DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.1000 Medicare Modernization Act

10 CCR 2505-10 8.1000

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

8.1000 MEDICARE MODERNIZATION ACT – LOW-INCOME SUBSIDY ELIGIBILITY

8.1000.1 DEFINITIONS

Action means a denial, reduction or termination of the Low-Income Subsidy.

Applicant means the Medicare Part D eligible individual applying for the Low-Income Subsidy.

Authorized Representative means a person designated by the Applicant to act on his/her behalf. Such authorization shall be in writing in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations located at 45 C.F.R. parts 160 and 164. A written designated power of attorney may substitute for the HIPAA compliant release.

Medicaid Eligibility Sites includes any County Human or Social Services office, and departmentally designated Medical Assistance Sites that accepts and processes Medicaid applications.

Full-Benefit Dual Eligible individual means an individual who is receiving full Medicaid benefits and is a recipient of Medicare benefits.

Medicare Part D means the prescription drug benefit provided to Part D eligible individuals pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

Low-Income Subsidy (LIS) means the financial assistance under Medicare Part D that is available to individuals who have limited financial means to pay for copayments, deductibles or premiums, depending upon their resources and income.

Notice of action means a letter on Department letterhead which contains:

1. A statement of what action the Department or its designee intends to take;

2. The reasons for the intended action;

3. The specific regulations that support, or the change in federal or state law that requires the action;

4. An explanation of:

   a. The Applicant's right to request an evidentiary hearing if one is available; or

   b. In cases of an action based on a change in law, the circumstances under which a hearing will be granted.

5. The method by which the Applicant may obtain a hearing;

6. That the Applicant may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman at the hearing.

Part D eligible individual means an individual who is entitled to Medicare Part A or enrolled in Part B.

Resources means liquid resources of the Applicant (and, if married, his/her spouse who is living in the same household), such as checking and savings accounts, stocks, bonds, and other resources that can be readily converted to cash within 20 days.

8.1000.2 APPLICATION FOR THE LOW-INCOME SUBSIDY THROUGH THE SOCIAL SECURITY ADMINISTRATION

8.1000.2.A. Applicants may apply for the Medicare Part D Low-Income Subsidy through the Social Security Administration (SSA). This can be done by calling SSA, visiting an SSA office, completing an online application, or completing an application form and mailing it to SSA. This is the encouraged method.

8.1000.2.B. If an applicant seeks assistance with an SSA application from a Medicaid Eligibility Site (internet, questions, filling out form), the Medicaid Eligibility Site shall assist the applicant. The Medicaid Eligibility Site shall order applications from SSA and provide to applicants on request.

8.1000.2.C. Any appeals, redeterminations, or notices applicable on a low-income subsidy application submitted through the SSA shall be the responsibility of the SSA.

8.1000.3 APPLICATION FOR THE LOW-INCOME SUBSIDY AT COLORADO MEDICAID ELIGIBLITY SITES

8.1000.3.A. Applicants may also apply for the Medicare Part D Low-Income Subsidy at their county of residence Medicaid Eligibility Site. If an Applicant applies at his/her county or residence Medicaid Eligibility Site, the Applicant's eligibility for a Medicare Savings Program (MSP) must first be determined.

8.1000.3.B. If the Applicant is determined to be eligible for a MSP, the Applicant shall be considered deemed eligible for the LIS and therefore shall not need to apply for the LIS. If the Applicant declines the MSP or is determined ineligible for an MSP, then the Applicant's eligibility for the LIS shall be determined.

8.1000.3.C. Application requirements.

1. Applications for the LIS shall be considered complete when the Applicant or Authorized Representative applying on the Applicant's behalf has:

   a. Completed all required elements of the application;

   b. Provided any statements from financial institutions, as requested, to support information in the application; and

   c. Certified, under penalty of perjury or similar sanction for false statements, as to the accuracy of the information provided on the application form.

2. Multiple applications. If the Applicant or his/her Authorized Representative has previously filed an application with their county of residence Medicaid Eligibility Site or SSA which seeks subsidy eligibility for any portion of the eligibility period covered by a subsequent application, the later application is void if the Applicant has received a positive subsidy determination on that earlier application from the State or SSA.

8.1000.3.D. RIGHT TO APPEAL

1. A notice of action to inform an Applicant shall be sent by the Medicaid Eligibility Site and include the following:

   a. Regulatory basis for the decision.

   b. Description of how the subsidy was calculated. What income, family size, and resources were used.

   c. Premium percentage Applicant is approved for, or reason for denial.

   d. Effective date of eligibility.

   e. Who made the decision and how to contact them.

   f. Appeal rights and procedures.

8.1000.3.E. OPPORTUNITY FOR HEARING

1. An Applicant shall have an opportunity for a state hearing where:

   a. The Department or a Medicaid Eligibility Site made the LIS determination; and

   b. An application for LIS is denied or is not acted upon with reasonable promptness; and

   c. The Applicant requesting the hearing believes the action is erroneous.

2. An Applicant shall not have an opportunity for hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all Applicants.

8.1000.3.F. REQUEST FOR HEARING

1. The request for a hearing shall be in writing and contain:

   a. The Applicant’s name, address and State Identification Number, if applicable;

   b. The action, denial or failure to act promptly on which the requested appeal is based; and

   c. The reason for appealing the action.

2. The request for a hearing shall be filed with the Office of Administrative Courts within 30 calendar days of the date of the Notice of Action.

3. The Applicant or his/her Authorized Representative shall be entitled to examine the complete case file and any other documents to be used at hearing at a reasonable time before the hearing or during the hearing. Documents and information that are confidential as a matter of law shall be exempt from this requirement unless they are to be offered as evidence during the hearing.

4. If the Applicant makes an oral request for a hearing to the Department or its designee, the Department or its designee shall prepare a written request for the individual's signature or have the individual prepare such a request.

8.1000.3.G. DENIAL OR DISMISSAL OF REQUEST FOR HEARING

1. The request for hearing shall be denied or dismissed if:

   a. The Applicant withdraws the request in writing; or

   b. The Applicant fails to appear at a scheduled hearing without good cause. Good cause shall mean a sudden severe illness, an accident, or other particular occurrence which, by its emergent nature and drastic effect, prevented appearance at the hearing.

2. The Applicant shall have ten calendar days from the date of the notice of dismissal of the scheduled hearing to explain, in a letter to the Administrative Law Judge, the reason for his/her failure to appear. If the Administrative Law Judge finds that there was good cause for the nonappearance, the Administrative Law Judge shall schedule another hearing date.

8.1000.3.H. FAIR HEARINGS

1. A hearing shall cover an Action regarding eligibility;

2. Conference telephone hearings may be conducted as an alternative to face-to-face hearings. All applicable provisions of the face-to-face hearing shall apply to telephone hearings.

3. Upon receipt of notice of a Department hearing of an appeal, the county of residence Medicaid Eligibility Site shall arrange for a suitable hearing room appropriate to accommodate the number of persons, including witnesses, who are expected to be in attendance. A Medicaid Eligibility Site representative must attend.

4. Except as otherwise specifically provided in these rules, the provisions of Section 24-4-105, C.R.S., as amended, shall apply to the conduct of fair hearings.

5. The hearing shall be private unless the Applicant requests, on the record, that the hearing be open to the public.

6. If the appellant is not fluent in English or has a language difficulty, the Department will arrange with county assistance to have a qualified interpreter present who will be sworn to translate correctly at the hearing.

8.1000.3.I. INITIAL DECISIONS

1. The Administrative Law Judge shall promptly prepare and issue a written Initial Decision and file it with the Office of Appeals of the Department. Initial decisions shall be based exclusively on evidence introduced at the hearing.

2. The Initial Decision shall be in writing and shall:

   a. Summarize the facts.

   b. Identify the regulations and evidence supporting the decision.

   c. Advise the Applicant that failure to file exceptions to the provisions of the Initial Decision shall waive the right to seek judicial review of a final agency decision affirming those provisions.

3. The Administrative Law Judge shall be bound by the Department's interpretation of statutes where the Department has regulations implementing such statutes.

4. The Administrative Law Judge shall have no jurisdiction or authority to determine issues of constitutionality or legality of the Department's regulations.

8.1000.3.J. REVIEW BY THE OFFICE OF APPEALS

1. The Department's Office of Appeals shall promptly serve the Initial Decision upon each party to the fair hearing by first class mail. Party shall include the Department even if the Department has not previously appeared as a party to the appeal.

2. Any party seeking to reverse, modify or remand the Initial Decision shall file exceptions with the Office of Appeals within 15 calendar days, plus three calendar days for mailing, of the date the Initial Decision is mailed to the parties.

3. Exceptions to Initial Decisions shall be in writing and shall state the specific grounds for reversal, modification or remand of the Initial Decision.

4. A transcript or a copy of the hearing tape is required where the party filing the exceptions asserts that the findings of fact in the Initial Decision are not supported by the weight of the evidence.

   a. The party requiring a transcript or a copy of the hearing tape shall request the transcript or tape from the Office of Administrative Courts prior to the filing of exceptions or with the exceptions. The exceptions shall state that a transcript or tape has been requested.

   b. The party requesting a transcript or copy of the hearing tape shall advance the cost therefore to the Office of Administrative Courts within five calendar days of the request.

   c. While review of the Initial Decision is pending, the transcript or a copy of the hearing tape shall be available for examination by any party to the appeal, during regular business hours of the Office of Appeal.

5. The Office of Appeals shall promptly serve a copy of the exceptions on each party by first class mail. Each party may file a written response to an exception filed by another party within ten calendar days from the date the exceptions were mailed to the parties.

6. The parties shall not have the right to oral argument to the Office of Appeals.

8.1000.3.K. FINAL AGENCY DECISIONS

1. The Final Agency Decision shall be based on the record except that the Office of Appeals may remand for rehearing if a party establishes in its exceptions that material evidence has been discovered which the party could not, with reasonable diligence, have produced at the hearing.

2. The record shall consist only of:

   a. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

   b. All papers and requests filed in the proceeding;

   c. The Initial Decision of the Administrative Law Judge; and

   d. Any exceptions and requests filed in response to the Initial Decision of the Administrative Law Judge.

3. The Applicant shall have access to the record at a convenient place and time.

4. The Office of Appeals shall issue a Final Agency Decision within 90 calendar days from the date the request for a hearing is received unless an extension has been granted to the Applicant in which case the 90 calendar day period shall be increased accordingly.

8.1000.3.L. NOTIFICATION OF DECISION

1. The Applicant shall be provided, in writing, with:

   a. A copy of the Final Agency Decision; and

   b. Notification of his/her right to seek judicial review and the effective date of the Final Agency Decision for purposes of requesting judicial review.

2. For purposes of requesting judicial review, the effective date of the Final Agency Decision shall be the third day after the date the decision is mailed to the parties, even if the third day falls on Saturday, Sunday or a legal holiday.

8.1000.3.M. CORRECTIVE ACTION

1. If the Final Agency Decision is favorable to the Applicant, corrective action shall be taken, within three working days after the effective date of the Final Agency Decision, retroactive to the date the incorrect action was taken.

8.1000.3.N. RECONSIDERATION OF FINAL AGENCY DECISION

1. A party may file a motion for reconsideration of a Final Agency Decision with the Office of Appeals:

   a. Upon a showing of good cause for failure to file exceptions to the Initial Decision within the allowed 15 calendar day period; or

   b. Upon a showing that the Final Agency Decision is based upon a clear or plain error of fact or law.

2. The motion for reconsideration shall be filed, in writing, with the Office of Appeals within 15 calendar days of the date that the Final Agency Decision is mailed to the parties. The motion shall state the specific grounds for reconsideration.

3. The Office of Appeals shall promptly serve a copy of the motion for reconsideration on each party by first class mail. Each party may file a written response to a motion for reconsideration filed by another party within ten calendar days from the date the motion was mailed to the parties.

4. The Office of Appeals shall promptly serve a copy of its decision on the motion for reconsideration on all parties by first class mail.

8.1000.3.O. REDETERMINATION OF ELIGIBILITY

1. A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medicare client continues to be eligible for the LIS. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months.

2. The county of residence Medicaid Eligibility Site shall promptly redetermine eligibility when:

   a. It receives and verifies information which indicates a change in an client's circumstances which may affect continued eligibility for the LIS; or

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

3. A redetermination form, approved by the Department, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself can not be required to be returned. The only verification that can be required at redetermination is the same minimal verification listed in 10 C.C.R. 2505-10, Section 8.105.5. The following procedures relate to mail-out redetermination:

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

   b. Required verification shall be returned by the client to the county of residence Medicaid Eligibility Site no later than ten working days after receipt of the redetermination verification information requires form;

   c. When the client is unable to complete the forms due to physical, mental or emotional disabilities, or other good cause, and has no one to help him/her, the county of residence Medicaid Eligibility Site shall either assist the client or refer him/her to a legal or other resource. When initial arrangements or a change in arrangements are being made, an extension of up to 30 days may be allowed. The action of the county of residence Medicaid Eligibility Site in assistance or referral shall be recorded in the case record.

4. When the redetermination verification information is not returned within the ten working day time period:

   a. A second request form shall be mailed to the client;

b. A Department approved notice of proposed action taken shall be mailed with the forms notifying the client of termination of LIS eligibility, but such action will not be taken if the completed and signed forms are returned within the prior notice period, or the client can show good cause as to why the forms cannot be returned timely.

c. If no response is received by the end of the prior notice period, action to terminate shall be taken.

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

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

b. Due to inaccurate or inconsistent data, the Medicare client shall immediately be contacted by telephone or in writing so that the worker may secure the proper information.

8.1000.4 ELIGIBILITY FOR THE LOW-INCOME SUBSIDY

8.1000.4.A. Deemed Eligible.

1. An Applicant shall be deemed eligible for the full LIS if the Applicant is:

a. A Full-Benefit Dual Eligible;

b. A recipient of Supplemental Security Income benefits under title XVI of the Social Security Act; or

c. Eligible for Medicaid as a Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or a Qualifying Individual (QI).

8.1000.4.B. Low-Income Subsidy.

1. Full premium subsidy. An Applicant shall be eligible for the Part D full premium subsidy if the Applicant meets the following requirements:

a. Has income below 135 percent of the Federal Poverty Limit (FPL).

b. Has resources at or below the resource thresholds set forth in 42 C.F.R. Section 423.773(b)(2) (2007). 42 C.F.R. Section 423.773(b)(2) (2007) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. An Applicant's resources include the assets or resources of the Applicant's spouse.

2. Low-Income Subsidy. An Applicant shall be eligible for a Part D partial subsidy if the Applicant meets the following requirements:

   a. Has income less than 150 percent of the FPL; and

   b. Has resources at or below the resource thresholds set forth in 42 C.F.R. Section 423.773(d)(2). 42 C.F.R. Section 423.773(d)(2) (2007) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. An Applicant's resources include the assets or resources of the Applicant's spouse.

8.1000.5 BENEFITS

8.1000.5.A. LIS is a Medicare Prescription Drug benefit and is not funded by the Department.

8.1000.5.B. Under Medicare Part D, the Department or its Medicaid Eligibility Sites are required to process LIS applications and any appeal arising from the Department's LIS eligibility determination.

8.1000.5.C. Any appeal concerning the Medicare Prescription Drug benefit itself shall be submitted to Medicare.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the History link that appears above the text in 10 CCR 2505-10. To view versions effective on or after 3/4/07, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]