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Title of Rule: Revision to the Medical Assistance Rule concerning the Hospice Benefit, Section 8.550
Rule Number: MSB 18-01-05-A
Division / Contact / Phone: Operations Section / Russ Zigler / 303-866-5927

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 18-01-05-A, Revision to the Medical Assistance Rule concerning the Hospice Benefit, Section 8.550
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) 8.550, 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).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.550 with the proposed text beginning at 8.550.1 through the end of 8.550.9. This rule is effective May 31, 2018.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning the Hospice Benefit, Section 8.550
Rule Number: MSB 18-01-05-A
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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 codifies existing practice by incorporating the policies documented in the Hospice Benefit Coverage Standard, with no substantive policy changes.

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 USC 1396d(o)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-5-304, C.R.S.

Initial Review Final Adoption
Proposed Effective Date Emergency Adoption

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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.

   Medicaid clients receiving hospice care will be affected by the proposed rule.

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

   The proposed rule codifies existing practice by incorporating the policies documented in the Hospice Benefit Coverage Standard, with no substantive policy changes. Therefore, the proposed rule will not impose a quantitative or qualitative impact on the affected class.

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.

   Since the proposed rule codifies existing practice, it does not impose additional costs or effect state revenues.

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

   There are no costs to the proposed rule. The benefit of the proposed rule is codifying existing practice and policy into rule. The cost of inaction is keeping Hospice policy in the Benefit Coverage Standard, rather than in rule. There are no benefits to inaction.

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

   Since the proposed rule codifies existing practice, there are no less costly methods or less intrusive methods for achieving its purpose.

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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.

   Since the proposed rule codifies existing practice, there are no alternative methods for achieving its purpose.

8.550 HOSPICE BENEFIT

8.550.1 DEFINITIONS

Alternative Care Facility (ACF) means an assisted living residence that is enrolled as a Medicaid provider.

Assisted Living Residence means an assisted living residence as defined in 6 CCR 1011-1 Chapter VII.

Benefit Period means a period during which the client has made an Election to receive Hhospice care defined as one or more of the following:

~~(~~1.~~)~~ An initial 90-day period.

~~(~~2.~~)~~ A subsequent 90-day period.

~~(~~3.~~)~~ An unlimited number of subsequent 60-day periods.

The periods of care are available in the order listed and may be Elected separately at different times.

Certification means that the client's attending physician and/or the Hospice Provider's medical director have affirmed that the client is Terminally Ill.

Client Record means a medical file containing the client's Election of Hospice, eligibility documentation, and other medical records.

Department means the Colorado Department of Health Care Policy and Financing. The Department is designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

Election/Elect means the client's written expression to choose Hospice care for Palliative and Supportive Medical Services.

Home Care Services means Hospice Services that are provided primarily in the client's home but may be provided in a residential facility and/or licensed or certified health care facility.

Hospice means a centrally administered program of palliative, supportive, and Interdisciplinary Team services providing physical, psychological, sociological, and spiritual care to Terminally Ill clients and their families.

Hospice Provider means a Medicaid and Medicare-certified Hospice provider.

Hospice Services means counseling, certified nurse ~~home health~~ aide, personal care worker, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteer services~~s~~.

Interdisciplinary Team ~~or Interdisciplinary Group~~ means a group of qualified individuals, consisting of at least a physician, registered nurse, clergy, ~~/~~counselors, volunteer director ~~and/~~or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice clients and their ~~/~~families.

Intermediate Care Facility for People with Intellectual Disabilities means a care facility which is designed, and functions, to meet the needs of four or more individuals with developmental disabilities, or related conditions, who require twenty-four hour active treatment services.

Medical Necessity or Medically Necessary is defined in Section 8.076.1.8.

Palliative and Supportive Medical Services means those services and/or interventions which are not curative but which produce the greatest degree of relief from the symptoms of the Terminal Illness.

Room and Board includes a place to live and the amenities that come with that place to live, ~~which~~ includ~~es~~ing but ~~is~~ not limited to provision of:

1. Meals and additional nutritional requirements, as prescribed;

2. Performance of personal care services, including assistance with activities of daily living;

3. Provision of social activities;

4. Equipment necessary to safely care for the client and to transport the client, as necessary;

5. Administration of medication;

6. Maintenance of the cleanliness of a client's room; and

7. Supervision and assistance in the use of durable medical equipment and prescribed therapies.

Terminally Ill/Terminal Illness means a medical prognosis of life expectancy of nine months or less, should the illness run its normal course.

8.550.2 ~~CERTIFICATION~~INITIATION OF HOSPICE

8.550.2.A. Certification

The Hospice Provider ~~shall~~ must obtain Certification that a client is Terminally Ill in accordance with the following ~~-~~procedures:

1. For the first Benefit Period of Hospice coverage or re-Election following revocation or discharge from the Hospice benefit, the Hospice Provider ~~shall~~ must obtain:

   a. A written Certification signed by either the Hospice Provider's medical director ~~of the Hospice~~ or the physician member of the ~~Hospice~~ Interdisciplinary ~~Group~~ Team and the client's attending physician. The written Certification ~~shall~~ must be obtained and placed in the Client Record ~~on file prior to submitting any claim for reimbursement to the Medicaid fiscal agent~~within two calendar days after Hospice Services are initiated. The written Certification ~~shall~~ must include:

      i) A statement of the client's life expectancy including diagnosis of the terminal condition, other health conditions whether related or unrelated to the terminal condition, and current clinically relevant information supporting the diagnoses and prognosis for life expectancy and Terminal Illness;~~.~~

      ii) The approval of the client's physician(s) for Hospice Services; and~~care.~~

      iii) The approval of the Hospice Provider of Hospice Services for the client.

   b. A verbal Certification statement from either ~~the medical director of the~~ Hospice Provider's medical director or the physician member of the ~~Hospice~~

Interdisciplinary ~~Group~~Team and the client's attending physician, if written certification cannot be obtained within two calendar days after Hospice ~~care~~Services ~~is~~are initiated. The verbal Certification ~~shall~~ must be documented, filed in the ~~medical~~ Client ~~r~~Record, and include the information described at Section 8.550.2.A.1.a.i, ii, and iii. Written Certification documentation ~~shall~~ must follow and be filed in the ~~medical~~ Client ~~r~~Record prior to submitting a claim for payment.

2. At the beginning of each subsequent Benefit ~~p~~Period, the Hospice Provider ~~shall~~ must~~l~~ obtain a written re-Certification prepared by either the attending physician, the Hospice Provider's medical director ~~of the Hospice~~ or the physician member of the ~~Hospice~~ Interdisciplinary ~~Group~~Team.

8.550.2.B.~~3~~ E~~LECTION~~lection P~~ROCEDURES~~rocedures

~~8.550.3.A.~~1. An Election of Hospice ~~care~~Services continues as long as there is no break in care and the client remains with the Elected Hospice Provider.

2~~1~~. If a client Elects to receive Hospice ~~care~~Services, the client or client representative ~~shall~~ must file an Election statement with the Hospice Provider that must be maintained in the Client's Record and must includ~~inge~~:

a. Designation of the Hospice ~~p~~Provider. A client must choose only one Hospice Provider as the designated Hospice Provider;

b. Acknowledgment that the client or client representative has ~~been given~~ a full understanding of the palliative rather than curative nature of Hospice ~~care~~Services~~.~~;

c. Designation by the client or client representative of the effective date for the Election period. ~~t~~Th~~at~~e ~~begins with the~~ first day of Hospice ~~care~~Services must be the same or a later date;~~.~~

d. An acknowledgement that for the duration of the Hospice Services, the client waives all rights to Medicaid payments for the following services:

i) Hospice Services provided by a Hospice Provider other than the ~~Hospice~~ provider designated by the client (unless provided under arrangements made by the designated Hospice Provider)~~.~~;

ii) Any Medicaid services that are related to the treatment of the terminal condition for which ~~h~~Hospice ~~care~~ Services w~~as~~ere Elected, or a related condition, or that are equivalent to ~~h~~Hospice ~~care~~Services, except for services that are:

1~~a~~) Provided by the designated ~~h~~Hospice Provider;~~,~~

2~~b~~) Provided by another ~~h~~Hospice Provider under arrangements made by the designated ~~h~~Hospice Provider;~~,~~

3~~c~~) Provided by the individual's attending physician if that physician is not an employee of the designated ~~h~~Hospice Provider or receiving compensation from the ~~h~~Hospice Provider for those services; and,

4) Services provided to clients ages 20 and under~~; and .~~.

e. A signature of either the client or client representative as allowed by Colorado law.

3~~2~~. A client or client representative may revoke the Election of Hospice Services ~~care~~ by filing a signed statement of revocation with the Hospice Provider. The statement ~~shall~~ must include the effective date of the revocation. The client ~~shall~~ must not designate an effective date earlier than the date that the revocation is made. Revocation of the Election of ~~h~~Hospice Services~~care~~ ends the current ~~h~~Hospice ~~b~~Benefit ~~p~~Period.

a. Clients who are dually eligible for Medicare and Medicaid must revoke the Election of Hospice Services under both programs.

4~~3~~. The client may resume coverage of the waived benefits as described at 8.550.2~~3~~.B~~A~~.~~1~~2.d. upon revoking the Election of Hospice ~~care~~Services.

5~~4~~. The client may re-Elect to receive Hospice ~~care~~ Services at any time after the services are discontinued due to discharge, revocation, or loss of Medicaid eligibility, should the client thereafter become eligible.

6~~5~~. The client may change the designation of the Hospice P~~p~~rovider once each Benefit Period. A change in designation of Hospice P~~p~~rovider is not a revocation of the client's Hospice Election. To change the designation of the Hospice P~~p~~rovider, the client ~~shall~~must file a statement with the current and new provider which includes:

a. The name of the Hospice Provider from which the client is receiving care and the name of the Hospice Provider from which he or she plans to receive care;~~.~~

b. The date the change is to be effective; and~~.~~

c. The signature of the client or client representative.

8.550.3 HOSPICE RELATED TO HCBS WAIVERS

8.550.3.A. Provision of Services

1. Hospice Services may be provided to a client who is enrolled in one of the Colorado Medicaid home and community-based services (HCBS) waivers, including the children with life limiting illness waiver.

2. HCBS waiver services may be provided for conditions unrelated to the client's terminal diagnosis. For children ages 20 and under, HCBS waivers services may be provided for conditions related or unrelated to the client's terminal diagnosis.~~HCBS waiver services may be provided for conditions unrelated to the client's terminal diagnosis. Children under 20 are exempt from the requirement that services be unrelated to the client's terminal diagnosis.~~

3. HCBS waiver services may also be provided to the client when these services are not duplicative of the services that are the responsibility of the Hospice Provider. HCBS waivers are those waivers as defined at ~~s~~Sections 8.500 ~~et seq~~through 8.599.

8.550.3.B. Waiver Coordination

1. The Hospice Provider must notify the HCBS waiver case manager or support coordinator of the client's Election of Hospice Services and the anticipated start date.

2. The Hospice Provider must coordinate Hospice Services and HCBS waiver services with the HCBS waiver case manager or support coordinator and must document coordination of these services in the Client Record. Documentation must include:

   a. Identification of the Hospice Services that will be provided;

   b. Identification of the HCBS waiver services that will be provided under the waiver; and

   c. Integration of Hospice Services and HCBS waiver services in the Hospice plan of care.

3. The Hospice Provider must invite the HCBS waiver case manager or support coordinator to participate in the Interdisciplinary Team meetings for the client when possible.

8.550.4 BENEFITS

8.550.4.A. Hospice Standard of Care

1. Hospice Services ~~shall~~ must be reasonable and Medically Necessary for the palliation or management of the Terminal Illness as well as any related condition, but not for the prolongation of life.

2. Clients ages 20 and under are exempt from the restriction on care for the prolongation of life.

8.550.4.B. Covered Services

Covered Hospice Services include, but are not limited to:

1. Nursing care provided by or under the supervision of a registered nurse.

2. Medical social services provided by a qualified social worker or counselor under the direction of a physician.

3. Counseling services, including dietary and spiritual counseling, provided to the Terminally Ill client and his or her family members or other persons caring for the client.

4. Bereavement counseling delivered through an organized program under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the client~~patient~~).

5. Short-term general inpatient care necessary for pain control and/or symptom management up to 20 percent of total Hospice Service days.

6. Short-term inpatient care of up to five consecutive days per Benefit Period to provide respite for the client's family or other home caregiver.

7. Medical appliances and supplies, including ~~drugs~~ pharmaceuticals and biologicals which are used primarily for symptom control and relief of pain related to the Terminal Illness.

8. Intermittent ~~home health~~certified nurse aide services available and adequate in frequency to meet the needs of the client. ~~A home health~~Certified nurse aides ~~is a certified nurse aide~~practice under the general supervision of a registered nurse. ~~Home health~~Certified nurse aide services may include unskilled personal care and homemaker services that are ~~incidental~~directly related to a visit.

9. Occupational therapy, physical therapy, and speech-language pathology appropriate to the terminal condition, provided for the purposes of symptom control or to enable the terminal client to maintain activities of daily living and basic functional skills.

10. Trained volunteer services.

11. Any other service that is specified in the client's plan of care as reasonable and Medically Necessary for the palliation and management of the client's Terminal Illness and related conditions and for which payment may otherwise be made under Medicaid.

8.550.4.C. [Expired 05/15/2014 per House Bill 14-1123]

8.550.4.D. Non-Covered Services

Services not covered as part of the H~~h~~ospice ~~b~~Benefit include, but are not limited to:

1. Services provided before or after the Hospice Election period.

2. Services of the client's attending or consulting physician that are unrelated to the terminal condition which are not waived under the Hospice B~~b~~enefit.

3. Services or medications received for the treatment of an illness or injury not related to the client's terminal condition.

4. Services which are not otherwise included in the Hospice benefit, such as electronic monitoring, non-medical transportation, and home modification under a Home and Community-Based Services (HCBS) program.

5. Personal care and homemaker services beyond the scope provided under Hospice Services which are contiguous with a ~~home health~~ certified nurse aide visit.

6. Hospice Services covered by other health insurance, such as Medicare or private insurance.

7. Hospice Services provided by family members.

8.550.4.E. Prior Authorization

Prior authorization is not required for Hospice Services.

8.550.4.F. Intermittent Home Health Certified Nurse Aide Services

Intermittent home health certified nurse aide services may be utilized with Hospice Services coordination for treatment of conditions that are not related to the terminal diagnosis and are not meant to cure the client's terminal condition. Children under 20 are exempt from this requirement.

8.550.4.G. Included Activities

Medicaid does not separately reimburse for activities that are the responsibility of the Hospice Provider, including coordination of care for the client and bereavement counseling.

8.550.5 ELIGIBLE PLACE OF SERVICE~~ILITY~~

8.550.5.A. Place of Service

~~Hospice Services are provided in a client's place of residence, which includes:~~

1. ~~1.~~ Hospice Services are provided in a client's place of residence, which includes:

   a. A residence such as, but not limited to, a house, apartment or other living space that the client resides within;

   b. An assisted living residence including an Alternative Care Facility~~ACF~~;

   c. A temporary place of residence such as, but not limited to, a relative's home or a hotel. Temporary accommodations may include homeless shelters or other locations provided for a client who has no permanent residence to receive Hospice Services;

   d. Other residential settings such as a group home or foster home;

   e. A licensed Hospice Facility or Nursing Facility (NF);

   f. An Intermediate Care Facility for the Intellectually Disabled (ICF/ID), or ~~Skilled~~ Nursing Facility (~~S~~NF), unless the client is in a waiver program which does not allow residency in an ICF/I~~F~~D or ~~S~~NF; or

   g. An Individual Residential Services & Supports (IRSS) or a Group Residential Services & Supports (GRSS) host home setting.

2. For Hospice clients residing in a NF, ICF/ID, IRSS or GRSS, the client must meet both the Hospice requirements and the requirements for receipt of those Medicaid-covered services.

3. Colorado Medicaid does not reimburse Hospice Services provided in hospitals except when the client has been admitted for respite services.

8.550.5.B. Hospice Setting Requirements

1. Nursing Facilities:

   a. Hospice Services may be provided to a client who resides in a Medicaid participating NF.

   b. When a client residing in a NF Elects Hospice Services, the client is considered a Hospice client and is no longer a NF client with the exception of the facility's responsibility to provide Room and Board to the client.

   c. In order for a client to receive Hospice Services while residing in a NF, the Hospice Provider must:

i) Notify the NF that the client has Elected Hospice and the expected date that Hospice Services will commence;

ii) Ensure the NF concurs with the Hospice plan of care;

iii) Ensure the NF is Medicaid ~~and Medicare~~ certified; and

iv) Execute a written agreement with the NF, which must include the following:

1) The means through which the NF and the Hospice Provider will communicate with each other and document these communications to ensure that the needs of clients are addressed and met 24 hours a day;

2) An agreement on the client's Hospice Service plan of care by the NF staff;

3) A means through which changes in client status are reported to the Hospice Provider and NF;

4) A provision stating that the Hospice Provider is considered the primary provider and is responsible for any Medically Necessary routine care or continuous care related to the Terminal Illness and related conditions;

5) A provision stating that the Hospice Provider assumes responsibility for determining the appropriate course of Hospice Services, including the determination to change the level of services provided;

6) An agreement that it is the NF provider's responsibility to continue to furnish 24 hour Room and Board care, meeting the personal care, durable medical equipment and nursing needs that would have been provided by the NF at the same level of care provided prior to Hospice Services being Elected;

7) An agreement that it is the Hospice Provider's responsibility to provide services at the same level and to the same extent that those services would be provided if the client were residing in his or her own residence;

8) A provision that the Hospice Provider may use NF personnel, where permitted by State law and as specified by the agreement, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a client's family in implementing the plan of care;

9) The NF remains responsible for compliance with mandatory reporting of such violations to the State's protective services agency. As such, the Hospice Provider and its staff or subcontractors must report all alleged violations of a client's person involving mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and

misappropriation of client property to the NF administrator within 24 hours of the Hospice Provider becoming aware of the alleged violation;

10) Bereavement services that the Hospice Provider will provide to the NF staff;

11) The amount to be paid to the NF or ICF/ID by the Hospice Provider; and

12) An agreement describing whether the Hospice Provider or the NF will be responsible for collecting the client's ~~financial contribution~~patient payment for his or her care.

2. Intermediate~~ittent~~ Care Facilities, Independent Residential Support Services, and Group Residential Support Services settings:

a. Hospice Services may be provided to a client who resides in a Medicaid participating ICF/ID, IRSS or GRSS residential settings. When a client resides in one of the settings, the client remains a resident of the ICF/ID, IRSS or GRSS residence. The Hospice Provider must provide services as if treating a client in his or her place of residence.

b. The Hospice Provider is not responsible for reimbursing the IRSS or GRSS for the client's Room and Board.

c. In order for a client to receive Hospice Services while residing in these settings, the Hospice Provider must work with the ICF/ID, IRSS or GRSS to:

i) Notify the ICF/ID, IRSS or GRSS that the client has Elected Hospice and the expected date that Hospice Services will commence;

ii) Ensure the ICF/ID, IRSS or GRSS concurs with the Hospice plan of care;

iii) Determine ~~what are~~ the responsibilities covered under the ICF/ID, IRSS or GRSS so that the Hospice Provider does not duplicate service (to include medication and supplies), ~~.~~ ~~I~~including:

1) An agreement that the Hospice Provider will be responsible to provide services at the same level and to the same extent as those services would be provided if the client were residing in his or her private residence; and

2) An agreement of the services the ICF/ID, IRSS or GRSS personnel will perform, where permitted by State law, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a client's family in implementing the plan of care;

iv) Develop a coordinated plan of care to ensure that the client's needs are met;

v) Develop a communication plan through which the Hospice Provider and the ICF/ID, IRSS or GRSS will communicate changes in the client's

condition or changes in the client's care plan to ensure that the client's needs are met; and

vi) Ensure bereavement services are available to the staff and caregivers of the client.

3. In settings other than nursing facilities and ICF/IDs, the Hospice Provider and assisted living residence or foster home must develop an agreement related to the provision of care to the client, including;

a. Hospice Provider staff access to and communication with staff or caregivers in these facilities or homes;

b. Developing an integrated plan of care;

c. Documenting both respective entities' records, or other means to ensure continuity of communication and easy access to ongoing information;

d. Role of any Hospice vendor in delivering and administering any supplies and medications;

e. Ordering, renewing, delivering and administering medications;

f. Role of the attending physician and process for obtaining and implementing orders;

g. Communicating client change of condition; and

h. Changes in the client's needs that necessitate a change in setting or level of care.

8.550.6 ELIGIBLE CLIENTS

8.550.6.A. Requirements

~~A client shall~~To be eligible to Elect Hospice ~~care~~ Services, ~~when~~ all of the following requirements must be ~~are~~ met:

1. Clients must be Medicaid eligible on the dates of service for which Medicaid-covered Hospice Services are billed. The services must be Medically Necessary, including certification of the client's Terminal Illness, and appropriate to the client's needs in order for Hospice Services to be covered by Medicaid.~~The client's residence is either a private residence, residential care facility, licensed Hospice facility, intermediate care facility for the mentally retarded (ICF-MR) or a skilled nursing facility (SNF), unless the client is in a waiver program which does not allow residency in an ICF-MR or SNF.~~

2. The client has been certified as being Terminally Ill by an attending physician ~~and/~~or the Hospice Provider's medical director.

3. Before services are provided, ~~A~~an initial plan of care must be ~~has been~~ established by the Hospice ~~p~~Provider in collaboration with the client and anyone else that the client wishes to have present for care planning. When the client is unable to direct his or her own care, care planning must involve the client's family or ~~/~~caregiver. ~~before services are provided.~~

4. The client has agreed to cease any and all curative treatment. Clients ages 20 and younger are exempt from this requirement.

54. Hospice clients residing in an ICF-~~MR~~/ID or ~~S~~NF ~~shall~~ must meet the Hospice eligibility criteria pursuant to Section 8.550 et. seq., together with functional eligibility, medical eligibility criteria, and the financial eligibility criteria for institutional care as required by ~~10 C.C.R. 2505-10,~~ Sections 8.400, 8.401, and 8.482.

6. Clients who do not meet eligibility requirements for State Plan Medicaid may be eligible for Medicaid through the long-term care eligibility criteria, which may require the client to pass a level of care assessment through a designated case management agency.

8.550.~~65~~.B. Special Requirements

1. Eligibility for, and access to, Hospice Services ~~shall~~does not fall within the purview of the long term care Single Entry Point system for prior authorization.

2. Nursing facility placement for a client who has Medicaid and has Elected Hospice ~~care~~Services in a nursing facility does not require a long term care ULTC 100.2 assessment. The nursing facility ~~shall~~must complete a Pre Admission Screening and Resident Review (PASRR).

8.550.~~76~~ DISCHARGE

8.550.~~76~~.A. A Hospice Provider may discharge a client when:

1. The client moves out of the Hospice Provider's service area or transfers to another Hospice Provider;~~.~~

2. The H~~h~~ospice Provider determines that the client is no longer Terminally Ill; or~~.~~

3. The Hospice Provider determines, under a policy set by the Hospice Provider for the purpose of addressing discharge for cause that meets the requirements of 42 C.F.R. Section 418.26(a)(3) (20~~05~~18), that the client's (or other person in the client's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care or the Hospice Provider's ability to operate effectively is seriously impaired. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. ~~Material that has been incorporated by reference in this rule may be examined at any state publications depository library.~~

a.~~4.~~ The Hospice Provider must:

i) ~~shall a~~Advise the client that a discharge for cause is being considered;

ii) M~~, m~~ake a serious effort to resolve the problem presented by the situation;

iii) A~~, a~~scertain that the proposed discharge is not due to the client's use of necessary Hospice ~~s~~Services;~~,~~

iv) ~~d~~Document the problem and the effort made to resolve the problem~~;~~, and

v) ~~e~~Enter this documentation into the client's medical record.

4~~5~~. The Hospice Provider ~~shall~~ must obtain a written discharge order from the Hospice Provider's medical director prior to discharging a client for any of the reasons in this section.

5~~6~~. The Hospice Provider medical director ~~shall~~ must document that the attending physician involved in the client's care has been consulted about the discharge and include the attending physician's review and decision in the discharge note.

~~7~~6. The Hospice Provider ~~shall~~ must have in place a discharge planning process that takes into account the prospect that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as Terminally Ill. The discharge planning process ~~shall~~ must include planning for any necessary family counseling, patient education, or other services before the client is discharged because he or she is no longer Terminally Ill.

7. The Hospice Provider must implement the discharge planning process to ensure to the maximum extent feasible, that the client's needs for health care and related services upon termination of Hospice Services will be met~~.~~;

8. The Hospice Provider must document whether the client or client's authorized representative was involved in the discharge planning~~; and~~.

9. The Hospice Provider must document the transition plan for the client.

8.550.8~~7~~ PROVIDER ~~QUALIFICATIONS~~REQUIREMENTS

8.550.8~~7~~.A. Licensure

The Hospice ~~shall~~ Provider must be licensed by the Colorado Department of Public Health and Environment, have a valid provider agreement with the Department and ~~meet the~~be Medicare certified as being in compliance with the conditions of participation for a Hospice Provider as set forth at 42 C.F.R. ~~Sections~~§§ 418.52 through 418.116 (2018).~~0 through 418.98 (2005) and 42 C.F.R. Section 418.100 (a) (c) (2005).~~ No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

8.550.8.B. Qualified Personnel

Hospice Services must be performed by appropriately qualified personnel:

1. Physicians who are a doctor of medicine or osteopathy licensed in accordance with the Colorado Medical Practice Act (C.R.S. § 12-36-101, ~~C.R.S.~~ et seq.);

2. Advanced Practice Nurses and Physician Assistants licensed in accordance with the Colorado Nurse Practice Act and the Colorado Medical Practice Act;

3. Registered Nurses (RN) and Licensed Practical Nurses (LPN), licensed in accordance with the Colorado Nurse Practice Act (C.R.S. § 12-38-101, ~~C.R.S.~~ et seq.);

4. Physical therapists who are licensed in accordance with the Colorado Physical Therapy Practice Act (C.R.S. § 12-41-101~~, C.R.S.~~ et seq.);

5. Occupational therapists who are licensed in accordance with the Colorado Occupational Therapy Practice Act (C.R.S. § 12-40.5-101, ~~C.R.S.~~ et seq.);

6. Speech language pathologists who are certified by the American Speech-Language-Hearing Association (ASHA);

7. Licensed clinical social workers who have a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education, or a baccalaureate degree in psychology, sociology, or other field related to social work and who are supervised by a social worker with a Master's Degree in Social Work and who have one year of social work experience in a health care setting;

8. Certified nurse aides who are certified in accordance with the Colorado Nurse Aide Practice Act (C.R.S. § 12-38-101, ~~C.R.S.~~ et seq.) and who have appropriate training. At the option of the Hospice Provider, homemakers with appropriate training may provide homemaking services, which is included as a component of Hospice Services;

9. Hospice volunteers who have received volunteer orientation and training that is consistent with Hospice industry standards;

10. Members of the clergy or religious support services; and

11. Members of the Hospice Interdisciplinary Team acting within the scope of his or her license, as determined by the Hospice Provider.~~ Material that has been incorporated by reference in this rule may be examined at any state publications depository library.~~

8.550.~~8~~7.~~C~~B. Laboratory Services

1. Laboratory services provided by Hospice Providers are subject to the requirements of 42 U.S.C. §~~Section~~ 263~~(~~a~~)~~ (2012~~05~~) entitled the Clinical Laboratory Improvement Act of 1967 (CLIA). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. ~~Material that has been incorporated by reference in this rule may be examined at any state publications depository library.~~

~~8.550.7.C.~~ 2. Hospice Providers ~~shall~~ must obtain a CLIA waiver from the Department of Public Health and Environment to perform laboratory tests. A Hospice Provider that collects specimens, including drawing blood, but does not perform testing of specimens is not subject to CLIA requirements.

8.550.8.D. P~~ROVIDER~~rovider R~~ESPONSIBILITIES~~esponsibilities

1. A Hospice Provider must routinely provide all core services by staff employed by the Hospice Provider. These services must be provided in a manner consistent with acceptable standards of practice. Core services include nursing services, certified nursing aide services, medical social services, and counseling.

2. ~~8.550.8.A.~~ The Hospice ~~p~~Provider may contract for physician services. The contracted provider(s) will function under the direction of the Hospice Provider's medical director.~~shall determine and document the amount, frequency, and duration of services in~~

~~accordance with the client's plan of care developed in consultation with the client and his or her physician.~~

3. A Hospice Provider may use contracted staff, if necessary, to supplement Hospice Provider employees in order to meet the needs of the client. A Hospice Provider may also enter into a written arrangement with another Colorado Medicaid and Medicare certified Hospice program for the provision of core services to supplement Hospice Provider employees/staff to meet the needs of clients. Circumstances under which a Hospice Provider may enter into a written arrangement for the provision of core services include:

   a. Unanticipated periods of high client loads, staffing shortages due to illness or other short-term, temporary situations that interrupt client care;

   b. Temporary travel of a client outside of the Hospice Provider's service area; and

   c. When a client resides in a NF, ICF/ID, IRSS or GRSS.

4. The Hospice Provider must ensure, prior to the provision of Medicaid Hospice Services, that clients are evaluated to determine whether ~~-~~or not they are Medicare eligible. Hospice Services are not covered by Medicaid during the period when a client is Medicare eligible, except for clients residing in a NF in which case Medicaid pays to the Hospice Provider an amount for Room and Board.

5. The Hospice Provider must ensure a client, or his or her legally authorized representative, completes the Hospice Election form prior to or at the time Medicaid Hospice Services are provided.

6. Medicare Hospice Election may not occur retroactively. Therefore, clients with retroactive Medicare eligibility may receive Medicaid covered services during the retroactive coverage period. The Hospice Provider must make reasonable efforts to determine a client's status concerning Medicare eligibility or a client's application for Medicare and must maintain documentation of these efforts. These efforts must include routine and regular inquiry to determine Medicare eligibility for clients who reach the age of sixty-five and regular inquiry for clients who indicate they receive Supplemental Security Disability Income (SSDI) and are approaching the 24th month of receipt of SSDI. See also Section 8.550.3.

7. Clients who are eligible for Medicare and Medicaid must Elect Hospice Services under both programs.

8. If a client becomes eligible for Medicaid while receiving Medicare Hospice benefits, Medicare Hospice coverage continues under its current Election period and Medicaid Hospice coverage begins at Medicaid's first Election period.

9.

~~8.550.8.B.~~ An individual C~~c~~lient ~~r~~Record ~~shall~~ must be maintained by the designated Hospice Provider and must includ~~e~~~~ing~~:

   ~~1~~a. ~~Eligibility for and Election of Hospice.~~Documentation of the client's eligibility for and Election of Hospice Services including the physician certification and recertification of Terminal Illness;

   b. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;

c.

~~2.~~ The amount, frequency, and duration of services delivered to the client based on the client's plan of care;~~.~~

d~~3~~. Documentation to support the care level for which the Hospice P~~p~~rovider has claimed reimbursement; and

e. Medicaid provider orders.~~.~~

10. ~~8.550.8.C.~~ Incomple~~adequa~~te documentation in the Client Record shall be a basis for recovery of overpayment.

11.~~8.550.8.D.~~ Notice of the client's Election and Benefit Periods ~~shall~~ must be provided to the Medicaid fiscal agent in such form and manner as prescribed by the Department.

~~8.550.8.E.~~12. The Hospice P~~p~~rovider ~~shall~~ must provide reports and keep records as the Department determines necessary including records that document the cost of providing care.

13~~8.550.8.F~~. The Hospice ~~p~~Provider ~~shall~~ must perform case management for the client. Medicaid ~~sha~~will not reimburse the Hospice ~~p~~Provider separately for this responsibility.

14. The Hospice Provider must designate an Interdisciplinary Team composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the clients and his or her family facing Terminal Illness and bereavement. Interdisciplinary Team members must provide the care and services offered by the Hospice Provider. The Interdisciplinary Team, in its entirety, must supervise the care and services.

15. The Interdisciplinary Team includes, but is not limited to:

a. A doctor of medicine or osteopathy, advanced practice nurse, or physician assistant (who is an employee or under contract with the Hospice Provider);

b. A registered nurse or licensed practical nurse;

c. A social worker;

d. A pastoral or other counselor; and

e. The volunteer coordinator or designee.

16. The Hospice Provider must designate a member of the Interdisciplinary Team to provide coordination of care and to ensure continuous assessment of each client's and family's needs and implementation of the interdisciplinary plan of care. The designated member must oversee coordination of care with other medical providers and agencies providing care to the client.

17. All Hospice Services and services furnished to clients and their families must follow an individualized written plan of care established by the Hospice Interdisciplinary Team in collaboration with the client's primary provider (if any), the client or his or her representative, and the primary caregiver in accordance with the client's needs and desires.

18. The plan of care must be established prior to providing Hospice Services and must be based on a medical evaluation and the written assessment of the client's needs and the needs of the client's primary caregiver(s).

19. The plan of care must be maintained in the client's record and must specify:

    a. The client's medical diagnosis and prognosis;

    b. The medical and health related needs of the client;

    c. The specific services to be provided to the client through Hospice and when necessary the NF, ICF/ID, IRSS or GRSS;

    d. The amount, frequency and duration of these services; and

    e. The plan of care review date.

20. The plan of care must be reviewed as needed, but no less frequently than every 15 days. The Interdisciplinary Team leader must document each review. The Interdisciplinary Team members, including the Medicaid provider who is managing the client's care, must sign the plan of care.

21. The Hospice Provider must ensure that each client and his or her primary care giver(s) receive education and training provided by the Hospice Provider as appropriate based on the client's and primary care giver(s)' responsibilities for the care and services identified in the plan of care.

22. The Hospice Provider is responsible for paying for medications, durable medical equipment, and medical supplies needed for the palliation and management of the client's Terminal Illness.

8.550.9 REIMBURSEMENT

8.550.9.A. Reimbursement Determination

Reimbursement follows the method prescribed in 42 C.F.R. ~~Sections~~ §§ 418.3012 through 418.3096 (2005~~13~~)18). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. ~~Material that has been incorporated by reference in this rule may be examined at any state publications depository library.~~

1. Reimbursement rates are determined by the following:

    a. Rates are published by the Department annually in compliance with the Centers for Medicare and Medicaid Services (CMS) state Medicaid Hospice reimbursement.

    b. Each care-level per-diem rate is subject to a wage index multiplier, to compensate for regional differences in wage costs, plus a fixed non-wage component.

    c. The Hospice wage indices are published annually by October 1 in the Federal Register.

d. Rates are adjusted for cost-of-living increases and other factors as published by the Centers for Medicare and Medicaid Services.

e. Continuous home care is reimbursed at the applicable hourly rate, the per-diem rate divided by 24 hours, multiplied by ~~times~~ the number of hourly units billed from eight up to 24 hours per day of continuous care (from midnight to midnight).

f. Reimbursement for routine home care and continuous home care ~~shall~~ must be based upon the geographic location at which the service is furnished and not on the business address of the Hospice ~~p~~Provider.

2. ~~8.550.9.B.~~ Reimbursement for Hospice ~~care~~Services ~~shall~~ must be made at one of four predetermined care level rates, including the routine home care rate, continuous home care rate, inpatient respite care rate, and general inpatient care rate. If no other level of care is indicated on a given day, it is presumed that routine home care is the applicable rate.

~~a~~1. Care levels ~~determination~~ and reimbursement guidelines:

~~a~~i) ~~.~~ The routine home care rate is reimbursed for each day the client is at home and not receiving continuous home care. This rate is paid without regard to the volume or intensity of Home Care Services provided. This is the service type that must be utilized when a client resides in a NF, ICF/ID, IRSS or GRSS unless the client is in a period of crisis.

~~b.~~ii) The continuous home care rate is reimbursed when continuous home care is provided and only during a period of medical crisis to maintain a client at home. A period of crisis is a period in which a client requires continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Either a registered nurse or a licensed practical nurse ~~shall~~must provide ~~nursing care. A nurse shall provide~~ more than half of the billed continuous homecare hours~~period of care~~. Homemaker and certified nurse aide services may also be provided to supplement nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours ~~shall~~ must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate shall be reimbursed up to 24 hours a day. Continuous home care must not be utilized when a client resides in a NF, ICF/ID, IRSS or GRSS unless the client is in a period of crisis.

~~c.~~iii) The inpatient respite care rate is paid for each day on which the client is in an approved inpatient facility for respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Payment for inpatient respite care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.~~B~~D.

~~d.~~iv) The general inpatient rate ~~shall~~ must be paid only during a period of medical crisis in which a client requires 24 hour continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Payment for general inpatient care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.B ~~D~~.

32. The Hospice Provider is paid a ~~r~~Room and ~~b~~Board fee in addition to the Hospice per diem for each routine home care day and continuous care day provided to clients residing in an ICF/ID ~~MR~~ or ~~S~~NF.

a. The payment for R~~r~~oom and ~~b~~Board is billed by and reimbursed to the Hospice provider on behalf of the client residing in the facility. The Department reimburses 95 percent of the facility per diem amount less any patient payments.

b. Payments for ~~r~~Room and ~~b~~Board are exempt from the computation of the Hospice payment cap.

c. The Hospice ~~p~~Provider ~~shall~~ must forward the ~~r~~Room and ~~b~~Board payment to the ~~S~~NF or ICF~~-MR~~/ID.

d. Clients who are eligible for Post Eligibility Treatment of Income (PETI) shall be eligible for PETI payments while receiving services from a Hospice Provider. The Hospice Provider ~~shall~~ must submit claims on behalf of the client and nursing facility or ICF~~-MR~~/ID.

e. Patient payments for ~~r~~Room and ~~b~~Board charges ~~shall~~ must be collected for Hospice clients residing in a ~~S~~NF or ICF/ID~~-MR~~ as required by ~~10 C.C.R. 2505-10,~~ Section 8.482. While the Medicaid ~~S~~NF and ICF~~-MR~~/ID ~~r~~Room and B~~b~~oard payments ~~shall~~must be made directly to the Hospice ~~p~~Provider, the patient payment ~~shall~~ must be collected by the nursing facility or ICF~~-MR~~/ID.

f. Nursing facilities, ICF~~-MRs~~/IDs, and Hospice ~~p~~Providers ~~shall be~~are responsible for coordinating care of the Hospice client and payment amounts.

43. The Hospice Provider is reimbursed for routine home care or continuous home care provided to clients residing in a NF~~, SNF,~~ or ICF/ID. If a client is eligible for Medicare and Medicaid and the client resides in a NF~~, SNF,~~ or ICF/ID, Medicare reimburses the Hospice Services, and Medicaid reimburses for Room and Board.

5. Reimbursement for date of discharge ~~shall be~~:

a. Reimbursement for date of discharge ~~shall~~ must be made at the appropriate home care rate for the day of discharge from general or respite inpatient care, unless the client dies at an inpatient level of care. When the client dies at an inpatient level of care, the applicable general or respite inpatient rate is paid for the discharge date.

b. Reimbursement for nursing facility and ICF~~-MR~~/ID residents is made for services delivered up to the date of discharge when the client is discharged, alive or deceased, including applicable per diem payment for the date of discharge.

8.550.9.~~C~~B. Reimbursement Limitations

1. Aggregate payment to the Hospice P~~p~~rovider is subject to an annual indexed aggregate cost cap. The method for determining and reporting the cost cap ~~shall~~ must be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Sections 418.308 and 418.309 (20~~05~~18). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

~~Material that has been incorporated by reference in this rule may be examined at any state publications depository library.~~

~~8.550.9.D~~2. Aggregate days of care provided by the Hospice Provider are subject to an annual limitation of no more than 20 percent general and respite inpatient care days. The method for determining and reporting the inpatient days percentage shall be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Section 418.302 (20~~05~~18). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. ~~Material that has been incorporated by reference in this rule may be examined at any state publications depository library.~~ Inpatient days in excess of the 20 percent limitation ~~shall~~ must be reimbursed at the routine home care rate.

~~8.550.9.E~~3. The Hospice ~~p~~Provider ~~shall~~ must not collect co-payments, deductibles, cost sharing or similar charges from the client for Hospice ~~care~~ Services ~~benefits~~ including biological~~s~~ and respite care.

4~~8.550.9.F~~.. The Hospice ~~p~~Provider ~~shall~~ must submit all billing to the Medicaid fiscal agent within such timeframes and in such form as prescribed by the Department.

5. Specific billing instructions for submission and processing of claims is provided in the Department's Hospice billing manual.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Citizenship and Identity Documentation Requirements
Rule Number: MSB 18-01-16-A
Division / Contact / Phone: Health Information Office / Jennifer VanCleave / 303-866-6204

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 18-01-16-A, Revision to the Medical Assistance Eligibility Rules Concerning Citizenship and Identity Documentation Requirements
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) 8.100.3.H, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.3.H with the proposed text starting at 8.100.3.H through the end of 8.100.3.H.10. This rule is effective May 31, 2018.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Citizenship and Identity Documentation Requirements
Rule Number: MSB 18-01-16-A
Division / Contact / Phone: Health Information Office / Jennifer VanCleave / 303-866-6204

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 will amend 10 CCR 2505-10 8.100.3.H to incorporate changes to acceptable document types to verify citizenship and identity, as detailed in 42 C.F.R. §435.407. In particular, 42 C.F.R. §435.407(f) states that photocopies, facsimile, scanned, or other copies of citizenship and identity documents must now be accepted to the same extent as an original document, unless the copy submitted is inconsistent with other information available to the agency, or the agency otherwise has reason to question the validity of the information contained in the document. Other updates will include reorganizing the hierarchy of acceptable citizenship documentation, to mirror the types of documents as listed in federal regulations as stand-alone evidence of citizenship and evidence of citizenship that must also be accompanied by an acceptable identity document.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. §435.407

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   25.5-4-205, C.R.S. (2017)

Initial Review **03/09/18** Final Adoption **04/13/18**
Proposed Effective Date **05/31/18** Emergency Adoption

DOCUMENT #04

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Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Citizenship and Identity Documentation Requirements
Rule Number: MSB 18-01-16-A
Division / Contact / Phone: Health Information Office / Jennifer VanCleave / 303-866-6204

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.

   With the proposed rule, applicants and/or recipients of Medical Assistance will now be allowed to submit photocopies, facsimiles, scans, or other copies, instead of only originals or certified copies, of citizenship and identity documentation. The hierarchy of acceptable forms of citizenship and identity documents will also be eliminated, and the section will be reorganized to mirror federal regulations. There will be no change to the citizenship requirements for eligibility.

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

   The proposed rule will remove the requirement that applicants and/or recipients of Medical Assistance may only submit originals or certified copies of citizenship and identity documents, as well as eliminating the hierarchy of acceptable forms of citizenship and identity documents currently listed in 8.100.H. This change may remove potential barriers to submitting requested verifications, which could lead to eligible individuals being approved for, and receiving Medical Assistance sooner.

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.

   While this change may result in individuals becoming eligible for medical assistance slightly faster, the Department does not expect significant impacts to caseload due to no changes in eligibility requirements. Therefore, the Department does not anticipate a change in cost for the implementation and enforcement of the proposed rule.

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

   If the rule is not changed, the Department will be out of compliance with federal regulation under 42 C.F.R. §435.407.

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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 were no alternative methods considered for the proposed rule.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.H. Citizenship and Identity Documentation Requirements

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

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

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

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

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

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

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

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

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

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

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

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

2) Special Provisions for Retroactive Reversal of a Previous Denial

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

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

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

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

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

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

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

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

a. Stand-alone ~~D~~documents for~~Primary Evidence~~evidence of ~~C~~citizenship and ~~i~~identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:

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

1) includes the applicant or recipient, and

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

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

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

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

1) Special Provisions for Retroactive Reversal of a Previous Denial

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

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

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

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

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

b. ~~Secondary~~ Evidence of c~~C~~itizenship. If ~~primary~~ evidence from the list in 8.100.3.H.2.a. is ~~unavailable~~not provided, an applicant or recipient shall provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H. 3. to establish identity. ~~Secondary e~~Evidence of citizenship includes:

i) A U.S. public birth certificate.

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

a) One of the 50 States,

b) The District of Columbia,

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

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

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

f) American Samoa,

g) Swain's Island, or

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

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

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

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

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

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

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

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

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

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

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

viii) A final adoption decree that:

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

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

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

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

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

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

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

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

2) The child is under the age of 18;

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

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

5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing,

1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

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

xiii) Extract of a hospital record on hospital letterhead.

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

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

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

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

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

xiv~~ii~~) Life, health, or other insurance record.

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

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

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

xv~~iii~~) Religious record.

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

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

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

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

xvi~~iv~~) Early school record that meets the following criteria:

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

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

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

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

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

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

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

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

1) Seneca Indian tribal census record;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Puerto Rico:

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

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

ii) US Virgin Islands:

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

2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a

U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

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

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

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

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

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

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

df) Referrals for Colorado Birth Certificates

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

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

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

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

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

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

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

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

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

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

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

e) Military dependent's identification card;

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

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

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

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

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

iii) All documents used must contain consistent identifying information.

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

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

i) Clinic, doctor, or hospital records; or

ii) School records.

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

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

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

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

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

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

d) The affidavit is not required to be notarized.

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

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

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

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

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

3) The affidavit is not required to be notarized.

k) Expired identity documents.

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

l) Referrals for Colorado Identification Cards

i) An applicant or client who does not possess a Colorado driver’s license or identification card shall be referred to the Department of Revenue Division of Motor Vehicles by the county department to obtain an identification card at no charge, pursuant to C.R.S. § 42-2-306(1)(a)(II).

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

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

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

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

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

4. Documentation Requirements

a. ~~Effective January 1, 2008, all citizenship and identity documents must either be originals or copies certified by the issuing agency, except as provided in 8.100.3.H.4.b. Uncertified copies, including notarized copies, are not acceptable.~~Documentation of citizenship and identity can include~~a~~Citizenship and identity documents may be submitted as originals, certified copies, photocopies, facsimiles, scans or other copies.

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

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

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

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

e. Individuals may present original citizenship and identity documents or copies certified by the issuing agency to Medical Assistance (MA) sites, School-based Medical Assistance sites, Presumptive Eligibility (PE) sites, Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), or any other location designated by the Department by published agency letter.

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

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

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

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

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

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

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

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

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

ii) There is a gap of more than five years between the ending date of the individual's last period of eligibility and a subsequent application for The Medical Assistance Program and the eligibility site has not retained the citizenship and identity documentation the individual previously provided.

5. Record Retention Requirements

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

6. Name Change Provisions

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

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

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

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

7. Reasonable Level of Assistance

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

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

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

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

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

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

8. Individuals Requiring Additional Assistance

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

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

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

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

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

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

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

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

9. Reasonable Opportunity Period

a. If a Medical Assistance applicant does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period. If the applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall be terminated.

b. The reasonable opportunity period is 90 calendar days and applies to MAGI, Adult, and Buy-In Programs:

i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I, include the following:

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical Assistance	8.100.4.G.3
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Transitional Medical Assistance	8.100.4.I.1-5

ii) For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715 include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.P
Medicaid Buy-In Program for Children with Disabilities	8.100.6.Q
Breast and Cervical Cancer Program (BCCP)	8.715

10. Good Faith Effort

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

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

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

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

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

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