THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning Medical Assistance Applications, §8.100
Rule Number:	MSB 10-07-15-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 10-07-15-A , Revisions to the Medical Assistance Rule Concerning Medical Assistance Applications, §8.100
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text from §8.100.1 Definitions through the final definition "SSA – Social Security Administration is an agency of the United States federal government . . ." with new text provided.

Please replace current text from §8.100.3.A "Application Requirements" through §8.100.3.A 10 with the new text provided.

Please replace current text from §8.100.3.O "Confidentiality" through 8.100.3.O.2 with new text provided.

Please replace current text from §8.110.4.A "Family and Children's Application Requirements" through 8.100.4.B.2.d with new text provided.

Please replace current text from §8.100.5 "Aged, Blind, and Disabled Medical Assistance General Eligibility" through 8.100.5.A.3 with the new text provided.

These changes are effective November 30, 2010.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning Medical Assistance Applications, §8.100
Rule Number:	MSB 10-07-15-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule change is to update terminology regarding eligibility applications for medical assistance programs. The Colorado Medical Assistance application was released in July 2010. This new application serves as a universal application for all medical assistance programs. This rule updates the title references for medical applications. This rule also amends the title of the financial/medical Single Purpose Application to reflect its current name, the Application for Assistance.

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:

4. State Authority for the Rule:

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

Initial Review	**09/10/2010**	Final Adoption	**10/08/2010**
Proposed Effective Date	**11/30/2010**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning Medical Assistance Applications, §8.100
Rule Number:	MSB 10-07-15-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rule should not affect any persons.

   Medicaid applicants will benefit from the new Colorado Medical Assistance application because they will have the opportunity to apply for all medical programs using one simplified, universal application.

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 updates current application terminology in rule. The rule should not impact any persons.

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

   There are no probable costs associated with the proposed rule.

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

   N/A

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

   N/A

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   N/A

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

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

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

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

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

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

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

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

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

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

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

Applicant is a person who has submitted an application for public benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Colorado ~~Public Health Insurance for Families~~ Medical Assistance application is the designated application for ~~the Family and Children's~~ Medical Assistance Programs and the CHP+ Program.

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

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

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

Community Spouse is a person who is legally married to an institutionalized spouse and is not in a medical institution or nursing facility. The community spouse remains in the community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Irrevocable means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than outlined in the document.

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

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

Long Term Care is a Medical Assistance category that provides nursing-home care, home-health care, personal or adult day care for individuals above the age of 65 or with a chronic or disabling condition that needs constant supervision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~Single Purpose Application is the designated application used to determine eligibility for Aged, Blind, and Disabled Medical Assistance Program categories and financial assistance.~~

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

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

8.100.3.A. Application Requirements

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

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

3. The applicant must sign the application form in order to receive Medical Assistance.

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

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

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

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

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

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

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

9. If an applicant is found to be ineligible for a particular program, the ~~Single Purpose~~ Application for Assistance shall be reviewed and processed for other financial programs the household has requested on the ~~Single Purpose~~ Application for Assistance and all other Medical Assistance Programs. Referrals to other community agencies and organizations shall be made for the applicant whenever available or requested.

10. If the applicant applied for the Medical Assistance Program on the Colorado ~~Public Health Insurance for Families~~ Medical Assistance application and was found ineligible, this application shall be reviewed for all other Medical Assistance eligibility programs and the Child Health Plan Plus (CHP+) program.

8.100.3.O. Confidentiality

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

2. A signature on the Colorado ~~Public Health Insurance for Families~~ Medical Assistance application and the ~~Single Purpose~~ Application for Assistance allows an eligibility site worker to consult banks, employers, or any other agency or person to obtain information or verification to determine eligibility. The identification of the worker as an eligibility site employee will, in itself, disclose that an application for the Medical Assistance Program has been made by an individual. In this type of contact, as well as other community contacts, the eligibility site should strive to maintain confidentiality. The signature on the Colorado ~~Public Health Insurance for Families~~ Medical Assistance application and the ~~Single Purpose~~ Application for Assistance also provides permission for the release of the

client's medical information to be provided by health care providers to the State and its agents for purpose of administration of the Medical Assistance Program.

8.100.4.A. Family and Children's Application Requirements

1. Persons requesting Family and Children's Medical Assistance need only to complete the Colorado ~~Public Health Insurance for Families~~ Medical Assistance application

2. Pregnant women and children may apply for Family and Children's Medical Assistance at eligibility sites other than the County Department of Social Services. These sites shall be approved by the Department to receive and initially process these applications. The application used shall be the Colorado ~~Public Health Insurance for Families~~ Medical Assistance application. The eligibility site shall determine eligibility.

3. The eligibility sites shall refer Medical Assistance clients who are pregnant and/or age 20 and under to EPSDT offices by copying the page of the Colorado ~~Public Health Insurance for Families~~ Medical Assistance application that includes the EPSDT benefit questions.

The eligibility site will then forward this page to the EPSDT office within five working days from the date of application approval.

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

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

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

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

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

   c. Earned income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call. If the applicant is self employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the ~~Public Health Insurance for Families~~ Colorado Medical Assistance application is sufficient verification of earnings, unless questionable.

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

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

8.100.5 Aged, Blind, and Disabled Medical Assistance General Eligibility

8.100.5.A. Application Requirements

1. When an individual applies for Medical Assistance on the basis of disability or blindness, the eligibility sites shall take the application and determine whether the individual is eligible for Long Term Care or any of the categories of assistance described in section 8.100.6 under Qualified Disabled and Working Individuals. If the applicant does not qualify for Medical Assistance on one of those bases, he/she shall be referred to the local Social Security office to apply for SSI.

2. Applicants who apply for Long Term Care Medical Assistance on the basis of disability or blindness shall complete a Medical Assistance disability determination application in addition to the required Medical Assistance application. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated eligibility site representative.

   The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.

.3. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the Colorado Medical Assistance application.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning Transitional Medicaid §8.100.4.I
Rule Number:	MSB 10-06-08-A
Division / Contact / Phone:	CCR / Corinne Lamberson / 6587

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 10-06-08-A, Revisions to the Medical Assistance Rule Concerning Transitional Medicaid §8.100.4.I
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

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

PUBLICATION INSTRUCTIONS*

Please replace current text from §8.100.4.I "Transitional Medical Assistance and 4 Month Extended Medical Assistance" through 8.100.4.I.8 with new text provided from §8.100.4.I "Transitional Medical Assistance and 4 Month Extended Medical Assistance" through §8.100.4.I.5. This change is effective November 30, 2010.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Rule Number: MSB 10-06-08-A

Division / Contact / Phone: CCR / Corinne Lamberson / 6587

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule is to provide Transitional Medicaid benefits for a period of 12 months to clients in the 1931 category of assistance who have earned income which puts them over the 1931 income limits. Transitional Medicaid clients must continue to meet the current policy requiring clients to receive the1931 category of assistance for 3 out of the last 6 months in order to receive Transitional Medicaid.

   Currently, Transitional Medicaid provides 6 months of guaranteed benefits with the potential for an additional 6 months of coverage. In order for eligibility to continue into the second 6 month extension period, the family must meet federal reporting requirements by submitting Transitional Benefits Reports (TBR) for continued eligibility. The TBR is used to determine eligibility for the 6th, 9th and 12th months.

   Eliminating complex reporting requirements and moving to 12 months of guaranteed coverage will eliminate the administrative burden on clients and eligibility sites. Transitional Medicaid with 12 months of coverage will provide families with a critical support to economic independence, create a correspondence cost savings with the elimination of the TBR and align Department goals to streamline and simplify the eligiblity process.

   This rule change also eliminates the outdated reference to Aid to Families with Dependent Children (AFDC) income counting methods due to House Bill 10-1043. This bill removed the outdated AFDC reference to the 30 and 1/3 income counting methodology and provides authority to develop an appropriate income counting method. The Department has streamlined its income counting methodologies by increasing program income limits, thus eliminating the need for the 30 and 1/3 income methodology.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

Initial Review	**09/10/2010**	Final Adoption	**10/08/2010**
Proposed Effective Date	**11/30/2010**	Emergency Adoption	

DOCUMENT #04

3. Federal authority for the Rule, if any:

   42 U.S.C. 1396a(71)(e)(1)(A)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-5-101(1)(b), C.R.S. (2009)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning Transitional Medicaid §8.100.4.I
Rule Number:	MSB 10-06-08-A
Division / Contact / Phone:	CCR / Corinne Lamberson / 6587

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.

   Families receiving 1931 Medicaid for 3 out of the last 6 months will be eligible for 12 months of Transitional Medicaid if the receipt of earned income puts the client over the 1931 income limits. This will assist newly employed families to maintain their access to health care while on the path to economic independence.

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 eliminate the administrative burden associated with Transitional Benefit Reports for eligibility sites and clients. Clients will receive 12 months of continuous coverage without eligibility site processing delays and will increase access to health care.

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.

   A majority of the clients currently receiving Transitional Medicaid will receive 12 months of coverage and with the anticipated administrative savings, the Department expects that the proposed rule will have no fiscal impact.

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

   The Department expects that the proposed rule will have no fiscal impact to the State, while eliminating an administrative burden or eligibility sites and clients. This will allow clients to receive 12 months of continuous coverage without eligibility site processing delays and will increase access to health care. Inaction will not streamline the eligibility determination process or relieve administrative burdens on eligibility sites or clients.

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

   There are less costly methods 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.

   None

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

1. Eligibility for Transitional Medical Assistance shall be ~~extended~~ granted for ~~up to~~ twelve months (beginning with the first month of ineligibility) to~~for~~ families who would otherwise become ineligible for Medical Assistance under 1931 Medical Assistance. The extension shall be applied for a~~n~~ family~~individual~~ who is eligible and receiving assistance under 1931 Medical Assistance in at least 3 of the 6 months immediately preceding the month in which the family would have become ineligible for 1931 Medical Assistance, and

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

   ~~b~~. ~~who becomes ineligible for 1931 Medical Assistance after allowable income deductions due solely to the loss of the $30 plus 1/3 or $30 disregards because of the expiration of the time limit.~~

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

~~3~~. ~~To be eligible for the first six months of Transitional Medical Assistance, the assistance unit shall be eligible in all respects before the increased earnings or hours, or loss of the $30 + 1/3 or $30 disregards. The employed family member shall be included in the 1931 Medical Assistance assistant unit.~~

~~4. Eligibility for Transitional Medical Assistance occurs:~~

   ~~a. When the individual is a dependent child as defined in this volume; or~~

   ~~b. When the household continues to include at least one child who was a member of the household in the month the assistance unit became ineligible for 1931 Medical Assistance benefits. The child need not be dependent under Title IV-A.~~

   ~~c. If it is determined that the household no longer has a child living in the home, Transitional Medical Assistance is discontinued at the end of the month in which the household does not include a dependent child.~~

3.~~5~~. To remain eligible for Transitional Medical Assistance:

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

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

   ~~Assistance Units are required to report earnings and necessary child care costs by the 21st of the fourth month of the twelve month Transitional Medical Assistance period via the appropriate reporting form. Failure to report without good cause shall result in ineligibility for Transitional Medical Assistance for months seven through twelve of the Transitional Medical Assistance period.~~

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

~~6. To continue to receive Medical Assistance during the second six months of Transitional Medical Assistance:~~

~~a. The family shall meet all initial eligibility requirements of the first six months of Transitional Medical Assistance;~~

~~b. Family's average gross earnings minus allowable deductions cannot exceed 185% of the federal poverty level for the household size; and~~

~~c. The family shall report the gross earnings and the necessary child care costs by the 21st day of the seventh month for each of the three proceeding months; and by the 21st day of the tenth month for each of the three proceeding months via the appropriate reporting form. Failure to report without good cause by the appropriate deadline causes ineligibility for the remainder of the second six month period.~~

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

5.~~8~~. Eligibility for medical assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for 1931 Medical Assistance due solely or partially to the receipt of support income. Support income may be child support, maintenance, or alimony. The extension shall be applied for a family which receives assistance under 1931 Medical Assistance in at least three of the six months immediately preceding the month in which the family becomes ineligible for assistance. To be eligible for the four month Medical Assistance extension, the family shall be eligible for 1931 Medical Assistance in all respects before the support income is applied. The support recipient shall be included in the 1931 Medical Assistance calculation for the extension to apply.

THIS PAGE NOT FOR PUBLICAITON

Title of Rule:	Medical Assistance Rule Regarding Medicaid Managed Care Grievance and Appeal Processes (Section 8.209)
Rule Number:	MSB 10-06-01-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 10-06-01-A, Medical Assistance Rule Regarding Medicaid Managed Care Grievance and Appeal Processes (Section 8.209)
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) 8.209, 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*

Please replace current text from §8.209 "MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES" through §8.209.7.K with the new text provided. This rule change is effective November 30, 2010.

*to be completed by MSB Board Coordinator

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Title of Rule:	Medical Assistance Rule Regarding Medicaid Managed Care Grievance and Appeal Processes (Section 8.209)
Rule Number:	MSB 10-06-01-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

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).

   This rule describes a process for handling grievances and appeals filed by clients of Medicaid Managed Care Organizations or Prepaid Inpatient Health Plans. This amendment will: (1) remove the exception that says prepaid inpatient health plans do not have to issue notices for payment denials; (2) change "appeal" to "grievance" to describe what clients can do when the managed care organization extends the timeframe for making a decision on a request for services; (3) extend the amount of time clients have for making grievances and appeals from twenty to thirty days from the notice of action; and (4) require oral appeals to be followed up in writing.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 438.404(c)(4)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-5-406, C.R.S. (Required features of managed care system).

Initial Review	**09/10/10**	Final Adoption	**10/08/10**
Proposed Effective Date	**11/30/10**	Emergency Adoption	

DOCUMENT #05

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Title of Rule:	Medical Assistance Rule Regarding Medicaid Managed Care Grievance and Appeal Processes (Section 8.209)
Rule Number:	MSB 10-06-01-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

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 Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), and their clients, are affected by the amendments to this 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.

   There is minimal quantitative impact. Qualitatively, the amendment gives clients in MCOs or PIHPs more time to file grievances and appeals. It gives PIHP members the right to receive a notice of action when there is a payment denial. It allows clients to file a grievance (but not an appeal) when the MCO or PIHP extends the timeframe for responding to a client's request for services. Finally, it requires that the MCO or PIHP submit an appeal in writing on a client's behalf after the client makes an oral appeal.

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.

   Not applicable.

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

   Clients will have the same opportunity as fee-for-service clients to exercise their grievance and appeal rights if the timeline for filing is extended. In addition, the changes will bring the Department into compliance with federal regulations.

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

   This method is very low cost and the best way to comply with federal regulations, and use the grievance process in managed care organizations the way it was intended to be used.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for most of these changes because they bring the Department into compliance with federal regulations. The extended timeline for filing a grievance or appeal gives managed care clients as much time to file as fee-for-service clients currently have.

8.209 MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES

8.209.1 GENERAL PROVISIONS

Medicaid members or their Designated Client Representatives enrolled in Managed Care Organizations (MCOs) may access and utilize the Medicaid Managed Care Grievance and Appeal Systems. The Grievance and Appeal Systems shall include a grievance process and an appeal process for handling grievances and appeals at the MCO or Prepaid Inpatient Health Plan (PIHP) level and access to the State fair hearing process for appeals. *[Eff 08/30/2006]*

8.209.2 DEFINITIONS

Action shall mean:

1. The denial or limited authorization of a requested service, including the type or level of service;

2. The reduction, suspension or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service ~~(except payment denials issued by a mental health prepaid inpatient health plan)~~;

4. The failure to provide services in a timely manner;

5. The failure to act within the timeframes provided below; or

6. The denial of a Medicaid member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one MCO.

Appeal shall mean a request for review of an action. *[Eff 08/30/2006]*

Designated Client Representative shall mean any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services. *[Eff 08/30/2006]*

Fair Hearing shall mean the formal adjudication process for appeals described at 10 CCR 2505-10, §8.057. *[Eff 08/30/2006]*

Grievance shall mean an oral or written expression of dissatisfaction about any matter other than an action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights. *[Eff 08/30/2006]*

Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract. *[Eff 08/30/2006]*

Quality of Care Complaint shall mean any grievance made in regards to the professional competence and/or conduct of a physician or other health care provider, which could adversely affect the health, or welfare of a member. *[Eff 08/30/2006]*

Timely Filing shall mean filing on or before the later of the following: within ten days of the MCO or PIHP postmarking the notice of action; or the intended effective date of the MCO's or PIHP's proposed action. *[Eff 08/30/2006]*

8.209.3 GRIEVANCE SYSTEM

8.209.3.A. The Grievance System is the overall system that includes grievances and appeals handled at the MCO and PIHP level and access to the State fair hearing process for appeals. *[Eff 08/30/2006]*

8.209.3.B. The MCO or PIHP shall provide a Department approved description of the grievance, appeal and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the MCO or PIHP. The description shall include: *[Eff 08/30/2006]*

1. The member's right to a State fair hearing for appeals. *[Eff 08/30/2006]*

    a. The method to obtain a hearing, and *[Eff 08/30/2006]*

    b. The rules that govern representation at the hearing. *[Eff 08/30/2006]*

2. The member's right to file grievances and appeals. *[Eff 08/30/2006]*

3. The requirements and timeframes for filing grievances and appeals. *[Eff 08/30/2006]*

4. The availability of assistance in the filing process. *[Eff 08/30/2006]*

5. The toll-free numbers that the member can use to file a grievance or an appeal by telephone. *[Eff 08/30/2006]*

6. The fact that, when requested by a member: *[Eff 08/30/2006]*

    a. Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and *[Eff 08/30/2006]*

    b. The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member. *[Eff 08/30/2006]*

8.209.3.C. The MCO or PIHP shall maintain record of grievances and appeals and submit a quarterly report to the Department. *[Eff 08/30/2006]*

8.209.4 APPEAL PROCESS

8.209.4.A. Notice of Action *[Eff 08/30/2006]*

1. The MCO or PIHP shall send the member written notice for each action. The notice shall be in writing and shall be available in English and the prevalent non-English languages spoken by members throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of members in the service area as identified by the State. *[Eff 08/30/2006]*

2. The notice shall state the following: *[Eff 08/30/2006]*

    a. The action the MCO or PIHP or its contractor has taken or intends to take; *[Eff 08/30/2006]*

    b. The reasons for the action; *[Eff 08/30/2006]*

    c. The member's or the Designated Client Representative's right to file an MCO or PIHP appeal; *[Eff 08/30/2006]*

    d. The date the appeal is due; *[Eff 08/30/2006]*

    e. The member's right to request a State fair hearing; *[Eff 08/30/2006]*

    f. The procedures for exercising the right to a fair hearing; *[Eff 08/30/2006]*

g. The circumstances under which expedited resolution is available and how to request it; *[Eff 08/30/2006]*

h. The member's right to have benefits continue pending resolution of the appeal, and how to request that benefits be continued; and *[Eff 08/30/2006]*

i. The circumstances under which the member may be required to pay the cost of these services. *[Eff 08/30/2006]*

3. The MCO or PIHP shall mail the notice of action within the following timeframes: *[Eff 08/30/2006]*

a. For termination, suspension or reduction of previously authorized Medicaid covered services, at least ten (10) calendar days before the date of action, except in the following circumstances: *[Eff 08/30/2006]*

i) The MCO or PIHP may shorten the period of advance notice to five (5) calendar days for the date of action if: *[Eff 08/30/2006]*

1) The MCO or PIHP has facts indicating probable fraud by the member; and *[Eff 08/30/2006]*

2) The facts have been verified, if possible, through secondary sources. *[Eff 08/30/2006]*

ii) The MCO or PIHP may mail notice not later than the date of action if: *[Eff 08/30/2006]*

1) The MCO or PIHP has factual information confirming the death of the member; *[Eff 08/30/2006]*

2) The MCO or PIHP receives a clear written statement signed by the member stating that: *[Eff 08/30/2006]*

a) He or she no longer wishes services; or *[Eff 08/30/2006]*

b) Gives information that requires termination or reduction of services and indicates that he/she understands that this is the result of supplying the information; *[Eff 08/30/2006]*

iii) The member has been admitted to an institution where he/she is ineligible under the plan for further services; *[Eff 08/30/2006]*

iv) The member's whereabouts is unknown and the post office returns mail directed to him or her indicating no forwarding address; *[Eff 08/30/2006]*

v) The MCO or PIHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; *[Eff 08/30/2006]*

vi) A change in the level of medical care is prescribed by the member's physician; *[Eff 08/30/2006]*

vii) The notice involves an action made with regard to the preadmission screening requirements of 1919(e) (7) of the Social Security Act; or *[Eff 08/30/2006]*

viii) Notice may be made as soon as practicable before transfer or discharge when: *[Eff 08/30/2006]*

1) The safety of individuals in the facility would be endangered; *[Eff 08/30/2006]*

2) The health of individuals in the facility would be endangered; *[Eff 08/30/2006]*

3) The resident's health improves sufficiently to allow a more immediate transfer or discharge; *[Eff 08/30/2006]*

4) An immediate transfer or discharge is required by the resident's urgent medical needs; or *[Eff 08/30/2006]*

5) A resident has not resided in the facility for 30 days. *[Eff 08/30/2006]*

b. For denial of payment ~~(except for payment denials issued by a mental health prepaid inpatient health plan)~~, at the time of any action affecting the claim. *[Eff 08/30/2006]*

c. For standard service authorization decisions that deny or limit services, within ten (10) calendar days. For expedited service authorizations, within three (3) days. *[Eff 08/30/2006]*

i) If the MCO or PIHP extends the timeframe for making a service authorization decision, it must give the member written notice of the reason for extending the timeframe and inform the member of the right to file a grievance to disagree with the timeframe extension.

ii) The MCO or PIHP must carry out its determination as expeditiously as the member's health condition requires, and no later than the date the extension expires.

~~4. If the MCO or PIHP extends the timeframe it must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file an appeal if he or she disagrees with that decision and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the due date the extension expires. *[Eff 08/30/2006]*~~

~~5. For service authorization decisions not reached within ten (10) calendar days on the date the timeframes expire. *[Eff 08/30/2006]*~~

~~6. For expedited service authorization decisions, within three (3) days. *[Eff 08/30/2006]*~~

8.209.4.B. The member of an MCO or PIHP shall file an appeal within ~~twenty~~ thirty (~~2~~30) calendar days from the date of the MCO's or PIHP's notice of action. *[Eff 08/30/2006]*

8.209.4.C. The MCO or PIHP shall give members reasonable assistance in completing any forms required by the MCO or PIHP, putting oral requests for a State fair hearing into writing and taking other procedural steps, including, but not limited to, providing interpretive services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *[Eff 08/30/2006]*

8.209.4.D. The MCO or PIHP shall send the member written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *[Eff 08/30/2006]*

8.209.4.E. The MCO or PIHP shall ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeals that involves clinical issues. *[Eff 08/30/2006]*

8.209.4.F The MCO or PIHP shall accept appeals orally or in writing~~.~~, and shall follow an oral appeal with a written appeal. *[Eff 08/30/2006]*

8.209.4.G The MCO or PIHP shall provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO or PIHP shall inform the member of the limited time available in the case of expedited resolution. *[Eff 08/30/2006]*

8.209.4.H The MCO or PIHP shall provide the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process. *[Eff 08/30/2006]*

8.209.4.I. The MCO or PIHP shall include as parties to the appeal, the member and the designated client representative or the legal representative of a deceased member's estate. *[Eff 08/30/2006]*

8.209.4.J. The MCO or PIHP shall resolve each appeal, and provide notice as expeditiously as the member's health condition requires, not to exceed the following: *[Eff 08/30/2006]*

1. For standard resolution of an appeal and notice to the affected parties, ten (10) working days from the day the MCO or PIHP receives the appeal. *[Eff 08/30/2006]*

2. For expedited resolution of an appeal and notice to affected parties, three (3) working days after the MCO or PIHP receives the appeal. *[Eff 08/30/2006]*

8.209.4.K. The MCO or PIHP may extend timeframes for the resolution of appeals by up to fourteen (14) calendar days: *[Eff 08/30/2006]*

1. If the member requests the extension; or *[Eff 08/30/2006]*

2. The MCO or PIHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO or PIHP shall give the member prior written notice of the reason for delay if the timeframe is extended. *[Eff 08/30/2006]*

8.209.4.L. The MCO or PIHP shall notify the member in writing of the resolution of an appeal. For notice of an expedited resolution, the MCO or PIHP shall also make reasonable efforts to provide oral notice. *[Eff 08/30/2006]*

8.209.4.M. The written notice shall include the results of the disposition/resolution process and the date it was completed. *[Eff 08/30/2006]*

1. For appeals not resolved wholly in favor of the member, *[Eff 08/30/2006]*

   a. The right to request a State fair hearing and how to do so; *[Eff 08/30/2006]*

   b. The right to request and to receive benefits while the hearing is pending, and how to make the request; and *[Eff 08/30/2006]*

   c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action. *[Eff 08/30/2006]*

8.209.4.N. The member of an MCO or PIHP need not exhaust the MCO or PIHP level appeal process before requesting a state fair hearing. The member shall request a state fair hearing within ~~twenty~~ thirty (~~2~~30) calendars days from the date of the MCO's or PIHP's notice of action. *[Eff 08/30/2006]*

8.209.4.O. In cases where the parent or guardian submits a request for a third party review to the Department of Human Services under 27-10.3-104 (1)(b) C.R.S. of the Child Mental Health Treatment Act, the member, parent or guardian and the MCO or PIHP shall have the right to request a state fair hearing. The request for the state fair hearing shall be submitted to the

Division of Administrative Hearings within ~~twenty~~ thirty (~~2~~30) calendar days from the date of the determination. The state fair hearing shall be considered a recipient appeal. *[Eff 08/30/2006]*

8.209.4.P. The MCO or PIHP shall establish and maintain an expedited review process for appeals when the MCO or PIHP determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. *[Eff 08/30/2006]*

8.209.4.Q. The MCO or PIHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *[Eff 08/30/2006]*

8.209.4.R. If the MCO or PIHP denies a request for expedited resolution, it shall transfer the appeal in the timeframe for standard resolution, make reasonable effort to give the member prompt oral notice of the denial and send a written notice of the denial for an expedited resolution within two (2) calendar days. *[Eff 08/30/2006]*

8.209.4.S. The MCO or PIHP shall provide for the continuation of benefits while the MCO or PIHP level appeal and the State fair hearing are pending if the member files the appeal timely, the appeal involves the termination, suspension or reduction of a previously authorized course of treatment, the services were ordered by an authorized provider, the original period covered by the original authorization has not expired and the member requests extension of benefits. *[Eff 08/30/2006]*

8.209.4.T. If at the member's request, the MCO or PIHP continues or reinstates the member's benefits while the appeal is pending, the benefits shall be continued until the member withdraws the appeal, ten days pass after the MCO or PIHP mails the notice providing the resolution of the appeal against the member, a State fair hearing office issues a final agency decision adverse to the member, or the time period or service limits of a previously authorized service has been met. *[Eff 08/30/2006]*

8.209.4.U. If the final resolution of the appeal upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the member while the appeal is pending to the extent that the services were furnished solely because of the requirements of this rule. *[Eff 08/30/2006]*

8.209.4.V. If the final resolution of the appeal reverses the MCO's or PIHP's action to deny, limit or delay services that were not furnished while the appeal was pending, the MCO or PIHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. *[Eff 08/30/2006]*

8.209.4.W. If the final resolution of the appeal reverses the MCO's or PIHP's action to deny authorization of services and the member received the services while the appeal was pending, the MCO or PIHP must pay for those services. *[Eff 08/30/2006]*

8.209.5 GRIEVANCE PROCESS

8.209.5.A The member of the MCO or PIHP shall have ~~twenty~~ thirty (~~2~~30) calendar days from the date of the incident to file a grievance expressing his/her dissatisfaction with any matter other than an action. *[Eff 08/30/2006]*

8.209.B. The MCO or PIHP shall send the member written acknowledgement of each grievance within two (2) working days of receipt. *[Eff 08/30/2006]*

8.209.5.C. The MCO or PIHP shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding a grievance that involves clinical issues. *[Eff 08/30/2006]*

8.209.5.D. The MCO or PIHP shall accept grievances orally or in writing. *[Eff 08/30/2006]*

1. The MCO or PIHP shall dispose of each grievance and provide notice as expeditiously as the member's health condition requires, not to exceed fifteen (15) working days from the day the MCO or PIHP receives the grievance. *[Eff 08/30/2006]*

8.209.5.E. The MCO or PIHP may extend timeframes for the disposition of grievances by up to fourteen (14) calendar days: *[Eff 08/30/2006]*

1. If the member requests the extension; or *[Eff 08/30/2006]*

2. The MCO or PIHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO or PIHP shall give the member prior written notice of the reason for delay if the timeframe is extended. *[Eff 08/30/2006]*

8.209.5.F. The MCO or PIHP shall notify the member in writing of the disposition of a grievance. *[Eff 08/30/2006]*

8.209.5.G. The written notice shall include the results of the disposition/resolution process and the date it was completed. *[Eff 08/30/2006]*

8.209.5.H. If the member is dissatisfied with the disposition of a grievance provided by the MCO or PHIP, the member may bring the unresolved grievance to the Department. *[Eff 08/30/2006]*

1. The Department will acknowledge receipt of the grievance and dispose of the issue. *[Eff 08/30/2006]*

2. The disposition offered by the Department will be final. *[Eff 08/30/2006]*