's income toward their living expenses. See section 8.100.7.K.

ii) For a Long-Term Care institution recipient with no family at home, an amount in addition to the personal needs allowance may be reserved for maintenance of the recipient's home for a temporary period, not to exceed 6 months, if a physician has certified that the person is likely to return to his/her home within that period. In regard to this additional reserve from recipient income for home maintenance, the amount of the deduction:

1) must be based on actual expenses such as mortgage payments, taxes, utilities to prevent freeze, etc.;

2) may not exceed the total of the current shelter and utilities components of the applicable standard of assistance (OAP for aged recipients; AND/SSI-CS or AB/SSI-CS for disabled or blind recipients).

~~iii) Effective April 8, 1988, an additional amount may be deducted from the patient payment for expenses incurred by a Long-Term Care institution recipient for medical or remedial care that is not paid for by Colorado Medical Assistance or any third party insurance. See section 8.100.7.W.~~

h. The necessity for the deduction from a recipient's income specified in section 8.100.7.V.3 shall be fully explained in the case record. Such additional reserve amount must be entered on the eligibility reporting form.

i. As of July 1, 1988, an SSI cash recipient may continue to receive SSI benefits when he/she is expected to be institutionalized for three months or less. This provision is intended to allow temporarily institutionalized recipients to pay the necessary expenses to maintain the principal place of residence.

i) Payments made under this continued benefit provision are not considered over-payments of SSI benefits if the recipient's stay is more than 90 days.

ii) The amount of Supplemental Security Income (SSI) benefit paid to an institutionalized individual is deducted from gross income when computing the patient payment.

j. When a nursing facility resident’s SSI is reduced due to institutionalization, the difference between the reduced SSI payment and the personal needs allowance amount shall be provided through the Adult Financial program so that the resident receives the full personal needs allowance.

4. Reduction of the Patient Payment

a. Patient payment may be reduced only under the following conditions:

i) A resident's income is equal to or less than the personal needs allowance and there is no long term care insurance payment, in which case the patient payment is zero; or

ii) A resident's income is equal to or less than the sum of all allowable and appropriate deductions, and there is no long term care insurance payment; or

iii) A resident is admitted to the Long Term Care institution from his/her home and the resident's funds are committed elsewhere for that month; or

iv) The resident is admitted from his/her home, where his/her funds were previously committed, to the hospital, and subsequently to the Long Term Care institution, in the same calendar month; or

v) The resident is discharged to his/her home, and the Eligibility Site determines that the income is necessary for living expenses; or

vi) The resident is admitted from another Long Term Care institution or from private pay within the facility and has committed the entire patient payment for the month for payment of care already provided in the month of admission.

vii) Medicare assesses a co-insurance payment for a QMB recipient; the recipient’s patient payment cannot be used for payment of Medicare co-insurance.

b. Patient payment may not be waived in the following instances:

i) Transfers between nursing facilities, except that the patient payment for the receiving facility may be waived if the patient payment has already been committed to the former nursing facility; or

ii) Discharges from nursing facility to a hospital or other medical institution when Medicaid is paying for services in the medical institution; or

iii) Changes from private pay within the facility and the patient payment is not already committed for care provided under private pay status; or

iv) The death of the resident.

c. The Eligibility Site shall verify and approve partial month patient payments due to transfers, discharges or death when calculated by the nursing facility based upon the nursing facility's per diem rate.

d. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.

5. Responsibilities of the Eligibility Site Regarding the Personal Needs Fund

a. It shall be the responsibility of the Eligibility Site to explain to the resident the various options for handling the personal needs monies, as well as the resident's rights to such funds. The resident has the option to allow the Long Term Care institution to hold such funds in trust.

b. It shall be the responsibility of the Eligibility Site to assure that the Long Term Care institution properly transfers or disposes of the resident's personal needs funds within 30 days of discharge from the Long Term Care institution, or transfer to another Long Term Care institution.

c. The Eligibility Site shall notify the State Department if they become aware that a Long Term Care institution has retained personal needs funds more than 30 days after the death of a resident.

6. For rules regarding post eligibility treatment of income, see the section in this volume titled "Post Eligibility Treatment of Income"

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services for Community Mental Health Supports, §8.509.15, Home and Community Based Services for Persons with Brain Injury, §8.515.3, and Home and Community Based Services for Persons with a Spinal Cord Injury, §8.517.2
Rule Number:	MSB 15-06-16-A
Division / Contact / Phone:	Long Term Services and Supports / Colin Laughlin and Cassandra Keller / 866-2549

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 15-06-16-A, Revision to the Medical Assistance Home and Community Based Services for Community Mental Health Supports, Section 8.509.15, Home and Community Based Services for Persons with Brain Injury, Section 8.515.3, and Home and Community Based Services for Persons with a Spinal Cord Injury, Section 8.517.2
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) 8.509.15, 8.517.2, and 8.515.3, 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*

Replace current text at §8.509.15.A.2.a. with new text provided. Replace current text beginning at §8.509.15.A.2.a.i. through the end of §8.509.15.A.2.d with new text provided beginning at §8.509.A.2.a.i through the end of §8.509.15.A.2.c.

Replace current text provided beginning at the first unnumbered paragraph at §8.515.3 through the end of §8.515.3.18 with the new text provided.

Replace current text at the last (ninth) unnumbered paragraph in §8.517.2 that begins “Spinal Cord Injury means…” with the new text provided.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Add new text provided beginning at §8.517.2.1 through the end of §8.517.2.1.31 with the new text provided. Replace current text at §8.517.5.A.2 with the new text provided.

All text indicated in blue is for clarification purposes only and should not be changed. All text not included in this document should remain as is with no changes.

*to be completed by MSB Board Coordinator

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Title of Rule:	Revision to the Medical Assistance Home and Community Based Services for Community Mental Health Supports, §8.509.15, Home and Community Based Services for Persons with Brain Injury, §8.515.3, and Home and Community Based Services for Persons with a Spinal Cord Injury, §8.517.2
Rule Number:	MSB 15-06-16-A
Division / Contact / Phone:	Long Term Services and Supports / Colin Laughlin and Cassandra Keller / 866-2549

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 BI, CMHS and SCI rules for targeting waiver eligibility are being updated in order to come into compliance with the Federal Mandate to migrate from ICD-9 to ICD-10 codes by October 1, 2015.

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:

   45 CFR §§ 162.1000 & 162.1002

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   CRS §§ 25.5-6-606; 25.5-6-704; 25.5-6-1304.

Initial Review — Final Adoption **10/09/2015**

Proposed Effective Date **11/30/2015** — Emergency Adoption

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services for Community Mental Health Supports, §8.509.15, Home and Community Based Services for Persons with Brain Injury, §8.515.3, and Home and Community Based Services for Persons with a Spinal Cord Injury, §8.517.2
Rule Number:	MSB 15-06-16-A
Division / Contact / Phone:	Long Term Services and Supports / Colin Laughlin and Cassandra Keller / 866-2549

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 on the BI and CMHS waivers will benefit from the proposed rule change by removing the ICD-9 codes listed in the targeting criteria of the rules and coming into compliance with the Federal Mandate. The cost of the proposed rule change is not projected to have any impact and will be covered by the current appropriation for HCBS BI, SCI, and CMHS waiver services.

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

There is not a quantitative nor a qualitative impact on clients.

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 will be no additional cost to the Department

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

In order to comply with the Federal Mandate, it will be necessary to change the rules in order to come into compliance.

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

There are no less costly or less intrusive 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.

There are no alternative methods for achieving the purpose of the proposed rule and of simplifying waivered services.

8.509.15 ELIGIBLE PERSONS

A.

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be certified by the Utilization Review Committee (URC) as functionally eligible for HCBS-CMHS. The URC shall only certify HCBS-CMHS eligibility for those clients:

a. Determined to meet the target group definition, ~~for the mentally ill as defined at Section 8.400.16; and~~ defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL);

i. A person experiencing a severe and persistent mental health need is defined as someone who:

1) Is 18 years of age or older with a severe and persistent mental health need; and

2) Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5); and

a) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and

b) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

ii. A severe and persistent mental health need does not include:

1) Intellectual or developmental disorders; or

2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.

b. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11-15; and

~~c. Who are determined to be persons with mental illness as defined by State Mental Health Services and documented by the case management agency;~~

~~d~~c. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

8.515.3 GENERAL DEFINITIONS

Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the ~~following~~ following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:~~International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes:~~:

1. ~~310 – 310.9 Specific n~~Nonpsychotic mental disorders due to brain damage; or

2. ~~348.1~~ Anoxic brain damage; or

3. ~~348.4~~ Compression of the brain; or

4. ~~349.82~~ Toxic encephalopathy; or

5. ~~430~~ Subarachnoid and/or intracerebral hemorrhage; or

~~431 Intracerebral hemorrhage~~

6. ~~433~~ Occlusion and stenosis of precerebral arteries; or

7. ~~436~~ Acute, but ill-defined cerebrovascular disease; or

8. ~~437 – 437.9~~ Other and ill-defined cerebrovascular disease; or

9. ~~438 – 438.9~~ Late effects of cerebrovasular disease; or

10. ~~800 – 800.9~~ Fracture of ~~vault of skull~~the skull or face; or

~~801 – 801.9 Fracture of base of skull~~

~~803 – 803.9 Other and unqualified skull fractures~~

~~804 – 804.9 Multiple fractures involving skull or face with other bones~~

11. ~~850 – 850.9~~ Concussion resulting in an ongoing need for assistance with activities of daily living; or

12. ~~851 – 851.9~~ Cerebral laceration and contusion; or

13. ~~852 – 8.52.5~~ Subarachnoid, subdural, and extradural hemorrhage, following injury; or

14. ~~853 – 853.1~~ Other unspecified intracranial hemorrhage following injury; or

15. ~~854 – 854.1~~ Intracranial injury ~~of other and unspecified nature~~; or

16. ~~905~~ Late effects of musculoskeletal and connective tissue injuries; or

17. ~~907~~ Late effects of injuries to the nervous system; or

18. Unspecified injuries to the ~~959.01 Hh~~ead ~~injury, unspecified~~resulting in ongoing need for assistance with activities of daily living.

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Service Plan means the plan developed by the case manager in coordination with the HCBS-BI client and/or the legal guardian to identify and document the HCBS-BI services, other Medicaid services, and any other non-Medicaid services or supports that the HCBS-BI client requires in order to live successfully in the community.

8.517.2 GENERAL DEFINITIONS

Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about beneficial physiologic and /or psychological changes.

Chiropractic Care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

Complementary and Integrative Health Provider means an individual or agency certified annually by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.Denver Metro Area means the counties of Adams, Arapahoe, Denver, Douglas, and Jefferson.

Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

Medical Director means an individual that is contracted with the Department of Health Care Policy and Financing to provide oversight of the Complementary and Integrative Health Services and the program evaluation.

Spinal Cord Injury means an injury to the spinal cord which is further defined at 8.517.2.1.~~and includes the International Classification of Diseases, 9th Edition, Clinical Modification (ICD 9CM) codes 952 through 954.9.~~

8.517.2.1 SPINAL CORD INJURY DEFINITION

A spinal cord injury is ~~defined as an injury to the spinal cord and is~~ limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Spinal cord injury unspecified
2. Complete lesion of spinal cord
3. Anterior cord syndrome
4. Central cord syndrome
5. Other specified spinal cord injury
6. Lumbar spinal cord injury without spinal bone injury

7. Sacral spinal cord injury without spinal bone injury

8. Cauda equina spinal cord injury without spinal bone injury

9. Multiple sites of spinal cord injury without spinal bone injury

10. Unspecified site of spinal cord injury without spinal bone injury

11. Injury to cervical nerve root

12. Injury to dorsal nerve root

13. Injury to lumbar nerve root

14. Injury to sacral nerve root

15. Injury to brachial plexus

16. Injury to lumbosacral plexus

17. Injury to multiple sites of nerve roots and spinal plexus

18. Injury to unspecified site of nerve roots and spinal plexus

19. Injury to cervical sympathetic nerve excluding shoulder and pelvic girdles

20. Injury to other sympathetic nerve excluding shoulder and pelvic girdles

21. Injury to other specified nerve(s) of trunk excluding shoulder and pelvic girdles

22. Injury to unspecified nerve of trunk excluding shoulder and pelvic girdles

23. Paraplegia

24. Paraplegia, Unspecified

25. Paraplegia, Complete

26. Paraplegia, Incomplete

27. Quadriplegia/Tetraplegia/Incomplete – unspecified

28. Quadriplegia – C1-C4/Complete

29. Quadriplegia – C1-C4/Incomplete

30. Quadriplegia – C5-C7/Complete

31. Quadriplegia – C5-C7/Incomplete

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall be offered only to persons who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a diagnosis of Spinal Cord Injury. This diagnosis must be outlined in 8.517.2.1 and documented on the individual's Professional Medical Information Page (PMIP) and in the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool.

3. Individuals shall have been determined to have a significant functional impairment as evidenced by a comprehensive functional assessment using the ULTC 100.2 assessment tool that results in at least the minimum scores required per Section 8.401.1.15.

4. Individuals shall reside in the Denver Metro Area as evidenced by residence in one of the following counties:

    a. Adams;

    b. Arapahoe;

    c. Denver;

    d. Douglas; or

    e. Jefferson