

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.100 Eligibility, Provider Screening, NPI

10 CCR 2505-10 8.100

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

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

300% Institutionalized Special Income Group is a Medical Assistance category that provides Long-Term Care Services to aged or disabled individuals.

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.

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.

Achieving a Better Life Experience (ABLE) accounts – Special savings accounts that are set up by (or for) certain individuals with disabilities in a qualified ABLE program that are exempt for eligibility. They can be established by any state's qualified ABLE Program. Colorado's ABLE program is administered by the Department of Higher Education.

Adjusted Gross Income (AGI)-means "gross income", as defined in federal tax rules, minus certain adjustments prescribed in the federal tax rules to derive the "Adjusted Gross Income" line on the tax return. These adjustments from gross income are taken before the taxpayer takes his or her Schedule A deductions or Standard Deduction.

Adult MAGI Medical Assistance Group provides Medical Assistance to eligible adults from the age of 19 through the end of the month that the individual turns 65, who do not receive or who are ineligible for Medicare.

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 periodic payments, either for life or a term of years.

Applicant is an individual who is seeking an eligibility determination for Medical Assistance through the submission of an application.

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 Public 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 a person who is related to the dependent child or any adult with whom the dependent child is living and who assumes responsibility for the dependent child's care.

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.

Children MAGI Medical Assistance group provides Medical Assistance coverage to tax dependents or otherwise eligible applicants through the end of the month that the individual turns 19 years old.

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.

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 Centered Boards are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Community Spouse is the spouse of an institutionalized spouse.

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 a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to graduate by 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.

Difficulty of Care Payments is a payment to an applicant or member as compensation for providing live-in home care to an individual who qualifies for foster care or Home and Community Based Services (HCBS) waiver program and lives in the home of the care recipient. This additional care must be required due to a physical, mental, or emotional handicap.

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 12 months or more.

Dual Eligible clients are Medicare beneficiaries 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.

Electronic Data Source is an interface established with a federal or state agency, commercial entity, or other data sources obtained through data sharing agreements to verify data used in determining eligibility. The active interfaces are identified in the Department's verification plan submitted to CMS.

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.

Employed means that an individual has earned income and is working part time, full time or is self-employed, and has proof of employment. Volunteer or in-kind work is not considered employment.

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.

FBR - The Federal Benefit Rate is the monthly Supplemental Security Income payment amount for a single individual or a couple. The FBR is used by the Aged, Blind and Disabled Medical Assistance Programs as the eligibility income limits.

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.

In-Kind Income is income a person receives in a form other than money. It may be received in exchange for work or service (earned income) or a non-cash gift or contribution (unearned income).

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.

Institutionalized Individual is a person who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Institutionalized Spouse is a Medicaid eligible client who begins a stay in a medical institution or nursing facility on or after September 30, 1989, or is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or receives Home and Community Based Services (HCBS) on or after July 1, 1999; and is married to a spouse who is not in a medical institution or nursing facility. An institutionalized spouse does not include any such individual who is not likely to be in a medical institution or nursing facility or to receive HCBS or PACE for at least 30 consecutive days. 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.

Insurance Affordability Program (IAP) refers to Medicaid, Child Health Plan *Plus* (CHP+), and premium and cost-sharing assistance for purchasing private health insurance through state insurance marketplace.

Legal Immigrant is an individual who is not a citizen or national and has been permitted to remain in the United States by the United States Citizenship and Immigration Services (USCIS) either temporarily or as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by USCIS.

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.

Limited Disability for the Medicaid Buy-In Program for Working Adults with Disabilities means that an individual has a disability that would meet the definition of disability under SSA without regard to Substantial Gainful Activity (SGA).

Long-Term Care is Medical Assistance services that provides nursing-home care, home-health care, personal or adult day care for individuals aged at least 65 years or with a chronic or disabling condition.

Long-Term Care Institution means class I nursing facilities, intermediate care facilities for intellectual and developmental disabilities (ICF/IDD) and swing bed facilities. Long-Term Care institutions can include hospitals.

Long-Term Services and Supports Level of Care Eligibility Determination is the determination using the state prescribed assessment instrument that an individual does or does not meet institutional level of care.

Long-Term Services and Supports Level of Care Eligibility Determination Screen is a comprehensive evaluation with an individual seeking services and appropriate collaterals (such as family members, friends, and/or caregivers) to determine the individual's eligibility for long-term services and supports based on their need for institutional level of care as determined using the state prescribed assessment instrument.

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 is the 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.

Minimum Essential Coverage is the type of coverage one must maintain to be in compliance with the Affordable Care Act in order to avoid paying a penalty for being uninsured. Minimum essential coverage may include but not limited to: Medicaid; CHP+; private health plans through Connect for Health Colorado; Medicare; job-based insurance, and certain other coverage.

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.

MAGI - Modified Adjusted Gross Income refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act. These MAGI groups include Parents and Caretaker Relatives, Pregnant Women, Children, and Adults. For a more complete description of the MAGI categories and pursuant rules, please refer to section 8.100.4.

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).

Non-Filer is an individual who neither files a tax return nor is claimed as a tax dependent. For a more complete description of how household composition is determined for the MAGI Medical Assistance groups, please refer to the MAGI household composition section at 8.100.4.E.

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.

Parent and Caretaker Relative is a MAGI Medical Assistance group that provides Medical Assistance to adults who are parents or Caretaker Relatives of dependent children.

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.

PEAK – the Colorado Program Eligibility and Application Kit is a web-based portal used to apply for public assistance benefits in the State of Colorado, including Medical Assistance.

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.

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 195% FPL, including women who are in their 12 months post-partum.

Premium means the monthly amount an individual pays to participate in a Medicaid Buy-In Program.

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.

Reasonable Compatibility refers to an allowable difference or discrepancy between the income an applicant self attests and the amount of income reported by an electronic data source. For a more complete description of how reasonable compatibility is used to determine an applicant's financial eligibility for Medical Assistance, please refer to the MAGI Income section at 8.100.4.C

Reasonable Explanation refers to the opportunity afforded an applicant to explain a discrepancy between self-attested income and income as reported by an electronic data source, when the difference is above the threshold percentage for reasonable compatibility.

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 unemancipated 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. § 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 High School Equivalency Diploma (HSED).

SGA – Substantial Gainful Activity is defined by the Social Security Administration. SGA is the term used to describe a level of work activity and earnings. Work is “substantial” if it involves performance of significant physical or mental activities or a combination of both, which are productive in nature. For work activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be substantial gainful activity. “Gainful” work activity is work performed for pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

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 Streamlined Application or “SSAp” is the general application for health assistance benefits through which applicants will be screened for Medical Assistance programs including Medicaid, CHP+, or premium and cost-sharing assistance for purchasing private health insurance through a state insurance marketplace.

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.

SSI - Supplemental Security Income is a Federal income supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind or disabled individuals with little or no income and resources.

SSI Eligible means an individual who is eligible to receive Supplemental Security Income under Title XVI of the Social Security Act, and may or may not be receiving the monetary payment.

TANF - Temporary Assistance to Needy Families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. It is the Block

Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

Tax Dependent is anyone expected to be claimed as a dependent by a Tax-Filer.

Tax-Filer is an individual, head of household or married couple who is required to and who files a personal income tax return.

Third Party is an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of Medical Assistance.

Title XIX is the portion of the federal Social Security Act which authorizes a joint federal/state Medicaid program. Title XIX contains federal regulations governing the Medicaid program.

TMA - Transitional Medical Assistance is a Medical Assistance category for families that lost Medical Assistance coverage due to increased earned income or loss of earned income disregards.

Unearned Income is the gross amount received in cash or kind that is not earned from employment or self-employment.

VA - Veterans Affairs is The Department of Veterans Affairs which provides patient care and Federal benefits to veterans and their dependents.

8.100.2 Legal Basis

Constitution of Colorado, Article XXIV, Old Age Pensions, section 7, established a health and medical care fund for persons who qualify to receive old age pensions.

Colorado Revised Statutes, Title 25.5, Article 4, Colorado Medical Assistance Act, section 102, provides for a program of Medical Assistance for individuals and families, whose income and resources are insufficient to meet the costs of necessary medical care and services, to be administered in cooperation with the federal government.

The Social Security Act, Title XIX, Grants to States for Medical Assistance Programs, and the consequent Federal regulations, Title 42, CFR (Code of Federal Regulations), Chapter IV, Subchapter C, set forth the conditions for states to obtain Federal Financial Participation in Medical Assistance expenditures.

Under the Colorado Medical Assistance Program, the Medicaid program provides coverage of certain groups specified in Title XIX of the Social Security Act. The OAP State Only Medical Assistance Program provides coverage to certain old age pension clients entitled to health and medical care under the Colorado Constitution.

The Department of Health Care Policy and Financing is the single State agency designated to administer the Colorado Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes. The Office of Medical Assistance of the Department is delegated the duties and responsibilities for administration of the Colorado Medical Assistance Program.

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.A. Application Requirements

1. The eligibility site shall advise individuals concerning the benefits of the Medical Assistance Program and determine or 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. If the applicant applied for Medical Assistance on the Single Streamlined Application and was found ineligible, this application shall be reviewed for all other Medical Assistance eligibility programs, the Child Health Plan Plus (CHP+) program and premium and cost-sharing assistance for purchasing private health insurance through the state insurance marketplace.
 - a. The application data and verifications shall be automatically transferred to the state insurance marketplace through a system interface when applicants are found ineligible for Medical Assistance eligibility programs. If an individual is pending for a Non-MAGI Medical Assistance eligibility program but has been found financially ineligible for MAGI Medical Assistance eligibility programs, the application data and verifications shall be transferred to the state insurance marketplace.
3. Persons applying 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 Application for Public Assistance.
4. If an applicant is found to be ineligible for a particular program, the Application for Public Assistance shall be reviewed and processed for other financial programs the household has requested on the Application for Public Assistance and all other Medical Assistance Programs. Referrals to other community agencies and organizations shall be made for the applicant whenever available or requested.
5. The applicant must sign the application form, give declaration in lieu of a signature by telephone, or may opt to use an electronic signature in order to receive Medical Assistance.
6. A family member, adult in the applicant's Medical Assistance Required Household or authorized representative may submit an application and request assistance on behalf of an applicant.
7. If the applicant is not able to participate in the completion of the application forms because they are a minor (as defined in C.R.S. § 13-22-101) or due to physical or mental incapacity, the spouse, other relative, friend, or representative acting responsibly on behalf of the applicant 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.
8. 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, under penalty of perjury, 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 8.a. are available, an authorized official of the institution may sign the application.

9. Application interviews or requested visits to the eligibility site for Medical Assistance shall not be required. All correspondence may occur by mail, email or telephone.
10. During normal business hours, eligibility sites shall not restrict the hours in which applicants may file an application. The eligibility site must afford any individual wishing to do so the opportunity to apply for Medical Assistance without delay.
11. The applicant has the right to withdraw his or her application at any time.

8.100.3.B. Residency Requirements

1. Individuals shall make application in the county in which they live. Individuals who reside in a county but who do not reside in a permanent dwelling nor have a fixed mailing address shall be considered eligible for the Medical Assistance Program, provided all other eligibility requirements are met. In no instance shall there be a durational residency requirement imposed upon the applicant, nor shall there be a requirement for the applicant to reside in a permanent dwelling or have a fixed mailing address. If an individual without a permanent dwelling or fixed mailing address is hospitalized, the county where the hospital is located shall be responsible for processing the application to completion. If the individual moves prior to completion of the eligibility determination the origination eligibility site completes the determination and transfers the case as applicable.
 - a. For applicants in Long Term Care institutions - The county of domicile for all Long Term Care clients is the county in which they are physically located and receiving services.
2. A resident of Colorado is defined as a person that is living within the state of Colorado and considers Colorado to be their place of residence at the time of application. For institutionalized individuals who are incapable of indicating intent as to their state of residence, the state of residence shall be where the institution is located unless that state determines that the individual is a resident of another state, by applying the following criteria:
 - a. for any institutionalized individual who is under age 21 or who is age 21 or older and incapable of indicating intent before age 21, the state of residence is that of the individual's parent(s) or legally appointed guardian at the time of placement;
 - b. for any institutionalized individual who became incapable of indicating intent at or after age 21, (1) the state of residence is the state in which the person was living when he or she became incapable of indicating intent, or (2) if this cannot be determined, the state of residence is the state in which the person was living when he or she was first determined to be incapable of indicating intent;
 - c. upon placement in another state, the new state is the state of residence unless the current state of residence is involved in the placement. If a current state arranged for an individual to be placed in an institution located in another state, the current state shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent;
 - d. in the case of conflicting opinions between states, the state of residence is the state where the individual is physically located.
3. For purposes of this section on establishing an individual's state of residence, an individual is considered incapable of indicating intent if:
 - a. the person has an I.Q. of 49 or less or has a mental age of 7 or less, based on standardized tests as specified in the persons in medical facilities section of this volume;

- b. the person is judged legally incompetent; or
 - c. medical documentation, or other documentation acceptable to the eligibility site, supports a finding that the person is incapable of indicating intent.
- 4. Residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.
- 5. A non-resident shall mean a person who considers his/her place of residence to be other than Colorado. Any person who enters the state to receive Medical Assistance or for any other reason is a non-resident, so long as they consider their permanent place of residence to be outside of the state of Colorado.

8.100.3.C. Transferring Requirements

- 1. When a family or individual moves from one county to another within Colorado, the client shall report the change of address to the eligibility site responsible for the current active Medical Assistance Program case(s). If a household applies in the county in which they live and then moves out of that county during the application determination process, the originating eligibility site shall complete the processing of that application before transferring the case. The originating eligibility site shall electronically transfer the case to the new county of residence in CBMS.
- 2. The originating eligibility site must notify the receiving eligibility site of the client's transfer of Medical Assistance. The originating eligibility site may notify the receiving eligibility site by telephone that a client has moved to the receiving county. If the family or individual wishes to apply for other types of assistance, they shall submit a new application to the receiving eligibility site.
- 3. If the household is transferring the current Medical Assistance case, the receiving eligibility site cannot mandate a new application, verification, or an office visit to authorize the transfer. The receiving eligibility site can request copies of specific case documents to be forwarded from the originating eligibility site to verify the data contained in CBMS.
- 4. If the originating eligibility site closes a case for the discontinuation reason of "unable to locate," the applicant shall reapply at the receiving eligibility site for the Medical Assistance Program.
- 5. If a case is closed for any other discontinuation reason than "unable to locate" and the client provides appropriate information to overturn the discontinuation with the originating eligibility site, then, upon transfer, the receiving eligibility site shall reopen the case with case comments in CBMS. These actions shall be performed according to timeframes defined by the Department.
- 6. When a recipient moves from his/her home to a nursing facility in another county or when a recipient moves from one nursing facility to another in a different county:
 - a. the initiating eligibility site will transfer the case electronically in the eligibility system to the eligibility site in which the nursing facility is located when the individual is determined eligible; and
 - b. The following items shall be furnished by the initiating eligibility site to the new eligibility site in hard copy format or via electronic transmission:
 - i) 5615 that was sent to the nursing facility indicating the case transfer; and
 - ii) Identification and citizenship documents; and

iii) Long-Term Services and Supports Level of Care Eligibility Determination

7. When transferring a case, the initiating eligibility site will send an AP-5615 form to the nursing facility administrator of the new nursing facility showing the date of case closure and the current patient payment at the time of transfer. Should the Medical Assistance Program reimbursement be interrupted, the receiving eligibility site will have the responsibility to process the application and back date the Medical Assistance eligibility date to cover the period of ineligibility.

8.100.3.D. Processing Requirements

1. The eligibility site shall process a Single Streamlined Application for Medical Assistance Program benefits within the following deadlines:
 - a. 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.
 - b. 45 days for all other Medical Assistance Program applicants.
 - c. The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.
 - d. In unusual circumstances, documented in the case record and in CBMS case comments, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or an administrative or other emergency beyond the agency's control.
 - e. Due to the Coronavirus COVID-19 Public Health Emergency, required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories, regardless of changes made for a redetermination or additional documentation for current Medicaid enrollees. The Department will allow these individuals to continue eligibility through the period of the COVID-19 pandemic federal emergency declaration. Once the federal emergency declaration has concluded, the Department will process eligibility redeterminations and /or changes for all members whose eligibility was maintained during the emergency declaration.
2. Upon request, applicants will be given an extension of time within the application processing timeframe to submit requested verification. Applicants may request an extension of time beyond the application processing timeframe to obtain necessary verification. The extension may be granted at the eligibility site's discretion. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.
3. The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.
4. For clients who apply for the Medical Assistance Program and a disability determination is required, the eligibility site shall send a notice informing the applicant of the reason for a delay beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay. The eligibility site shall send this notice no later than 91 days following the application for the Medical Assistance Program.
5. For information regarding continuation of benefits during the pendency of an appeal to the Social Security Administration (SSA) based upon termination of disability benefits see section 8.057.5.C.

6. Effective July 1, 1997, as a condition of eligibility for the Medical Assistance Program, any legal immigrant who is applying for or receiving Medical Assistance shall agree in writing that, during the time period the client is receiving Medical Assistance, he or she will not sign an affidavit of support for the purpose of sponsoring an alien who is seeking permission from the United States Immigration and Citizenship Services to enter or remain in the United States. A legal immigrant's eligibility for Medical Assistance shall not be affected by the fact that he or she has signed an affidavit of support for an alien before July 1, 1997.
7. Eligibility sites at which an individual is able to apply for Medical Assistance benefits shall also provide the applicant the opportunity to register to vote.
 - a. The eligibility site shall provide to the applicant the prescribed voter registration application.
 - b. The eligibility site shall not:
 - i) Seek to influence the applicant's political preference or party registration;
 - ii) Display any political preference or party allegiance;
 - iii) Make any statement to the applicant or take any action, the purpose or effect of which is to discourage the applicant from registering to vote; and
 - iv) Make any statement to an applicant which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.
 - c. The eligibility site shall ensure the confidentiality of individuals registering and declining to register to vote.
 - d. Records concerning registration and declination to register to vote shall be maintained for two years by the eligibility site. These records shall not be part of the public assistance case record.
 - e. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the eligibility site is located not later than ten (10) days after the date of acceptance; except that if a registration application is accepted within five (5) days before the last day for registration to vote in an election, the application shall be transmitted to the county clerk and recorder for the county not later than five (5) days after the date of acceptance.
8. Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote in the new county of residence. The new county of residence shall follow the above procedure. The new county of residence shall notify its county clerk and recorder of the client's change in address within five (5) days of receiving the information from the client.

8.100.3.E. Retroactive Medical Assistance Coverage

1. An applicant for Medical Assistance shall be provided such assistance any time during the three months preceding the date of application, or as of the date the person became eligible for Medical Assistance, whichever is later. That person shall have received medical services at any time during that period and met all applicable eligibility requirements.

2. An explanation of the conditions for retroactive Medical Assistance shall be given to all applicants. Those applicants who within the three months period prior to the date of application or as of the date the person became eligible for Medical Assistance, whichever is later, have received medical services which would be a benefit under the Colorado State Plan, can request retroactive coverage on the application form. The determination of eligibility for retroactive Medical Assistance shall be made as part of the application process. An applicant does not have to be eligible in the month of application to be eligible for retroactive Medical Assistance. The applicant or client may verbally request retroactive coverage at any time following the completion of an application. Verification required to determine Medical Assistance Program eligibility for the retroactive period shall be secured by the eligibility site to determine retroactive eligibility. Proof of the declared medical service shall not be required.

8.100.3.F. Groups Assisted Under the Program

1. The Medical Assistance Program provides benefits to the following persons who meet the federal definition of categorically needy at the time they apply for benefits:
 - a. Parents and Caretaker Relatives, Pregnant Women, Children, Adults, and Family Planning Medical Assistance as defined under the Modified Adjusted Gross Income (MAGI) Medical Assistance section 8.100.4.
 - b. Persons who meet legal immigrant requirements as outlined in this volume, who were or would have been eligible for SSI but for their alien status, if such persons meet the resource, income and disability requirements for SSI eligibility.
 - c. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B. See section 8.100.3.M for more information on SISC Codes.
 - d. Persons who are eligible for financial assistance under Old Age Pension (OAP) and SSI, but are not receiving the money payment.
 - e. Persons who would be eligible for financial assistance from OAP or SSI, except for the receipt of Social Security Cost of Living Adjustment (COLA) increases, or other retirement, survivors, or disability benefit increases to their own or a spouse's income. This group also includes persons who lost OAP or SSI due to the receipt of Social Security Benefits and who would still be eligible for the Medical Assistance Program except for the cost of living adjustments (COLA's) received. These populations are referenced as Pickle and Disabled Widow(er)s.
 - f. Persons who are blind, disabled, or aged individuals residing in the medical institution or Long Term Care Institution whose income does not exceed 300% of SSI.
 - g. Persons who are blind, disabled or aged receiving HCBS whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.
 - h. A disabled adult child who is at least 18 years of age and who was receiving SSI as a disabled child prior to the age of 22, and for whom SSI was discontinued on or after May 1, 1987, due to having received of OASDI drawn from a parent(s) Social Security Number, and who would continue to be eligible for SSI if the above OASDI and all subsequent cost of living adjustments were disregarded. This population is referenced as Disabled Adult Child (DAC).

- i. Children age 18 and under who would otherwise require institutionalization in an Long Term Care Institution, Nursing Facility (NF), or a hospital but for which it is appropriate to provide care outside of an institution as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).
- j. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility criteria but do meet the state eligibility criteria for the OAP State Only Medical Assistance Program. These persons qualify for a SISC Code C.
- k. Persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergencies only.
- l. Persons with a disability or limited disability who are at least 16, with income less than or equal to 450% of FPL after income disregards, regardless of resources, and who are employed.
- m. Children with a disability who are age 18 and under, with household income less than or equal to 300% of FPL after income disregards, regardless of resources.
- n. Due to the Coronavirus COVID-19 Public Health Emergency, an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection of COVID-19 may be eligible to receive services for COVID-19 testing, treatment, or care for complications related to COVID-19. To qualify for this limited benefit, the applicant must satisfy residency and immigration-or citizenship and not be enrolled in other health insurance.

8.100.3.G. General and Citizenship Eligibility Requirements

- 1. To be eligible to receive Medical Assistance, an eligible person shall:
 - a. Be a resident of Colorado;
 - b. Meet the following requirements while being an inmate, in-patient or resident of a public institution:
 - i). The following individuals, if eligible, may be enrolled for Medical Assistance
 - 1. Patients in a public medical institution
 - 2. Residents of a Long-Term Care Institution
 - 3. Prior inmates who have been paroled
 - 4. Resident of a publicly operated community residence which serves no more than 16 residents
 - 5. Individuals participating in community corrections programs or residents in community corrections facilities ("halfway houses") who have freedom of movement and association which includes individuals who:
 - a) are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision;

- b) can use community resources (e.g., libraries, grocery stores, recreation, and education) at will;
 - c) can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state; and/or
 - d) are residing at their home, such as house arrest, or another location
- ii). Inmates who are incarcerated in a correctional institution such as a city, county, state or federal prison may be enrolled, if eligible, with benefits limited to an inpatient stay of 24 hours or longer in a medical institution.
- c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;
- d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;
- e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;
- f. Meet all other requirements of the Medical Assistance Program for which application is being made; and
- g. Fall into one of the following categories:
 - i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or
 - ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or
 - iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:
 - 1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");
 - 2) paroled into the United States for at least one year under 8 U.S.C. § 1182(d)(5); or
 - 3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

- 4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. §1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or
- iv) Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:
 - 1) lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or
 - 2) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or
 - 3) granted asylum under section 208 of the INA, or
 - 4) refugee under section 207 of the INA, or
 - 5) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA, or
 - 6) Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, or
 - 7) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 5304(e)(2016), or
 - 8) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461), or
 - 9) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict, or
 - 10) a victim of a severe form of trafficking in persons, as defined in section 103 of the Victims of Trafficking and Violence Protection Act of 2000, Pub. L.106-386, as amended (22 U.S.C. § 7105(b) (2016)), or
 - 11) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA, or
 - 12) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA, or
 - 13) Compact of Free Association (COFA) migrants, including citizens of Micronesia, the Marshall Islands, and Palau, pursuant to section 208 of the Consolidated Appropriations Act of 2021 (in effect December 27, 2020).

- v) The statutes listed at sections 8.100.3.G.1.g.iii.1-5 and at 8.100.3.G.1.g.iv.3-11 are incorporated herein by reference. No amendments or later editions are incorporated. These regulations are available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Pursuant to C.R.S. 24-4-103(12.5)(b)(2016), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.
- vi) Be a lawfully admitted non-citizen who is a pregnant women or a child under the age of 19 years in the United States who falls into one of the categories listed in 8.100.3.G.1.g.iii or into one of the following categories listed below. These individuals are exempt from the 5-year waiting period:
 - 1) granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a,or
 - 2) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C 1254a and pending applicants for TPS granted employment authorization,
 - 3) granted employment authorization under 8 CFR 274a.12(c),or
 - 4) Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.
 - 5) Deferred Enforced Departure (DED), pursuant to a decision made by the President,
 - 6) granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum,
 - 7) granted an administrative stay of removal under 8 CFR 241.6(2016), or
 - 8) Beneficiary of approved visa petition who has a pending application for adjustment of status.
 - 9) Pending an application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who-
 - a) as been granted employment authorization; or
 - b) Is under the age of 14 and has had an application pending for at least 180 days.
 - 10) granted withholding of removal under the Convention Against Torture,
 - 11) A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C. 1101(a)(27)(J), or
 - 12) Citizens of Micronesia, the Marshall Islands, and Palau, or

- 13) is lawfully present American Samoa under the immigration of laws of American Samoa.
 - 14) A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or under 8 U.S.C. 1101(a)(17), or
 - 15) A non-citizen who has been paroled into the United States for less than one year under 8 U.S.C. § 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.
- vii) Be an Afghan Humanitarian Parolee who falls into one of the following categories listed below, as defined in Section 2502 of the Extending Government Funding and Delivering Emergency Assistance Act of 2021 (HR 5305). These individuals are exempt from the 5-year waiting period until March 31, 2023, or through the termination of their parole period, whichever is later:
- 1) paroled into the United States between July 31, 2021 – September 30, 2022; or
 - 2) paroled into the United States after September 30, 2022, and
 - a) is the spouse or child of an individual in subparagraph 1 as defined under section 101(b) of the Immigration and Nationality Act (8 U.S.C. 4 1101(b)); or
 - b) is the parent or legal guardian of an individual in subparagraph 1 who is determined to be an unaccompanied child under 6 U.S.C.279(g)(2).
- viii) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but who are not citizens, and are not eligible non-citizens, according to the criteria set forth in 8.100.3.G.1.g, shall receive Medical Assistance benefits for emergency medical care only and/or reproductive health care services upon request. The rules on confidentiality prevent the Department or eligibility site from reporting to the United States Citizenship and Immigration Services persons who have applied for or are receiving assistance. These persons need not select a primary care physician as they are eligible only for emergency medical services and/or reproductive health care services.

For non-qualified aliens receiving Medical Assistance emergency only benefits, the following medical conditions will be covered:

An emergency medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- 1) placing the patient's health in serious jeopardy;
- 2) serious impairment of bodily function; or
- 3) serious dysfunction of any bodily organ or part.

Applicants are not required to obtain a written statement by their physician for their application to be complete and processed. For emergency care, a physician must certify and declare the presence of an emergency medical condition when services are provided and shall indicate that services were for a medical emergency on the claim form. This will suffice as the physician statement for an emergency medical condition when services were provided. Medical Assistance coverage for emergency medical care only is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care. Medical Assistance benefits for reproductive health care services are limited to care and services that provide reproductive health and/or family planning services only. Once a member has been determined eligible for either of these emergency and/or reproductive health services, the member will not be required to submit a new application before 12 months for any other emergency and/or reproductive health services. Members will have the option to advise the Department, at any time, that they no longer need the services. Members receiving emergency and/or limited reproductive health services will receive a renewal at 12 months to redetermine their eligibility.

2. For determinations of eligibility for Medical Assistance, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 8.100.3.G(1)(g)(ii) (iii) (iv)(vi) or (vii) and has declared that he or she has a legal immigration status.
 - a. The Verify Lawful Presence (VLP) interface will be used to verify immigration status. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) Program to verify legal immigration status.
 - i) If an automated response from VLP confirms that the information submitted is consistent with VLP data for immigration status verification requirements, no further action is required for the individual and no additional documentation of immigration status is required.
 - ii) If the VLP cannot automatically confirm the information submitted, the individual will be contacted with a request for additional documents and/or information needed to verify their legal immigration status through the VLP interface. If a response from the VLP interface confirms that the additional documents and/or information received from the individual verifies their legal immigration status, no further action is required for the individual and no additional documentation of immigration status is required.
3. Reasonable Opportunity Period
 - a. If the verification through the electronic interface is unsuccessful then the applicant will be provided a reasonable opportunity period, of 90 days, to submit documents indicating a legal immigration status, as listed in 8.100.3.G.1.g. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period.
 - b. If the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.
 - c. The reasonable opportunity period applies to MAGI, Adult and Buy-In Programs.

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

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical Assistance	8.100.4.G.3
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Legal Immigrant Prenatal Medical Assistance	8.100.4.G.6
Transitional Medical Assistance	8.100.4.I.1-5

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

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

8.100.3.H. Citizenship and Identity Documentation Requirements

1. For determinations of initial eligibility and redeterminations of eligibility for Medical Assistance made on or after July 1, 2006, citizenship or nationality and identity status must be verified unless such satisfactory documentary evidence has already been provided, as described in 8.100.3.H.4.b. This requirement applies to an individual who declares or who has previously declared that he or she is a citizen or national of the United States.
 - a. The following electronic interfaces shall be accepted as proof of citizenship and/or identity as listed and should be used prior to requesting documentary evidence from applicants/clients:
 - i) SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.
 - ii) Department of Motor Vehicles (DMV) Interface is an acceptable interface to verify identity. An automated response from DMV confirms that the data submitted is consistent with DMV data for identity verification requirements. No further action is required for the individual and no additional documentation of identity is required.
 - b. This requirement does not apply to the following groups:
 - i) Individuals who are entitled to or who are enrolled in any part of Medicare.

- ii) Individuals who receive Supplemental Security Income (SSI).
 - iii) Individuals who receive child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care.
 - iv) Individuals who receive adoption or foster care assistance under Title IV-E of the Social Security Act.
 - v) Individuals who receive Social Security Disability Insurance (SSDI).
 - vi) Children born to a woman who has applied for, has been determined eligible, and is receiving Medical Assistance on the date of the child's birth, as described in 8.100.4.G.5. This includes instances where the labor and delivery services were provided before the date of application and were covered by the Medical Assistance Program as an emergency service based on retroactive eligibility.
- 1) A child meeting the criteria described in 8.100.3.H.1.b.vi shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence at any time in the future, regardless of any subsequent changes in the child's eligibility for Medical Assistance.
 - 2) Special Provisions for Retroactive Reversal of a Previous Denial
 - a) If a child described at 8.100.3.H.1.b.vi was previously determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial shall be reversed. Eligibility shall be effective retroactively to the date of the child's birth provided all of the following criteria are met:
 - (1) The child was determined to be ineligible for Medical Assistance during the period between July 1, 2006 and October 1, 2009 solely for failure to meet the citizenship and identity documentation requirements as they existed during that period;
 - (2) The child would have been determined to be eligible for Medical Assistance had 8.100.3.H.1.b.vi and/or 8.100.3.H.1.b.vi.2.a been in effect during the period from July 1, 2006 through October 1, 2009; and
 - (3) The child's parent, caretaker relative, or legally appointed guardian or conservator requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.
 - b) A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.P.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

- c) A child granted retroactive eligibility for Medical Assistance shall be subject to the requirements described at 8.100.4.G.2. for continued eligibility.
 - vii) Individuals receiving Medical Assistance during a period of presumptive eligibility.
- 2. Satisfactory documentary evidence of citizenship or nationality includes the following:
 - a. Stand-alone documents for evidence of citizenship and identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:
 - i) A U.S. passport issued by the U.S. Department of State that:
 - 1) includes the applicant or recipient, and
 - 2) was issued without limitation. A passport issued with a limitation may be used as proof of identity, as outlined in 8.100.3.H.3.
 - ii) A Certificate of Naturalization (DHS Forms N-550 or N-570) issued by the Department of Homeland Security (DHS) for naturalized citizens.
 - iii) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) issued by the Department of Homeland Security for individuals who derive citizenship through a parent.
 - iv) A document issued by a federally recognized Indian tribe, evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).
 - 1) Special Provisions for Retroactive Reversal of a Previous Denial
 - a) For a member of a federally recognized Indian tribe who was determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial of eligibility shall be reversed and eligibility shall be effective as of the date on which the individual was determined to be ineligible provided all of the following criteria are met:
 - (1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity documentation requirements as they existed during that period;
 - (2) The individual would have been determined to be eligible for Medical Assistance had 8.100.3.H.2.a.iv) been in effect on or after July 1, 2006; and
 - (3) The individual or a legally appointed guardian or conservator of the individual requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

- b) A member of a federally recognized Indian tribe for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.P.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed as provided in this subsection 2.
- b. Evidence of citizenship. If evidence from the list in 8.100.3.H.2.a. is not provided, an applicant or recipient shall provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H. 3. to establish identity. Evidence of citizenship includes:
 - i) A U.S. public birth certificate.
 - 1) The birth certificate shall show birth in any one of the following:
 - a) One of the 50 States,
 - b) The District of Columbia,
 - c) Puerto Rico (if born on or after January 13, 1941),
 - d) Guam (if born on or after April 10, 1899),
 - e) The Virgin Islands of the U.S. (if born on or after January 17, 1917),
 - f) American Samoa,
 - g) Swain's Island, or
 - h) The Northern Mariana Islands (NMI) (if born after November 4, 1986 (NMI local time)).
 - 2) The birth record document shall have been issued by the State, Commonwealth, Territory or local jurisdiction.
 - 3) The birth record document shall have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship, as described in 8.100.3.H.2.d.
 - ii) A Certification of Report of Birth (DS-1350) issued by the U.S. Department of State to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.
 - iii) A Report of Birth Abroad of a U.S. Citizen (Form FS-240) issued by the U.S. Department of State consular office overseas for children under age 18 at the time of issuance. Children born outside the U.S. to U.S. military personnel usually have one of these.
 - iv) A Certification of birth issued by the U.S. Department of State (Form FS-545 or DS-1350) before November 1, 1990.

- v) A U.S. Citizen I.D. card issued by the U.S. Immigration and Naturalization Services (INS):
 - 1) Form I-179 issued from 1960 until 1973, or
 - 2) Form I-197 issued from 1973 until April 7, 1983.
- vi) A Northern Mariana Identification Card (I-873) issued by INS to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986.
- vii) An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC."
- viii) A final adoption decree that:
 - 1) shows the child's name and U.S. place of birth, or
 - 2) a statement from a State approved adoption agency that shows the child's name and U.S. place of birth. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
- ix) Evidence of U.S. Civil Service employment before June 1, 1976. The document shall show employment by the U.S. government before June 1, 1976.
- x) U.S. Military Record that shows a U.S. place of birth such as a DD-214 or similar official document showing a U.S. place of birth.
- xi) Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.
- xii) Child Citizenship Act. Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

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

- 1) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this part);
- 2) The child is under the age of 18;
- 3) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

- 4) The child was admitted to the United States for lawful permanent residence (as verified through the Systematic Alien Verification for Entitlements (SAVE) Program); and
 - 5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.
- xiii) Extract of a hospital record on hospital letterhead.
- 1) The record shall have been established at the time of the person's birth;
 - 2) The record shall have been created at least 5 years before the initial application date; and
 - 3) The record shall indicate a U.S. place of birth;
 - 4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.
 - 5) Souvenir "birth certificates" issued by a hospital are not acceptable.
- xiv) Life, health, or other insurance record.
- 1) The record shall show a U.S. place of birth; and
 - 2) The record shall have been created at least 5 years before the initial application date.
 - 3) For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.
- xv) Religious record.
- 1) The record shall have been recorded in the U.S. within 3 months of the date of the individual's birth;
 - 2) The record shall show that the birth occurred in the U.S.;
 - 3) The record shall show either the date of birth or the individual's age at the time the record was made; and
 - 4) The record shall be an official record recorded with the religious organization.

- xvi) Early school record that meets the following criteria:
 - 1) The school record shows the name of the child;
 - 2) The school record shows the child's date of admission to the school;
 - 3) The school record shows the child's date of birth;
 - 4) The school record shows a U.S. place of birth for the child; and
 - 5) The school record shows the name(s) and place(s) of birth of the applicant's parents.
- xvii) Federal or State census record showing U.S. citizenship or a U.S. place of birth and the applicant's age.
- xviii) One of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for The Medical Assistance Program. For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.
 - 1) Seneca Indian tribal census record;
 - 2) Bureau of Indian Affairs tribal census records of the Navajo Indians;
 - 3) U.S. State Vital Statistics official notification of birth registration;
 - 4) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth;
 - 5) Statement signed by the physician or midwife who was in attendance at the time of birth; or
 - 6) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.
- xix) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicate a U.S. place of birth.
- xx) Medical (clinic, doctor, or hospital) record.
 - 1) The record shall have been created at least 5 years before the initial application date; and
 - 2) The record shall indicate a U.S. place of birth.
 - 3) An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
 - 4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.
- xxi) Written affidavit. Affidavits shall only be used in rare circumstances. They may be used by U.S. citizens or nationals born inside or outside the U.S. If documentation is by affidavit, the following rules apply:

- 1) There shall be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit);
 - 2) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient;
 - 3) In order for the affidavit to be acceptable the persons making them shall provide proof of their own U.S. citizenship and identity.
 - 4) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit shall contain this information as well;
 - 5) The applicant/recipient or other knowledgeable individual (guardian or representative) shall provide a separate affidavit explaining why the evidence does not exist or cannot be obtained; and
 - 6) The affidavits shall be signed under penalty of perjury pursuant to 18 U.S.C. §1641 and Title 18 of the Criminal Code article 8 part 5 and need not be notarized.
- c. Evidence of citizenship for collectively naturalized individuals. If a document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. A second document from 8.100.3.H.3. to establish identity shall also be presented.
- i) Puerto Rico:
 - 1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; OR
 - 2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.
 - ii) US Virgin Islands:
 - 1) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; OR
 - 2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

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- 3) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.
 - iii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):
 - 1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR
 - 2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR
 - 3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).
 - 4) If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile, and the individual is not a U.S. citizen.
 - d) Referrals for Colorado Birth Certificates
 - i) An applicant or client who was born in the State of Colorado who does not possess a Colorado birth certificate shall receive a referral to the Department of Public Health and Environment by the county department to obtain a birth certificate at no charge, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C).
 - ii) The referral shall be provided on county department letterhead and shall include the following:
 - 1) The name and address of the applicant or client;
 - 2) A statement that the county department requests that the Department of Public Health and Environment waive the birth certificate fee, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C); and
 - 3) The name and contact telephone number for the county caseworker responsible for the referral.
 - iii) An applicant or client who has been referred to the Department of Public Health and Environment to obtain a birth certificate shall not be required to present a birth certificate to satisfy the citizenship documentation requirement at 8.100.3.H.2. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.2. to satisfy the citizenship documentation requirement.
 - 3. The following documents shall be accepted as proof of identity and shall accompany a document establishing citizenship from the groups of documentary evidence outlined in 8.100.3.H.2.b. through d.

- a) A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
- b) School identification card with a photograph of the individual;
- c) U.S. military card or draft record;
- d) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses;
- e) Military dependent's identification card;
- f) U.S. Coast Guard Merchant Mariner card;
- g) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. The document is acceptable if it carries a photograph of the individual or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color; or
- h) Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted evidence of citizenship listed under 8.100.3.H.2.b. or 8.100.3.H.2.c. The following requirements must be met:
 - i) No other evidence of identity is available to the individual;
 - ii) The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity; and
 - iii) All documents used must contain consistent identifying information.
 - iv) These documents include, but are not limited to, employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds/titles.
- i) Special identity rules for children. For children under 16, the following records are acceptable:
 - i) Clinic, doctor, or hospital records; or
 - ii) School records.
 - 1) The school record may include nursery or daycare records and report cards; and
 - 2) The school, nursery, or daycare record must be verified with the issuing school, nursery, or daycare.
 - 3) If clinic, doctor, hospital, or school records are not available, an affidavit may be used if it meets the following requirements:
 - a) It shall be signed under penalty of perjury by a parent or guardian;

- b) It shall state the date and place of birth of the child; and
 - c) It cannot be used if an affidavit for citizenship was provided.
 - d) The affidavit is not required to be notarized.
 - e) An affidavit may be accepted on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual until that age.
- j) Special identity rules for disabled individuals in institutional care facilities.
 - i) An affidavit may be used for disabled individuals in institutional care facilities if the following requirements are met:
 - 1) It shall be signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility; and
 - 2) No other evidence of identity is available to the individual.
 - 3) The affidavit is not required to be notarized.
- k) Expired identity documents.
 - i) Identity documents do not need to be current to be acceptable. An expired identity document shall be accepted as long as there is no reason to believe that the document does not match the individual.
- l) Referrals for Colorado Identification Cards
 - i) An applicant or client who does not possess a Colorado driver's license or identification card shall be referred to the Department of Revenue Division of Motor Vehicles by the county department to obtain an identification card at no charge, pursuant to C.R.S. § 42-2-306(1)(a)(II).
 - ii) The referral shall be provided on county department letterhead and shall include the following:
 - 1) The name and address of the applicant or client;
 - 2) A statement that the county department requests that the Department of Revenue Division of Motor Vehicles waive the identification card fee, pursuant to C.R.S § 42-2-306(1)(a)(II).; and
 - 3) The name and contact telephone number for the county caseworker responsible for the referral.
 - iii) An applicant or client who has been referred to the Division of Motor Vehicles to obtain an identification card shall not be required to present a Colorado identification card to satisfy the identity documentation requirement at 8.100.3.H.3. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.3. to satisfy the identity documentation requirement.

4. Documentation Requirements

- a. Citizenship and identity documents may be submitted as originals, certified copies, photocopies, facsimiles, scans or other copies.
- b. Individuals who submitted notarized copies of citizenship and identity documents as part of an application or redetermination before January 1, 2008 shall not be required to submit originals or copies certified by the issuing agency for any application or redetermination processed on or after January 1, 2008.
- c. All citizenship and identity documents shall be presumed to be genuine unless the authenticity of the document is questionable.
- d. Individuals shall not be required to submit citizenship and identity documentation in person. Documents shall be accepted from a Medical Assistance applicant or client or from his or her guardian or authorized representative in person or by mail.
 - i) Individuals are strongly encouraged to use alternatives to mailing original documents to counties, such as those described in 8.100.3.H.4.e.
- e. Individuals may present original citizenship and identity documents or copies certified by the issuing agency to Medical Assistance (MA) sites, School-based Medical Assistance sites, Presumptive Eligibility (PE) sites, Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), or any other location designated by the Department by published agency letter.
 - i) Staff at these locations shall make a copy of the original documents and shall complete a "Citizenship and Identity Documentation Received" form, stamp the copy, or provide other verification that identifies that the documents presented were originals. The verification shall include the name, telephone number, organization name and address, and signature of the individual who reviewed the document(s). This form, stamp, or other verification shall be attached to or directly applied to the copy.
 - ii) Upon request by the client or eligibility site, the copy of the original document with the "Citizenship and Identity Documentation Received" form, stamp, or other verification as described in 8.100.3.H.4.e. i) shall be mailed or delivered directly to the eligibility site within five business days.
- f. Counties shall accept photocopies of citizenship and identity documents from any location described in 8.100.3.H.4.e provided the photocopies include the form, stamp, or verification described in 8.100.3.H.4.e.i).
- g. Counties shall develop procedures for handling original citizenship and identity documents to ensure that these documents are not lost, damaged, or destroyed.
 - i) Upon receiving the original documents, eligibility site staff shall make a copy of the original documents and shall complete a "Citizenship and Identity Documentation Received" form, stamp the copy, or provide other verification that identifies that the documents presented were originals, as described in 8.100.3.H.4.e. i). This form, stamp, or other verification shall be attached to or directly applied to the copy.
 - ii) The original documents shall be sent by mail or returned to the individual in person within five business days of the date on which they were received.

- iii) To limit the risk of original documents being lost, damaged, or destroyed, counties are strongly encouraged to make copies of documents immediately upon receipt and to return original documents to the individual while he or she is present.
 - h. Once an individual has provided the required citizenship and identity documentation, he or she shall not be required to submit the documentation again unless:
 - i) Later evidence raises a question about the individual's citizenship or identity; or
 - ii) There is a gap of more than five years between the ending date of the individual's last period of eligibility and a subsequent application for The Medical Assistance Program and the eligibility site has not retained the citizenship and identity documentation the individual previously provided.
- 5. Record Retention Requirements
 - a. The eligibility site shall retain a paper or electronically scanned copy of an individual's citizenship and identity documentation, including any verification described in 8.100.3.H.4.e.i), for at least five years from the ending date of the individual's last period of Medical Assistance eligibility.
- 6. Name Change Provisions
 - a. An individual who has changed his or her last name for reasons including, but not limited to, marriage, divorce, or court order shall not be required to produce any additional documentation concerning the name change unless:
 - i) With the exception of the last name, the personal information in the citizenship and identity documentation provided by the individual does not match in every way;
 - ii) In addition to changing his or her last name, the individual also changed his or her first name and/or middle name; or
 - iii) There is a reasonable basis for questioning whether the citizenship and identity documents belong to the same individual.
- 7. Reasonable Level of Assistance
 - a. The eligibility site shall provide a reasonable level of assistance to applicants and clients in obtaining the required citizenship and identity documentation.
 - b. Examples of a reasonable level of assistance include, but are not limited to:
 - i) Providing contact information for the appropriate agencies that issue the required documents;
 - ii) Explaining the documentation requirements and how the client or applicant may provide the documentation; or
 - iii) Referring the applicant or client to other agencies or organizations which may be able to provide further assistance.

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

8. Individuals Requiring Additional Assistance

- a. The eligibility site shall provide additional assistance beyond the level described in 8.100.3.H.7 to applicants and clients in obtaining the required citizenship and identity documentation if the client or applicant:
 - i) Is unable to comply with the requirements due to physical or mental impairments or homelessness; and
 - ii) The individual lacks a guardian or representative who can provide assistance.
- b. Examples of additional assistance include, but are not limited to:
 - i) Contacting any known family members who may have the required documentation;
 - ii) Contacting any known current or past health care providers who may have the required documentation; or
 - iii) Contacting other social services agencies that are known to have provided assistance to the individual.
- c. The eligibility site shall document its efforts to provide additional assistance to the client or applicant. Such documentation shall be subject to the record retention requirements described in 8.100.3.H.5.a.

9. Reasonable Opportunity Period

- a. If a Medical Assistance applicant does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period. If the applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall not be terminated during the federal Coronavirus COVID-19 Public Health Emergency. Required documentation will be requested during the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable opportunity period will be given to request proper documentation from the member.
 - i) During the federal Coronavirus COVID-19 Public Health Emergency the Department will continue eligibility for all Medical Assistance categories, regardless of requested documentation and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.
- b. The reasonable opportunity period is 90 calendar days if unable to verify proof of citizenship/identity and applies to MAGI, Adult, and Buy-In Programs:
 - i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I, include the following:

<u>Commonly Used Program Name</u>	<u>Rule Citation</u>
Children's Medical Assistance	8.100.4.G.2

Parent and Caretaker Relative Medical Assistance	8.100.4.G.3
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Transitional Medical Assistance	8.100.4.I.1-5

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

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

10. Good Faith Effort

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

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

- i) Providing verbal or written statements describing the individual's effort at obtaining the required documentation;
- ii) Providing copies of emails, letters, applications, checks, receipts, or other materials sent or received in connection with a request for documentation; or
- iii) Providing verbal or written statements of the individuals' efforts at identifying people who could attest to the individual's citizenship or identity, if citizenship and/or identity are included in missing documentation.

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

8.100.3.I. Additional General Eligibility Requirements

1. Each person for whom Medical Assistance is being requested shall furnish a Social Security Number (SSN); or, if one has not been issued or is unknown, shall apply for the number and submit verification of the application, unless an exception below applies. The application for an SSN shall be documented in the case record by the eligibility site. Upon receipt of the assigned SSN, the client shall provide the number to the eligibility site. This requirement does not apply to those individuals who are not requesting Medical Assistance yet appear on the application, nor does it apply to individuals applying for emergency medical services, limited reproductive health services, or eligible newborns born to a Medical Assistance eligible mother.
 - a. An applicant's or client's refusal to furnish or apply for a Social Security Number affects the family's eligibility for assistance as follows:
 - i) that person cannot be determined eligible for the Medical Assistance Program; and/or
 - ii) if the person with no SSN or proof of application for SSN is the only dependent child on whose behalf assistance is requested or received, assistance shall be denied or terminated.
 - b. Exception: An individual who qualifies for any of the following exceptions must not be required to provide an SSN:
 - i.) The individual is not eligible to receive an SSN; or
 - ii) The individual does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or
 - iii) The individual refuses to obtain an SSN because of a well-established religious objection.
 - c. Due to the COVID-19 Public Health Emergency, the Department will accept self-attestations for SSN verification. At the end of the COVID-19 Public Health Emergency, verification for eligibility criteria will be required as specified prior to the public health emergency.
2. A person who is applying for or receiving Medical Assistance shall assign to the State all rights against any other person (including but not limited to the sponsor of an alien) for medical support or payments for medical expenses paid on the applicant's or client's behalf or on the behalf of any other person for whom application is made or assistance is received.

All appropriate clients of the Medical Assistance Program shall have the option to be referred for child support enforcement services using the form as specified by the Department.
3. A person who is applying for or receiving Medical Assistance shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources are any health coverage or insurance other than the Medical Assistance Program. A client's refusal to supply information regarding third party resources may result in loss of Medical Assistance Program eligibility.
4. A person who is eligible for Medical Assistance shall be free to choose any qualified and approved participating institution, agency, or person offering care and services which are benefits of the program unless that person is enrolled in a managed care program operating under Federal waiver authority.

8.100.3.J. Supplemental Security Income (SSI) And Aid To The Needy Disabled (AND) Recipients

1. Persons who may be eligible for benefits under either MAGI Medical Assistance or SSI:
 - a. shall be advised of the benefits available under each program;
 - b. may apply for a determination of eligibility under either or both programs;
 - c. have the option to receive benefits under the program of their choice, but may not receive benefits under both programs at the same time; and
 - d. may change their selection if their circumstances change or if they decide later that it would be more advantageous to receive benefits from the other program.
2. Any family member who is receiving financial assistance from SSI or OAP-A is not considered a member of the Medical Assistance required household, is not counted as a member of the household, and the individual's income and resources are disregarded in making the determination of need for Medical Assistance.
 - a. Exception: For MAGI Medical Assistance a family member who is receiving SSI, when appropriate can be counted as a member of the household and their income when appropriate can be considered in making the determination of eligibility for MAGI Medical Assistance. For treatment of income and household construction for MAGI Medical Assistance cases, see section 8.100.4.
3. An individual receiving Aid to the Needy Disabled (AND) may also receive MAGI Medical Assistance, if the recipient meets the eligibility requirements for MAGI Medical Assistance. For these individuals, eligibility sites shall not include the applicant's AND payment when calculating income to determine the household's financial eligibility for MAGI Medical Assistance.

8.100.3.K. Consideration of Income

1. Income or resources of an alien sponsor or an alien sponsor's spouse shall be countable to the sponsored alien effective December 19, 1997. Forms used prior to December 19, 1997, including but not limited to forms I-134 or I-136 are legally unenforceable affidavits of support. The attribution of the income and resources of the sponsor and the sponsor's spouse to the alien will continue until the alien becomes a U.S. citizen or has worked or can be credited with 40 qualifying quarters of work, provided that an alien crediting the quarters to the applicant/client has not received any public benefit during any creditable quarter for any period after December 31, 1996.
 - a. Exception: When the sponsored alien is a pregnant woman or a child the income or resources of an alien sponsor or an alien sponsor's spouse will not be countable to the sponsored alien.
2. Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.
3. Earned income is payment in cash or in kind for services performed as an employee or from self-employment.
4. Earned in kind income shall be income produced as a result of the performance of services by the applicant/client, for which he/she is compensated in shelter or other items in lieu of wages.

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5. Received means “actually” received or legally becomes available, whichever occurs first; the point at which the income first is available to the individual for use. For example, interest income on a savings account is counted when it is credited to the account.
 6. All Home Care Allowance (HCA) income paid to a Medical Assistance applicant or member by the HCA recipient to provide home care services is countable earned income.
 7. An applicant or member who is a live-In home care provider to a care recipient receiving a Difficulty of Care Payment and who is being determined for a MAGI Medical Assistance program, must meet the following requirements for Difficulty of Care payments to be excluded as countable income:
 - a. The care provider receiving payments for personal care or supportive services provided to a care recipient must live full-time in the same home with the care recipient; and
 - b. The care recipient must either
 - i) receiving personal care or supportive services must be enrolled in Long Term Service Supports (LTSS), with additional services through a Home-Based Services (HCBS) waiver program; or
 - ii) The care recipient must be enrolled in the Buy-In Program for Working Adults with Disabilities, and receive additional services through the Home and Community Based Services (HCBS) waiver program.
 - c. Exception: Difficulty of Care Payments are not excluded if the payments are for more than 10 qualified foster individuals under the age of 19 or 5 qualified foster individuals who are over the age of 19
 8. Participation in the Workforce Investment Act (WIA) affects eligibility for Medical Assistance as follows:
 - a. Wages derived from participation in a program carried out under WIA (work experience or on-the-job training) and paid to a caretaker relative is considered countable earned income.
 - b. Training allowances granted by WIA to a dependent child or a caretaker relative of a dependent child to participate in a training program is exempt.
 - c. Wages derived from participation in a program carried out the under Workforce Investment Act (WIA) and paid to any dependent child who is applying for or receiving Medical Assistance are exempt in determining eligibility for a period not to exceed six months in each calendar year.
 9. An individual involved in a profit-making activity as a sole proprietor, partner in a partnership, independent contractor, or consultant shall be classified as self-employed.
 - a. To determine the net profit of a self-employed applicant/client deduct the cost of doing business from the gross income. These business expenses include, but are not limited to:
 - i) the rent of business premises,
 - ii) wholesale cost of merchandise,
 - iii) utilities,
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- iv) taxes,
 - v) labor, and
 - vi) upkeep of necessary equipment.
 - b. The following are not allowed as business expenses:
 - i) Depreciation of equipment;
 - 1) Exception: For the purpose of calculating MAGI-based income, depreciation of equipment is an allowable business expense if the equipment is not used for capital improvements.
 - ii) The cost of and payment on the principal of loans for capital asset or durable goods;
 - iii) Personal expenses such as personal income tax payments, lunches, and transportation to and from work.
 - c. Appropriate allowances for cost of doing business for Medical Assistance clients who are licensed, certified or approved day care providers are (1) \$ 55 for the first child for whom day care is provided, and (2) \$ 22 for each additional child. If the client can document a cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.
 - d. When determining self-employment expenses and distinguishing personal expenses from business expenses it is a requirement to only allow the percentage of the expense that is business related.
10. Self-employment income includes, but is not limited to, the following:
- a. Farm income - shall be considered as income in the month it is received. When an individual ceases to farm the land, the self-employment deductions are no longer allowable.
 - b. Rental income - shall be considered as self-employment income only if the Medical Assistance client actively manages the property at least an average of 20 hours per week.
 - c. Board (to provide a person with regular meals only) payment shall be considered earned income in the month received to the extent that the board payment exceeds the maximum food stamp allotment for one-person household per boarder and other documentable expenses directly related to the provision of board.
 - d. Room (to provide a person with lodging only) payments shall be considered earned income in the month received to the extent that the room payment exceeds documentable expenses directly related to the provision of the room.
 - e. Room and board payments shall be considered earned income in the month received to the extent that the payment for room and board exceeds the food stamp allotment for a one-person household per room and boarder and documentable expenses directly related to the provision of room and board.
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11. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes, but is not limited to, the following:
 - a. Pensions and other period payments, such as:
 - i) Private pensions or disability benefits
 - 1) Exception: Refer to section 8.100.4 for treatment of private disability benefits for MAGI Medical Assistance.
 - ii) Social Security benefits (Retirement, survivors, and disability)
 - iii) Workers' Compensation payments
 - iv) Railroad retirement annuities
 - v) Unemployment insurance payments
 - vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).
 - vii) Alimony and support payments
 - viii) Interest, dividends and certain royalties on countable resources
12. For all Medical Assistance categories, the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan (ARP) Act Recovery Rebate, known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.
13. Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra \$600.00 a week for qualifying individuals, is exempt as countable unearned income for all Medical Assistance categories.
14. Federal Income Tax refunds, Earned Income Tax Credit payments, or Child Tax Credits, are exempt from consideration as income.

8.100.3.L Consideration of Resources

Consideration of Resources

1. Resources are counted in determining eligibility for the Aged, Blind and Disabled, and Long-Term Care institutionalized and Home and Community Based Services categories of Medical Assistance. Resources are not counted in determining eligibility for the MAGI Medical Assistance programs, the Medicaid Buy-in Program for Working Adults with Disabilities, or the Medicaid Buy-In Program for Children with Disabilities, See section 8.100.5 for rules regarding consideration of resources.
2. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan (ARP) Act Recovery Rebate known as COVID-19 Economic Stimulus, shall be an exempt resource for the first 12 months following the receipt of the Recovery Rebate, after which the remaining balance will be considered a countable resource for all Medical Assistance categories which include an asset test.

8.100.3.M. Federal Financial Participation (FFP)

1. The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medical Assistance Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons.
2. The SISC codes are as follows:
 - a. Code A - for institutionalized persons whose income is under 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; and non-institutionalized persons receiving Home and Community Based Services, whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; code A signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments;
 - b. Code B - for persons eligible to receive financial assistance under SSI; persons eligible to receive financial assistance under OAP "A" who, except for the level of their income, would be eligible for an SSI payment; persons who are receiving mandatory State supplementary payments; and persons who continue to be eligible for Medical Assistance after disregarding certain Social Security increases; code B signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program and also for SMIB premium payments;
 - c. Code C - for persons eligible to receive assistance under OAP "A", OAP "B", or OAP Refugee Assistance for financial assistance only; who do not receive SSI payment and do not otherwise qualify under SISC code B as described in item B. above; code C signifies that no FFP is available in Medical Assistance program expenditures.
 - d. Code D1 – for persons eligible to receive assistance under AwDC from program implementation through 12/31/2013; Code D1 signifies 50% FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program.
 - e. Code E1 - for persons eligible to receive assistance under the Medicaid Buy-In Program for Working Adults with Disabilities and whose annual adjusted gross income, as defined under IRS statute, is less than or equal to 450% of FPL – after SSI earned income deductions; as well as for children eligible to receive assistance under the Medicaid Buy-In Program for Children with Disabilities and whose household income is less than or equal to 300% of FPL after income disregards. Code E1 signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments.
3. Recipients of financial assistance under State AND, State AB, or OAP "C" are not automatically eligible for Medical Assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.3.N. 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 Single Streamlined Application and the Application for Public 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 Single Streamlined Application and the Application for Public 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.
3. Eligibility site staff may release a client's Medical Assistance state identification number and approval eligibility spans to a Medical Assistance provider for billing purposes.

Eligibility site staff may inform a Medical Assistance provider that an application has been denied but may not inform them of the reason why.
4. Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State and the eligibility site.
5. The eligibility site must obtain permission from a family, individual, or authorized representative, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of Medical Assistance payment. This permission must be obtained unless the request is from State authorities, federal authorities, or State contractors acting within the scope of their contract. If, because of an emergency situation, time does not permit obtaining consent before release, the eligibility site must notify the family or individual immediately after supplying the information.
6. The eligibility site policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials. If a court issues a subpoena for a case record or for any eligibility site representative to testify concerning an applicant or recipient, the eligibility site must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.
7. The following types of information are confidential and shall be safeguarded:
 - a. Names and addresses of applicants for and recipients of the Medical Assistance Program;
 - b. Medical services provided;
 - c. Social and economic conditions or circumstances;
 - d. Agency evaluation of personal information;
 - e. Medical data, including diagnosis and past history of disease or disability;
 - f. All information obtained through the Income and Eligibility Verification System (IEVS), the Federal Data Services Hub (FDSH), Equifax The Work Number (TWN), Colorado Department of Labor and Employment, SSA or Internal Revenue Service;
 - g. Any information received in connection with identification of legally liable third party resources;

- h. Any information received for verifying income and resources if applicable, or other eligibility and the amount of Medical Assistance payments;
 - i. Social Security Numbers.
- 8. The confidential information listed above may be released to persons outside the eligibility site only as follows:
 - a. In response to a valid subpoena or court order;
 - b. To State or Federal auditors, investigators or others designated by the Federal or State departments on a need-to-know basis;
 - c. To individuals executing Income and Eligibility Verification System;
 - d. Child Support enforcement officials;
 - e. To a recipient or applicant themselves or their designated representative.
 - f. To a Long Term Care institution on the AP-5615 form.
- 9. The applicant/recipient may give a formal written release for disclosure of information to other agencies, such as hospitals, or the permission may be implied by the action of the other agency in rendering service to the client. Before information is released, the eligibility site should be reasonably certain the confidential nature of information will be preserved, the information will be used only for purposes related to the function of the inquiring agency, and the standards of protection established by the inquiring agency are equal to those established by the State Department. If the standards for protection of information are unknown, a written consent from the recipient shall be obtained.

8.100.3.O. Protection Against Discrimination

- 1. Eligibility sites are to administer the Medical Assistance Program in such a manner that no person will, on the basis of race, color, sex, age, religion, political belief, national origin, or handicap, be excluded from participation, be denied any aid, care, services, or other benefits of, or be otherwise subjected to discrimination in such program.
- 2. The eligibility site shall not, directly or through contractual or other arrangements, on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap:
 - a. Provide aid, care, services, or other benefits to an individual which is different, or provided in a different manner, from that of others;
 - b. Subject an individual to segregation barriers or separate treatment in any manner related to access to or receipt of assistance, care services, or other benefits;
 - c. Restrict an individual in any way in the enjoyment or any advantage or privilege enjoyed by others receiving aid, care, services, or other benefits provided under the Medical Assistance Program;
 - d. Treat an individual differently from others in determining whether he/she satisfies any eligibility or other requirements or conditions which individuals shall meet in order to receive aid, care, services, or other benefits provided under the Medical Assistance Programs;

- e. Deny an individual an opportunity to participate in programs of assistance through the provision of services or otherwise, or afford him/her an opportunity to do so which is different from that afforded others under the Medical Assistance Program.
- 3. No distinction on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap is permitted in relation to the use of physical facilities, intake and application procedures, caseload assignments, determination of eligibility, and the amount and type of benefits extended by the eligibility site to Medical Assistance recipients.
- 4. An individual who believes he/she is being discriminated against may file a complaint with the eligibility site, the Department, or directly with the Federal government. When a complaint is filed with the eligibility site, the county director is responsible for an immediate investigation of the matter and taking necessary corrective action to eliminate any discriminatory activities found. If such activities are not found, the individual is given an explanation. If the person is not satisfied, he/she is requested to direct his/her complaint, in writing, to the State Department, Complaint Section, which will be responsible for further investigation and other necessary action consistent with the provisions of Title VI of the 1963 Civil Rights Act, as amended 42 U.S.C. §2000e et seq. and section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. §791.

8.100.3.P. Redetermination of Eligibility

- 1. "Redetermination of eligibility" means a case review and necessary verification to determine whether the Medical Assistance Program member continues to be eligible to receive Medical Assistance.

"Reconsideration period" means the 90-day period following termination of eligibility.

Beginning on the case approval date, a redetermination shall be accomplished at least every 12 months for Title XIX Medical Assistance only cases. An eligibility site may redetermine eligibility through telephone, mail, or online electronically means.

- 2. The eligibility site shall promptly redetermine eligibility when:
 - a. it receives and verifies information which indicates a change in a member's circumstances which may affect continued eligibility for Medical Assistance; or
 - b. it receives direction to do so from the Department.

The eligibility site shall redetermine eligibility according to timelines defined by the Department.

- 3. Ex Parte Review: A redetermination form will not be sent to the member if all current eligibility requirements can be verified by reviewing information from another assistance program or if this information can be verified through an electronic verification system – this process is referenced as Ex Parte Review. The use of telephonic or electronic redeterminations shall be noted in the case record. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to the redetermination month, and all other eligibility requirements are met, then an approval notice will be sent for all eligible members of the household who are requesting assistance. This approval notice shall include directions on how to view the information used to determine eligibility.

4. If all required information is not available and/or the information received does not support a finding of eligibility, a redetermination form will be issued to the household at least 30 days prior to the end of the eligibility period. The redetermination form shall be prepopulated with the current information on file and sent to the household at least 30 days prior to the redetermination period ending. As part of the ex parte review, the member will be informed of any verification needed to determine eligibility.

The redetermination form shall direct members to verify that the information provided is accurate or to report any changes to the information. Members must complete and return the redetermination with necessary verifications and the signature form. If a member fails to sign the signature form or comply with any of these requirements, the member will be terminated from the program for failure to complete the redetermination process.

The following procedures relate to mail-out redetermination:

- a. A Redetermination Form shall be mailed to the member together with any other forms to be completed;
- b. Members shall provide requested forms, verifications and information to the eligibility site within 10 working days;
- c. When the member 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 eligibility site shall either assist the member 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 thirty days shall be allowed. The action of the eligibility site in assistance or referral shall be recorded in the case record and CBMS case comments.
- d. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the individual.
- e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the individual. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.
- f. Members who return properly completed redetermination forms and requested information during the reconsideration period shall not be required to submit a new application for eligibility. If redetermination forms and requested information are not returned within 90 days after termination, the member must submit a new application to obtain enrollment in the program.
- g. For individuals who are determined to be eligible for Medical Assistance within the reconsideration period, the effective date of coverage will be the first day of the month in which the redetermination form was returned. If the member has a gap in coverage due to submitting the redetermination within the reconsideration period, the member can request up to three months in retroactive coverage.

5. When the redetermination verification information is received by the eligibility site, it shall be date stamped. Within fifteen 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 at that time. Verifications shall be documented in the case file and CBMS case comments. 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 to the member with a letter specifying the items that require completion. The member shall return the completed request form to the eligibility site no later than ten working days.;
 - b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance member shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department.
6. Due to the federal Coronavirus COVID-19 Public Health Emergency, the Department will continue eligibility for all Medical Assistance categories, regardless of a redetermination and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.

8.100.3.Q. Continuous Eligibility (CE) for Medical Assistance programs

1. Continuous eligibility applies to children under age 19, who through an eligibility determination, reassessment or redetermination, are found eligible for a Medical Assistance program. The continuous eligibility period may last for up to 12 months.
 - a. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.
 - i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, any changes to income or other factors made to the child's case during the 14-day no fault period may change his or her eligibility for Medical Assistance.
 - b. Exception: A child's continuous eligibility period will end effective the earliest possible month if any of the following occur:
 - i) Child is deceased
 - ii) Becomes an inmate of a public institution
 - iii) The child is no longer part of the Medical Assistance required household
 - iv) Is no longer a Colorado resident
 - v) Is unable to be located based on evidence or reasonable assumption
 - vi) Requests to be withdrawn from continuous eligibility
 - vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.G.3 and 8.100.3.H.9

- viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 30-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.
- 2. The continuous eligibility period will begin on the first day of the month the application is received or from the date all criteria is met. Continuous eligibility is applicable to children enrolled in the following Medical Assistance programs:
 - a. MAGI-Medical Assistance, program as specified in section 8.100.4.G.2
 - b. SSI Mandatory, as specified in section 8.100.6.C
 - i.) When a child is no longer eligible for SSI Mandatory they will be categorized as eligible within the MAGI-Child category for the remainder of the eligibility period.
 - c. Long- Term Care services
 - i.) When a child is no longer eligible for Long-Term Care services they will be categorized as eligible within the MAGI- Child category for the remainder of the eligibility period.
 - d. Medicaid Buy-In program specified in section 8.100.6.Q
 - i) Exception: Enrollment will be discontinued if there is a failure to pay premiums
 - e. Pickle
 - f. Disabled Adult Child DAC)
- 3. Children, under the age of 19, no longer enrolled in Foster Care Medicaid will be eligible for the MAGI-Medical Assistance program. The continuous eligibility period will begin the month the child is no longer enrolled in Foster Care Medicaid as long as they meet one of the following conditions:
 - a. Begin living with other Relatives
 - b. Are reunited with Parents
 - c. Have received guardianship

8.100.4 MAGI Medical Assistance Eligibility [Eff. 01/01/2014]

8.100.4.A. MAGI Application Requirements

- 1. Persons requesting a MAGI Medical Assistance category need only to complete the Single Streamlined Application.
- 2. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults may apply for Medical Assistance at sites other than the County Department of Social Services, including eligibility sites and Certified Application Assistance Sites (CAAS). The Department shall approve these sites to receive and initially process these applications. The application used shall be the Single Streamlined 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 (designated by the Department) by:
 - a. Copying the page of the Single Streamlined 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; or by:
 - b. Means of secure, electronic data transfer approved by the Department

8.100.4.B. MAGI Category Verification Requirements

1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:
 - a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.
 - i) Due to the COVID-19 Public Health Emergency, at the time of application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the federally-declared COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.
 - 1) Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet federal and state citizenship and immigration status requirements, are only eligible to receive emergency medical services.
 - b. Verification of citizenship and identity as outlined in section 8.100.3.H under Citizenship and Identity Documentation Requirements.
 - c. Earned Income: Income -may be self-attested by an applicant or member and verified through an electronic data source. Individuals who provide self-attestation of income - may provide a SSN for electronic wage verification purposes.

If the self-attested earned income cannot be verified electronically, due to a missing SSN, the applicant must provide documentation of income. Earned income must be verified by wage stubs, tax documents, written documentation from the employer stating the employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

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.

Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded.

- d. Unearned income: Unearned income can be self-attested by an applicant. Certain types of unearned income, such as unemployment and survivor benefits may be verified through electronic data sources. Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded, for all people whose eligibility was maintained during the emergency declaration, for these individuals to maintain eligibility.
 - e. Verification of Legal Immigrant Status: Immigration status may be self-declared by an applicant applying for Medical Assistance, to determine eligibility for full Medical Assistance benefits. This declaration of legal immigration status will be verified through the Verify Lawful Presence (VLP) interface. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) program to verify legal immigration status. See section 8.100.3.G for a description of the VLP interface. If status cannot be verified, or if the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.
- 2. Additional Verification: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.
 - 3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.
 - 4. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.
 - 5. The criteria of age and relationship may be declared by the client unless questionable. If questionable, these criteria may be established with information provided from:
 - a. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or
 - b. records or statements from sources such as: a court, school, government agency, hospital, or physician.
 - 6. Establishing that a dependent child meets the eligibility criteria of:
 - a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;
 - b. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.

8.100.4.C. MAGI Methodology for Income Calculation

1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from all derived sources, The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:
 - a. Earned Income:
 - i) Wages, salaries, tips;
 - ii) Gross income derived from business;
 - iii) Gains derived from dealings in property;
 - iv) Distributive share of partnership gross income (not a limited partner);
 - v) Compensation for services, including fees, commissions, fringe benefits and similar items; and
 - vi) Taxable private disability income.
 - b. Unearned Income:
 - i) Interest (includes tax exempt interest);
 - ii) Rents;
 - iii) Royalties;
 - iv) Dividends;
 - v) Alimony received counts as unearned income if the divorce or legal separation is executed on or before December 31, 2018. Alimony received will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019;
 - vi) Pensions and annuities;
 - vii) Income from life insurance and endowment contracts;
 - viii) Income from discharge of indebtedness;
 - ix) Income in respect of a decedent;
 - x) Income from an interest in an estate or trust;
 - xi) Social Security (SSA) income;

- xii) Distributive share of partnership gross income (limited partner);
- xiii) Capital gains;
- xiv) Lottery/Gambling Winnings;
 - 1) If less than \$79,999 winnings are counted as income in the month received.
 - 2) If over \$79,999 but less than \$89,999 it is counted as income and it is divided equally between two months.
 - 3) For every additional \$10,000 over \$89,999, one month is added, and divided equally and counted as income for each month.
 - 4) Lottery/gambling winnings of an individual will continue to count only in the month received in determining the eligibility for the members of their household.
 - 5) An applicant/member may request a hardship exemption when an application is denied or enrollment is terminated due to Lottery/Gambling winnings.
 - a. The applicant/member must demonstrate a severe medical or financial hardship.
 - b. The applicant/member must provide a written request and documentation to their County Department of Human Services, within 30 calendar days from the date of their denial or termination notice.
- xv) Student loan debt that is discharged, forgiven, or cancelled is treated as taxable income to the borrower, with certain exceptions.
 - 1) This debt will not be considered income for the borrower in the event of death or permanent and total disability of the student (the borrower and the student may or may not be the same person) if discharged during tax years 2018 through 2025.
 - 2) At the Departments discretion, this debt will not be considered countable income for the borrower if discharged, forgiven, or cancelled under programs which include, but not limited to:
 - a) Public Service loan forgiveness;
 - b) Teacher loan forgiveness;
 - c) Healthcare loan forgiveness; and
 - d) Closed School discharge.
- c. Additional Income: In addition to the types of income identified in section 8.100.4.C.1.a-b., the following income is included in the MAGI calculation.
 - i) Any tax exempt interest income.

- ii) Untaxed foreign wages and salaries.
- iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits).
- d. The following are Income exclusions:
 - i) An amount received as a lump sum is counted as income only in the month received;
 - ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses;
 - iii) Child support received;
 - iv) Worker's Compensation;
 - v) Supplemental Security Income (SSI);
 - vi) Veteran's Benefits;
 - vii) The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan (ARP) Act Recovery Rebate, also known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.
 - viii) Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra \$600.00 a week for qualified individuals, is exempt as countable unearned income.
 - ix) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.
- e. Allowable Deductions: For an in-depth treatment of allowable deductions from gross income, refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

The following deductions may be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income (AGI) including (but not limited to):

- i) Student loan interest deductions;
- ii) Certain Self-employment expenses SEP, SIMPLE and qualified plans, and health insurance deductions;
- iii) Deductible part of self-employment tax;

- iv) Health savings account deduction;
 - v) Certain business expenses of reservists, performing artist, and fee-basis government officials;
 - vi) Reimbursed expenses of employees;
 - vii) Moving expenses for active duty military who are moving due to a permanent change of station;
 - viii) IRA deduction: Regular Individual Retirement Account (IRA) contributions claimed on a federal income tax return and which does not exceed the IRA contributions limits; (Pre-tax contributions to a 401(k) or 403(b) retirement plan are excluded from earned income);
 - ix) Penalty on early withdrawal of savings;
 - x) Domestic production activities deduction;
 - xi) Alimony paid may be deducted only if the divorce or legal separation is executed on or before December 31, 2018. It cannot be deducted if the divorce or separation is modified or executed on or after January 1, 20019;
 - xii) Certain educator expenses;
 - xiii) Certain pre-tax contributions;
 - xiv) Net operating losses; and
 - xv) Capital losses.
- f. Income of children and tax dependents:
- i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income above the tax filing threshold..
 - 1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a child is required to file taxes.
 - ii) The income of a person, other than a child or spouse, who expects to be claimed as a tax dependent will not be included in the household income of the taxpayer unless that tax dependent has income above the tax filing threshold.
 - 1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a tax dependent is required to file taxes.
 - ii) The income of a child or tax dependent who does not live with their natural, adopted, or step parent will always count towards the determination of their own eligibility, even if the child's or tax dependent's income is below the tax filing threshold.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive a reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing supporting documentation within the Reasonable Opportunity Period of 30 calendar days.
 - a. Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:
 - i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable MAGI Medical Assistance program income standard, that income shall be determined reasonably compatible and the applicant shall be determined eligible.
 - ii) If the amount attested by the applicant is below the applicable MAGI Medical Assistance program income standard, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.
 - iii) If both amounts are above the applicable MAGI Medical Assistance program income standard the income shall be determined reasonably compatible, and the applicant shall continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.
 - b. If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy shall be requested during the federal Coronavirus COVID-19 Public Health Emergency. If the applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall not be terminated during the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable opportunity period will be given to request proper documentation from the member.
 - i) During the federal Coronavirus COVID-19 Public Health Emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.
3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application shall be sufficient verification of earnings, unless questionable.
4. Budget Periods for MAGI-based Income determination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.
 - a. Applicants who are found financially ineligible based on current or previous monthly household income and family size, and whose household has earned income from self-employment, seasonal employment, and/or commission-based employment, shall have their financial eligibility determined using annualized self-employment, seasonal employment, and commission-based employment income.

5. If an applicant does not meet the financial eligibility requirements for Medical Assistance based on MAGI, but meets all other eligibility requirements, the applicant shall be found eligible for MAGI Medical Assistance if the applicant's income, as calculated using the methodology for determining eligibility for Advanced Premium Tax Credits or Cost Sharing Reductions through the marketplace, is below 100% of the federal poverty level.

8.100.4.D. Income Disregard

1. An income disregard equivalent to five percentage points of the Federal Poverty Level for the applicable family size will be subtracted from MAGI-based income.
 - a. If an individual's MAGI-based countable income is above the income threshold for the applicable MAGI program under title XIX (Medicaid) or title XXI (CHP+) of the Social Security Act, the five percent (5%) disregard will be applied for each qualifying MAGI program as the last step to determine eligibility.
 - b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be applied to determine eligibility.

8.100.4.E. Determining MAGI Household Composition.

1. MAGI household composition is similar to, but not necessarily the same as a tax household. To determine MAGI household composition, the individual's relationship to the tax filer must be established as declared on the Single Streamlined Application.
 - a. In the case of an applicant who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and does not expect to be claimed as a tax dependent by anyone else, then the applicant's MAGI household shall consist of the following:
 - i) The Tax-Filer;
 - ii) The Tax-Filer's spouse if living in the home;
 - iii) All persons whom the Tax-Filer expects to claim as a tax dependent on their personal income tax return
 - b. In the case of an applicant who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the applicant's MAGI household shall be:
 - i) The Tax Dependent;
 - ii) The Tax-Filer and their spouse if living in the home;
 - iii) The Tax-Filer's other tax dependents;
 - iv) The Tax Dependent's spouse, if living with the Tax Dependent.
 - c. The MAGI household of an applicant who expects to be claimed as a tax dependent is as outlined in 8.100.4.E.b above, except in the following circumstances:
 - i) The applicant expects to be claimed as a tax dependent by someone other than a spouse, biological, adoptive or step parent.

- ii) The applicant is a child under 19 who is expected to be claimed by one parent as a tax dependent and is living with both parents, but the parents do not expect to file a joint tax return.
 - iii) The applicant is a child under 19 and who expects to be claimed as a tax dependent by anon-custodial parent.
- d. If the applicant meets one of the exceptions in 8.100.4.E.c above or is a non-filer, household composition shall be determined using the following non-filer rules and the applicant's household shall consist of the following:
 - i) The applicant;
 - ii) The applicant's spouse who lives in the household;
 - iii) The applicant's natural, adopted, and step children under the age of 19, who live in the household; and
 - iv) In the case of applicants under the age of 19, the applicant's natural, adoptive, and step parents and natural, adoptive, and step siblings under age 19, who live in the household.
- 2. When a household includes a pregnant woman, regardless of the Medical Assistance category, the pregnant woman is counted as herself plus the number of children she is expected to deliver.
- 3. When a household includes an individual applying for the limited Family Planning Medical Assistance category, the individual is counted as a household of two in addition to any other household members.
- 4. Married couples living together will each be included in the other's MAGI household regardless of whether or not they expect to file taxes jointly, separately or if one expects to be claimed as a tax dependent of the other.
- 5. If a child is claimed as a tax dependent by both parents who are married and who will file taxes jointly but one parent lives outside of the household due to separation or pending divorce, the child's household composition is determined by non-filer rules. The parent living outside of the household will not be counted as part of the household.
- 6. An individual who is both a tax dependent and a tax filer will be considered a tax dependent for the purpose of determining eligibility for Medical Assistance.

8.100.4.F. MAGI Category Presumptive Eligibility

- 1. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medical Assistance presumptive eligibility sites. A child under the age of 19 may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites. Presumptive eligibility is available to applicants for limited family planning who are not pregnant. There are no restrictions of age or gender under the limited family planning presumptive eligibility category.
- 2. To be eligible for presumptive eligibility:

- a. a pregnant woman shall have an attested pregnancy, declare that her household's income shall not exceed 195% of the federal poverty level (MAGI-equivalent) and declare that she is a United States citizen or a lawfully residing immigrant. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website
 - b. a child under the age of 19 shall have a declared household income that does not exceed 133% of federal poverty level (MAGI-equivalent) and declare that the child is a United States citizen or a documented immigrant.
 - c. To qualify for limited family planning presumptive eligibility, an applicant must have declared household income greater than 133% but not exceeding 260% of the federal poverty level. The applicant cannot be eligible for a Medicaid eligibility category that provides full coverage. The applicant must declare they are a United States citizen or a lawfully residing immigrant. An applicant applying for limited family planning presumptive eligibility will be counted individually as a household member of two.
3. Presumptive eligibility sites shall be certified by the Department to make presumptive eligibility determinations. Sites shall be re-certified by the Department every 2 years to remain approved presumptive eligibility sites.
4. The presumptive eligibility site shall forward the application to the county within five business days.
5. The presumptive eligibility period begins on the date the applicant(s) is determined eligible and ends with the day an eligibility determination for Medical Assistance is made for the applicant(s)
6. A presumptive eligible client may not appeal the end of a presumptive eligibility period.
7. Presumptively eligible women and Medical Assistance clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in the State Hearings section of this volume.

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.
2. Children applying for Medical Assistance whose total household income does not exceed 142% of the federal poverty level shall be determined financially eligible for Medical Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website.
 - a. Children are eligible for Children's MAGI Medical Assistance through the end of the month in which they turn 19 years old. After turning 19, the individual may be eligible for a different Medical Assistance category.
3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 68% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household.
 - a. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even if:

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- i) The child is under the jurisdiction of the court (for example, receiving probation services);
 - ii) Legal custody is held by an agency that does not have physical possession of the child;
 - iii) The child is in regular attendance at a school away from home;
 - iv) Either the child or the relative is away from the home to receive medical treatment;
 - v) Either the child or the relative is temporarily absent from the home;
 - vi) The child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.
 - 4. Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.
 - a. A dependent child living in the household of a parent or caretaker relative shall have minimum essential coverage, in order for the parent or caretaker relative to be eligible for Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is considered a dependent child.
 - b. Due to the COVID-19 Public Health Emergency an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection with COVID-19 may be eligible to receive services for COVID-19 testing only. To qualify for this limited benefit, the applicant must satisfy residency and immigration or citizenship status and not be enrolled in other health insurance.
 - 5. Pregnant Women whose household income does not exceed 195% of the federal poverty level (MAGI-equivalent) are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the 12th month following the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage will be provided regardless of changes in the woman's financial circumstances once the income verification requirements are met.
 - a. A pregnant women's eligibility period will end effective the earliest possible month, if the following occurs:
 - i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 30day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

6. A lawfully admitted non-citizen who is pregnant and who has been in the United States for less than five years is eligible for Medical Assistance if she meets all of the other eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-5 and 8.100.3.G.1.g.vi.1-15. This population is referenced as Legal Immigrant Prenatal.
7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as "Eligible Needy Newborn". This coverage also applies in instances where the mother received Medical Assistance to cover the child's birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.
 - a. To receive Medical Assistance under this category, the birth must be reported verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn
8. Applicants applying for Medical Assistance whose total household income is greater than 133% but does not exceed 260% of the federal poverty level shall be determined financially eligible for limited Family Planning Medical Assistance services. The applicant must satisfy residency and immigration or citizenship status to qualify for this limited benefit. The limited family planning services eligibility category has no age or gender restriction and is available for those not eligible for a Medicaid eligibility category that provides full coverage.

8.100.4.H. Needy Persons

1. Medical Assistance shall be provided to certain needy persons under 21 years of age, including the following:
 - a. Those receiving care in a Long Term Care Institution eligible for Medical Assistance reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement and whose household income is less than the MAGI needs standard for his/her family size when the client applies for assistance. Clients that are receiving benefits under this category and are still receiving active inpatient treatment in the facility at age 21 shall be eligible to age 22. This population is referenced as Psych <21.
 - b. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. A child shall be the responsibility of the county, even if the child may be in a medical institution at that time. See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR § 2509-1). 12 CCR § 2509-1 (2013) is hereby incorporated by reference. The incorporation of 12 CCR § 2509-1 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

- c. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.
 - d. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose household income is less than the MAGI needs standard for his/her family size.
 - e. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.
 - f. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medical Assistance for the child.
 - g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the date the individual attained 18 years of age or was emancipated. Eligibility shall be extended until the individual's 21st birthday for these individuals with the exception of those receiving subsidized adoption payments.
2. Medical Assistance shall be extended to certain needy persons until the end of the month of the individual's 26th birthday, including the following:
- a. Those individuals that were formerly in foster care under the responsibility of the State or Tribe on their 18th, 19th, 20th or up to their 21st birthday and were receiving Medical Assistance.
 - i) This extension does not apply to youth that are receiving subsidized adoption payments or
 - ii) To youth that are enrolled in mandatory Medical Assistance.
 - b) Former Foster Care youth are not subject to either an income or resource test.
 - c) Former Foster Care youth's newborn shall be considered a needy newborn.

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

1. Eligibility for Transitional Medical Assistance shall be granted for twelve months (beginning with the first month of ineligibility) to individuals who are no longer eligible for the Parent/Caretaker Relative category due to a change in income.

The extension shall be applied to individuals who:

- a. Were eligible for the Parent/Caretaker Relative category in at least three of the six months preceding the month in which the individual would have become ineligible, and

- b. Are no longer eligible for coverage under the Parent/Caretaker Relative category because of new or increased income from employment or hours of employment
 - i) At least one Parent/Caretaker Relative must continue to be employed and cannot terminate employment without good cause. This does not need to be the same person for the whole period the family is receiving Transitional Medical Assistance.
- 2. Any dependent child or Parent/Caretaker Relative who was or becomes part of the Medical Assistance household after the individual has begun receiving Transitional Medical Assistance is eligible for the remaining months of Transitional Medical Assistance.
 - a. A dependent child in the household who received Medical Assistance through continuous eligibility, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance.
 - b. An individual in the household who received Medical Assistance, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance
- 3. To become or remain eligible for Transitional Medical Assistance:
 - a. 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.
 - b. If health insurance is available from the employer to the employee, at no cost to the Medical Assistance recipient, the client shall enroll in the insurance program.
- 4. When Transitional Medical Assistance ends the case will be reassessed 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. Eligibility for Medical Assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for Medical Assistance due solely or partially to the receipt of support income, such as alimony. The extension shall be applied for a family which receives assistance under 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 meet all other eligibility criteria for Medical Assistance before the alimony income is applied.
 - a. Alimony received will be countable income only if the divorce or legal separation is executed on or before December 31, 2018. Alimony will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019.

8.100.4.J. Express Lane Eligibility

Express Lane Eligibility shall allow for automatic initiation of Medical Assistance enrollment by using available data and findings from other programs as listed below.

- 1. Free/Reduced Lunch Program
 - a. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district-

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- i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.
 - ii) Children who meet all necessary eligibility requirements as outlined in this volume shall be automatically enrolled.
 - iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity shall receive 90days of eligibility while awaiting this verification.
 - iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.
 - v) Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in this volume.
 - vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the Single Streamlined Application for Medical Assistance.
 - b. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district-
 - i) Families who are automatically enrolled Free/Reduced Lunch recipient children shall not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.
 - ii) These families must apply for Medical Assistance in order to give consent for request of benefits.
2. Direct Certification
- a. Individuals who have submitted a Food Assistance or Colorado Works application
 - i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.
 - ii) Children who meet all necessary eligibility requirements as outlined throughout 8.100.4 shall be automatically enrolled
 - iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.
 - iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.
 - v) Eligibility is based on income declared on the Food Assistance or Colorado Works application as well as eligibility requirements outlined throughout this volume.
 - vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility shall be evaluated using the Single Streamlined Application for Medical Assistance.

- vii) Individuals whose eligibility is not determined through Express Lane Eligibility can also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

8.100.5. Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan 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 Aged, Blind, and Disabled categories of assistance described in section 8.100.6. 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.
 - a. Applicants who apply for Long-Term Care Medical Assistance on the basis of disability or blindness, or who apply for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities without a current disability determination, shall complete a Medical Assistance disability determination application in addition to the required Single Streamlined Application. The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.
 - b. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded to 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.
 - c. For the Medicaid Buy-In Program for Working Adults with Disabilities, if an individual does not meet the Social Security Administration definition of disability, the state disability determination contractor can review the individual's circumstances to determine if the individual meets limited disability.
 - d. Due to the Coronavirus COVID-19 Public Health Emergency, if a person's existing disability determination has expired, the person shall remain enrolled in Medical Assistance until the emergency has ended and the state has processed the verification of eligibility, unless the individual requests a voluntary termination of eligibility.
2. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the Single Streamlined Application.

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals applying for Medical Assistance:
 - a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

- i) Due to the Coronavirus COVID-19 Public Health Emergency, at application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.
 - 1) Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet the federal and state criteria of citizenship and immigration status are only eligible to receive emergency medical services.
- b. Verification of citizenship and identity as outlined in the section 8.100.3.H under Citizenship and Identity Documentation Requirements.
- c. Earned income may be self-attested by an applicant or member and verified through an electronic data source through the IEVS, FDSH, or the TWN. Individuals who provide self-attestation of earned income may also provide a SSN for wage verification purposes. If the self-attested earned income cannot be verified electronically due to a missing SSN, the applicant must provide documentation of income. Verification of earned income must be provided in accordance to the requirements outlined in 8.100.4.B.1.c

When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive a reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation within the Reasonable Opportunity Period (ROP) of 30 calendar days.

Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

- i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable Medical Assistance program income standard, that income shall be determined reasonably compatible and the applicant shall be determined eligible.
- ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.
- iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.

If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy will not be requested during the federal COVID-19 Public Health Emergency. If the applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall not be terminated during the federal Coronavirus COVID-19 Public Health Emergency. When the federal Public Health Emergency has ended, a reasonable opportunity period will be given to request proper documentation from the member.

- iv) During the federal Coronavirus COVID-19 Public Health Emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.

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 Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

As of CBMS implementation, 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. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. 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.

- v) During the federal COVID-19 Public Health Emergency, all earned income and self-employment may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.
- d. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.
 - i) During the federal COVID-19 Public Health Emergency, all unearned income may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.
 - e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

Resource information that is verified through an electronic data source, such as the Asset Verification Program, shall be a valid verification. Supplemental physical verifications for the same resource is not required unless further information is needed for clarification.

- i) During the federal COVID-19 Public Health Emergency, all resources may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified resources shall be provided.
- f. 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.

- g. Additional verification-If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.
- h. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

8.100.5.C. Effective Date of Eligibility

1. Eligibility for the Aged, Blind and Disabled categories shall be approved effective on the later of:
 - a. The first day of the month of the Single Streamlined Application for Medical Assistance; or
 - b. The first day of the month the person becomes eligible for Medical Assistance.
2. The date that eligibility begins for Long-Term Care Medical Assistance is defined in section 8.100.7.A and B.
3. For the Medicaid Buy-In Program for Children with Disabilities, any child who is determined to be eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits during the entire month.
4. Clients applying for Medical Assistance under the Aged, Blind and Disabled category shall be reviewed for retroactive eligibility as described at 8.100.3.E. When reviewing for retroactive eligibility for an individual who is SSI eligible or applied and became SSI eligible in each of the retroactive months, the applicant must:
 - a. Be aged at least 65 years; or
 - b. Meet the Social Security Administration definition of disability by:
 - i) Being approved as eligible to receive either SSI or SSDI, on or prior to the date of a medical service; or
 - ii) Having a disability onset date determined on or prior to the date of a medical service; and
 - c. Meet the financial requirements as described at 8.100.5.E.

8.100.5.D. Medical Assistance Estate Recovery Program

1. The eligibility site shall provide written information from the Department to the following people explaining the provisions of the Medical Assistance Estate Recovery Program and how those provisions may pertain to the applicant/client:
 - a. Applicants age 55 and older who are institutionalized.
 - b. Applicants/clients who will turn age 55 before their next eligibility re-determination who are institutionalized.
 - c. Clients age 55 and older who are approved for admittance to an institution

8.100.5.E. Availability of Resources and Income

Consistent with the legislative declaration outlined at C.R.S. § 25.5-4-300.4, Medicaid should be the payer of last resort for payment of medically necessary goods and services furnished to clients. All other sources of payment, including an individual's own countable income and resources, should be utilized to the fullest extent possible before Medicaid is accessed.

1. Income, which includes earned and unearned income, shall be calculated on a monthly basis regardless of whether it is received annually, semi-annually, quarterly or weekly.
2. For married couples, the income and resources of both spouses are counted in determining eligibility for either or both spouses. Refer to section 8.100.7.C for exceptions.
3. Resources and income shall be considered available when actually available; or, shall be deemed available when all of the following apply to the resources or income of the individual or individual's spouse:
 - a. has any ownership interest in income or resources or equity value of a resource;
 - b. has the right, authority, or power to convert the resource or income to cash or to cause the resource or income to be converted to cash; and
 - c. is not legally restricted from using the resource or income for his or her support and maintenance.
4. Resources and income shall not be considered unavailable merely because the individual or individual's spouse may need to initiate legal proceedings to access the resources or income.
5. If the applicant or client demonstrates with clear and convincing evidence that appropriate steps are being taken to secure the resources, Medical Assistance shall not be delayed or terminated. Verification of efforts to secure the resources must be provided at regular intervals as requested by the Eligibility Site.
6. Resources will be considered available and Medical Assistance shall be denied or terminated if the applicant or client refuses or fails to make a reasonable effort to secure potential resources or income.
7. Timely and adequate notice must be given regarding a proposed action to deny, reduce, or terminate assistance due to failure to make reasonable efforts to secure resources or income. If upon receipt of the prior notice, the individual acts to secure the potential resource, the proposed action to deny, reduce, or terminate assistance must be withdrawn, and assistance must be approved or continued until the resource or income is, in fact, available.
8. If the resources or income has been transferred to a trust, the trust shall be submitted for review to the Department to determine the effect of the trust on eligibility in accordance with section 8.100.7.E.
9. A resource may not necessarily be unavailable by virtue that an individual may be unaware of his or her ownership of an asset. The Department will not treat the unknown asset as a resource during the period in which the individual was unaware of his/her ownership. However, the value of the previously unknown asset, including any monies such as interest that have accumulated on the asset through the month of discovery, is evaluated under regular income-counting rules in the month of discovery, and the asset is a resource subject to the resource-counting rules following the month of discovery.

- a. The burden is on the individual to prove by clear and convincing evidence that the asset was unavailable by virtue of being unknown by the recipient.
- b. Unknown assets shall not be deemed an overpayment pursuant to Section 8.065 of the Department's regulations where the asset was unknown through no fault of the individual.
- c. If the previously unknown asset causes the individual to be ineligible, the individual may repay the Department from the excess resources to retain Medicaid eligibility.

8.100.5.F. Income Requirements

1. This section reviews how income is looked at for the ABD and Long Term Care Medical Programs and determining premiums for the Medicaid Buy-In Program for Working Adults with Disabilities. For more general income information and income types refer to the Medical Assistance General Eligibility Requirements section 8.100.3.
2. Income for the ABD Medical Programs eligibility is income which is received by an individual or family in the month in which they are applying for or receiving Medical Assistance, or the previous month if income for the current month is not yet available to determine eligibility.
3. A self-declared common law spouse retains the same financial responsibility as a legally married spouse. Once self-declared as married under the common law, financial responsibility remains unless legal separation or divorce occurs. If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other. This is not changed by the fact that the unmarried individuals may share a common child.
4. Earned income is countable as income in the month received and a countable resource the following month. Earned Income includes the following:
 - a. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment;
 - b. Net earnings from self-employment;
 - c. Payments for services performed in a sheltered workshop or work activities center;
 - d. Certain Royalties and honoraria.
5. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment.

Unearned income is countable as income in the month received and any unspent amount is a countable resource the following month. Unearned income includes, but is not limited to, the following:

- a. Death benefits, reduced by the cost of last illness and burial;
- b. Prizes and awards;
- c. Gifts and inheritances;
- d. Interest payments on promissory notes established on or after March 1, 2007;
- e. Interest or dividend payments received from any resources;

- f. Lump sum payments from workers' compensation, insurance settlements, etc.
 - g. Dividends, royalties or other payments from mineral rights or other resources listed for sale within the resource limits
 - h. Income from annuities that meet requirements for exclusion as a resource
 - i. Lottery/Gambling winnings
 - 1) An applicant/member may request a hardship exemption when denied/or terminated due to Lottery/Gambling winnings.
 - a. The applicant/member must demonstrate a severe medical or financial hardship, as determined by the Department.
 - b. The applicant/member must provide a written request and documentation to their County Department of Human Services, within 30 calendar days from the date of their denial or termination notice.
 - j. Pensions and other period payments, such as:
 - i) Private pensions or disability benefits;
 - ii) Social Security benefits (Retirement, survivors, and disability);
 - iii) Workers' Compensation payments;
 - iv) Railroad retirement annuities;
 - v) Unemployment insurance payments;
 - vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME);and
 - vii) Alimony and support payments.
 - k. Support and maintenance in kind - The support and maintenance in kind amount should not be greater than one third of the Federal Benefit Rate (FBR). Use the Presumed Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the support and maintenance in kind amount. Use one third of the FBR if an amount is not declared by the client.
6. For the purpose of determining eligibility for the Long Term Care and Aged, Blind, and Disabled Medical Assistance categories the following shall be exempt from consideration as either income or resources:
- a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification.
 - b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act.
 - c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive payments (lump sum) for nine months following receipt and the remainder countable as a resource thereafter.

- d. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC).
- e. Home produce utilized for personal consumption.
- f. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner toward the purchase of a replacement dwelling are considered exempt for up to 6 months.
- g. The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:
 - i) Experimental Housing Allowance Program (EHAP) payments made by HUD under section 23 of the U.S. Housing Act.
 - ii) The United States Housing Act of 1937 (§ 1437 et seq. of 42 U.S.C.);
 - iii) The National Housing Act (§ 1701 et seq. of 12 U.S.C.);
 - iv) Section 101 of the Housing and Urban Development Act of 1965 (§ 1701s of 12 U.S.C., § 1451 of 42 U.S.C.);
 - v) Title V of the Housing Act of 1949 (§ 1471 et seq. of 42 U.S.C.); or
 - vi) Section 202(h) of the Housing Act of 1959.
- h. Payments made from Indian judgment funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458).
- i. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed \$ 2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to \$ 2000, received by a client in one calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to \$ 2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s).
- j. Assistance from other agencies and organizations.
- k. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for Medical Assistance.
- l. Payments received for providing foster care.

- m. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act.
- n. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program.
- o. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program
- p. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act.
- q. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended.
- r. Monies received pursuant to the "Civil Liberties Act of 1988" P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts).
- s. Payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y).
- t. A child receiving subsidized adoption funds shall be excluded from the Medical Assistance budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household.
- u. The Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.
- v. Any money received from the Radiation Exposure Compensation Trust Fund, Including the Energy Employees Occupational Illness Compensation Program Act, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.
- w. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are actual expenses for food, housing, medical items, clothing, transportation, or personal needs items.
- x. Payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.
- y. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds.

- z. All wages paid by the United States Census Bureau for temporary employment related to the decennial Census.
- aa. Any grant or loan to an undergraduate student for educational purposes made or insured under any programs administered by the Commissioner of Education (Basic Education Opportunity Grants, Supplementary Education Opportunity Grants, National Direct Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program, the BYRD Honor Scholarship programs and the College Work Study Program.
- bb. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).
- cc. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.
- dd. The additional unemployment compensation of \$25 a week enacted through the American Recovery and Reinvestment Act of 2009.

8.100.5.G. Deeming Of Income And Resources For The OAP Program

- 1. All aliens who apply for OAP on or after April 16, 1988, for three years after the date of admission into the United States, shall have the income and resources of their sponsors other than relatives deemed for their care. Refer to the Medical Assistance General Eligibility Requirements section 8.100.3.K for specific information on deeming of income and resources.

8.100.5.H. Income Allocations and Disregards

- 1. The following income allocations and disregards are only applicable to SSI related, OAP, Medicare Savings Programs (MSP), and the Medicaid Buy-In Program for Working Adults with Disabilities.

These allocations and disregards are not applicable to the HCBS waivers or the LTC programs.

For the Medicaid Buy-In Program for Working Adults with Disabilities, the applicant's spouse's income does not count toward the applicant.

- a. Income of spouses living together is considered mutually available for SSI related, OAP, and Medicare Savings Programs (MSP).
 - b. For a person living in the household of another and not paying shelter costs, one third of the Federal Benefit Rate (FBR) is counted as in-kind income and is added to the countable income. This does not apply to unemancipated children.
- 2. For the purposes of this rule, the following definitions apply:
 - a. unemancipated child is:
 - i) a child under age 18 who is living in the same household with a parent or spouse of a parent, or

- ii) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment.
 - b. Ineligible child is a child who is not applying or eligible for SSI.
 - c. Ineligible parent/spouse is a parent or spouse who is not applying or eligible for SSI.
3. Countable income is calculated by reducing the gross income by the following allocations and disregards.
- a. Income allocations are the part of the gross income that is allocated to individuals in the home who are not eligible for Supplemental Security Income or Old Age Pension. The allocation reduces the gross income that is deemed available to the applicant/client. The allocation is deducted from the gross income prior to applying the other disregards.

The allocations are:

- i) An Ineligible Child Allocation is an amount equal to one half the current year's SSI FBR that is disregarded from the ineligible parents' gross income. This allocation is used to meet the needs of ineligible children in the household. This allocation is available for each ineligible child in the home. The amount of the allocation is reduced by any of the ineligible child's own income.
 - ii) An Ineligible Parent(s) Allocation is an amount equal to the current year's SSI FBR for a single individual or a couple, as applicable. This amount is used to meet the needs of the ineligible parent(s) in the home with an applicant/client child.
 - iii) No allocations are allowed for applicant/recipient spouses who do not have children in the home.
 - b. Allocations are applied to the income in the following manner:
 - i) Allocation disregards are deducted from unearned income before earned income.
 - ii) Ineligible child allocation disregards are deducted from parents' income before any standard disregards are applied.
 - iii) Ineligible parent(s) allocation disregards are deducted after any ineligible child allocation disregards and after the standard income disregards.
4. Income disregards
- a. \$20 General Income Disregard

If there is unearned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied, a General Income Disregard of \$20 shall be applied as follows:

- i) The first \$20 of total available unearned income (except for SSI income) must be disregarded. The remaining amount of unearned income is countable.
- ii) If the client has less than \$20 of unearned income, the difference between the gross unearned income and the \$20 deduction shall be applied as an earned income disregard, if applicable.

- iii) Only one \$20 general income disregard is allowed per couple and is divided between the two spouses. If one of the spouses has no income the other spouse shall get the full \$20 disregard.
- b. \$65 Plus One Half Remainder Earned Income Disregard
 - i) If there is earned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied:
 - 1) Deduct the first \$65 of all earned income.
 - 2) Divide the remaining income in half.
 - 3) The result is the amount of earned income used for determining eligibility.
- c. Child support received by an applicant/recipient child is reduced by one third of the total child support payment. This reduction does not apply to ineligible children when calculating the ineligible child allocation disregard.
- d. The first \$400 of the gross monthly earned income is exempt for a blind or disabled child who is a student that is regularly attending school. The exemption cannot exceed \$1,620 in a calendar year.
- e. Title 20 of the Code of Federal Regulations, § 416.1112 (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.5.I. Determining Ownership of Income

- 1. If payment is made solely to one individual, the income shall be considered available income to that individual.
- 2. If payment is made to more than one individual, the income shall be considered available to each individual in proportion to their interests.
- 3. In case of a married couple in which there is no document establishing specific ownership interests, one-half of the income shall be considered available to each spouse.
- 4. Income from the Community Spouse's Monthly Income Allowance, as defined in the spousal protection rules in this volume at 8.100.7.R, is income to the community spouse.

8.100.5.J. Income-Producing Property

- 1. Net rental income from an exempt home or a life estate interest in an exempt home is countable after the following allowable deductions:
 - a. Property taxes and insurance
 - b. Necessary reasonable routine maintenance expenses
 - c. Reasonable management fee for a professional property manager.

2. Non-business property that is necessary to produce goods or services essential to self- support is excluded up to \$6,000.
3. Property used in a trade or business which is essential to self-support is excluded up to a limit of \$6,000 if it produces 6% return of the \$6,000 excluded value.

8.100.5.K. Department of Veterans Affairs (VA) Payments

The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall not be considered as income when determining eligibility.

1. The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall not be used as patient payment to the medical facility:
 - a. for a veteran or surviving spouse of a veteran in a medical facility other than State Veterans Home; or
 - b. for a veteran or surviving spouse of a veteran in a State Veterans Home with dependents.
2. For a veteran or surviving spouse of a veteran in a State Veterans Home with no dependents the portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall be used as patient payment to the medical facility.

8.100.5.L. Reverse Mortgages

1. In accordance with C.R.S. § 11-38-110, reverse mortgages payments made to a borrower shall not be treated as income for eligibility purposes.
2. Funds remaining the following month after the payment is made will be countable as a resource.
3. Any payments from a reverse mortgage that are transferred to another individual without fair consideration shall be analyzed in accordance with the rules on transfers without fair consideration in the Long-Term Care section and may result in a penalty period of ineligibility.

8.100.5.M. Resource Requirements

1. Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is \$2,000. For a married couple, the resource limit is \$3,000. If one spouse is institutionalized, refer to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses. Effective January 1, 2011, the resource limits for the Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), and Qualified Individuals 1 (QI-1) programs are \$8,180 for a single individual and \$13,020 for a married individual living with a spouse and no other dependents. The resource limits for the QMB, SLMB, and QI programs shall be adjusted annually by the Centers for Medicare and Medicaid Services on January 1 of each year. These resource limits are based upon the change in the annual consumer price index (CPI) as of September of the previous year. Resources are not counted for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities.
2. The following resources are exempt in determining eligibility:

- a. A home, which is any property in which an individual or spouse of an individual has an ownership interest and which serves as the individual's principal place of residence. The property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.
 - i) Only one principal place of residence is excluded for a single individual or a married couple.
 - ii) The individual's ownership interest in the home must have an equity value that:
 - 1) From January 1, 2006 thru December 31, 2010 is \$500,000 or less, or;
 - 2) Is less than the amount that results from the year to year percentage increase to the \$500,000 limit. The increase is based upon the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.
 - iii) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual intends to return to that home, then the individual does not meet the residency requirement for Colorado Medicaid eligibility.
 - iv) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless the individual's spouse or dependent relative lives in the home.
 - v) If an individual or spouse of an individual owns a home located inside Colorado with an equity value lower than the limit in subparagraph (1), above, and if the individual intends to return to that home, then the home is considered an exempt resource if:
 - 1) The individual is institutionalized; and
 - 2) The intent to return home is documented in writing.
 - vi) If an individual or spouse of an individual owns a home with an equity value greater than the limit that is located inside Colorado, and if the individual intends to return to that home, then the home is considered to be a countable resource unless spouse or dependent relative lives in the home.
 - vii) If an individual or spouse of an individual owns a home of any value located inside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless spouse or dependent relative lives in the home.
 - viii) If an individual or spouse moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence.
 - ix) If an individual leaves his or her home to live in an institution, the home shall still be considered the principal place of residence, irrespective of the individual's intent to return as long as the individual's spouse or dependent relative continues to live there.

- x) The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.
- xi) The intent to return home applies to the home in which the individual or spouse of the individual was living prior to being institutionalized or to a replacement home as long as the individual's spouse or dependent relative continues to live in the home.
- xii) The intent to return home also applies if the individual is living in an assisted living facility or alternative care facility and receives HCBS while in that facility or transfers into a Long-Term Care institution to receive services.
- xiii) For an individual in a Long-Term Care institution, receiving HCBS, or enrolled in PACE, the exemption for the principal place of residence does not apply to a residence which has been transferred to a trust or other entity, such as a partnership or corporation.
 - 1) The exemption shall be regained if the residence is transferred back into the name of the individual.
- xiv) The principal place of residence, which is subject to estate recovery, becomes a countable resource upon the execution and recording of a beneficiary deed.

The exemption can be regained if a revocation of the beneficiary deed is executed and recorded.
- b. Excess property will not be included in countable resources as long as reasonable efforts to sell it have been unsuccessful. Reasonable efforts to sell means:
 - i.) The property is listed with a professional such as a real estate agent, broker, dealer, auction house, etc., at current market value.
 - ii) If owner listed, the property must be for sale at current market value, advertised and shown to the public.
 - iii) Any reasonable offer must be accepted.
 - iv) If an offer is received that is at least two-thirds of the current market value, that offer is presumed reasonable.
 - v) The client must continue reasonable efforts to sell and must submit verification of these efforts to the Eligibility Site on a quarterly basis. Reasonable effort is at Eligibility Site discretion.
 - vi) If the exemption is used to become eligible under the Spousal Protection rules, the property shall continue to be viewed according to 8.100.7.L while efforts to sell it are being made.
 - vii) Eligibility under this exemption is conditional. Once the property sells, the client shall be ineligible until the resources are below the prescribed limit.
- c. One automobile is totally excluded regardless of its value if it is used for transportation for the individual or a member of the individual's household. An automobile includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

- d. Household goods are not counted as a resource to an individual (and spouse, if any) if they are:
 - i) Items of personal property, found in or near the home, that are used on a regular basis; or
 - ii) Items needed by the household for maintenance, use and occupancy of the premises as a home.
 - iii) Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.
- e. Personal effects are not counted as a resource to an individual (and spouse, if any) if they are:
 - i) Items of personal property ordinarily worn or carried by the individual; or
 - ii) Articles otherwise having an intimate relation to the individual.
 - iii) Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments.
 - iv) Items of cultural or religious significance to the individual and items required because of an individual's impairment are also not counted as a resource.
- f. The cash surrender value of all life insurance policies owned by an individual and spouse, if any, is exempt if the total face value of all life insurance policies does not exceed \$1,500 on any person. If the total face value of all the life insurance policies exceeds \$1,500 on one person, the cash surrender value of those policies will be counted.
- g. Term life insurance having no cash surrender value, and burial insurance, the proceeds of which can be used only for burial expenses, are not countable toward the resource limit.
- h. The total value of burial spaces for the applicant/recipient, his/her spouse and any other members of his/her immediate family is exempt as a resource. If any interest is earned on the value of an agreement for the purchase of a burial space, such interest is also exempt.
- i. An applicant or recipient may own burial funds through an irrevocable trust or other irrevocable arrangement which are available for burial and are held in an irrevocable burial contract, an irrevocable burial trust, or in an irrevocable trust which is specifically identified as available for burial expenses without such funds affecting the person's eligibility for assistance.
- j. An applicant or recipient may also own up to \$1,500 in burial funds through a revocable account, trust, or other arrangement for burial expenses, without such funds affecting the person's eligibility for assistance. This exclusion only applies if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual or spouse's burial expenses. Interest on the burial funds is also excluded if left to accumulate in the burial fund. For a married couple, a separate \$1,500 exemption applies to each spouse.

The \$1,500 exemption is reduced by:

- i) the amount of any irrevocable burial funds such as are described in the preceding subparagraph, and
 - ii) the face value of any life insurance policy whose cash surrender value is exempt.
- k. Achieving a Better Life Experience (ABLE) Accounts.

3. Countable resources include the following:

- a. Cash;
- b. Funds held by a financial institution in a checking or savings account, certificate of deposit or money market account;
- c. Current market value of stocks, bonds, and mutual funds;
- d. All funds in a joint account are presumed to be a resource of the applicant or client. If there is more than one applicant or client account holder, it is presumed that the funds in the account belong to those individuals in equal shares. To rebut this presumption, evidence must be furnished that proves that some or all of the funds in a jointly held account do not belong to him or her. To rebut the sole ownership presumption, the following procedure must be followed:
 - i) Submit statements from all of the account holders regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent.
 - ii) Submit account records showing deposits, withdrawals and interest in the months for which ownership of funds is at issue.
 - iii) Correct the account title and submit revised account records showing that the applicant or client is no longer an account holder or separate the funds to show they are solely owned by the individual within 45 days.
- e. Any real property that is subject to a recorded beneficiary deed and on which an estate recovery claim can be made.
- f. For applications filed on or after January 1, 2006, an individual's home if the individual's equity interest in the home exceeds the equity value limit described at 8.100.5.M.2.a.i)1).
- g. Real property not exempt as the principal place of residence and not exempt as income producing property with a value of \$6,000 or less, as described at 8.100.5.J.
- h. When the applicant alleges that the sale of real property would cause undue hardship to the co-owner due to loss of housing, all of the following information must be obtained:
 - i) The applicant or client's signed statement to that effect.
 - ii) Verification of joint ownership.
 - iii) A statement from the co-owner verifying the following:
 - 1) The property is used as his principal place of residence.

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- 2) The co-owner would have to move if the property were sold.
 - 3) The co-owner would be unable to buy the applicant or client's interest in the property.
 - 4) There is no other readily available residence because there is no other affordable housing available or no other housing with the necessary modifications for the co-owner if he is a person with disabilities.
- i. Personal property such as a mobile home or trailer or the like, that is not exempt as a principal place of residence or that is not income producing.
 - j. Personal effects acquired or held for their value or as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.
 - k. The equity value of all automobiles that are in addition to one exempt vehicle.
 - l. The cash surrender value of all life insurance policies owned by an individual and spouse is counted if the total face value of all the policies combined exceeds \$1,500 on any person.
 - m. Promissory notes established before April 1, 2006 are treated as follows:
 - i) The fair market value of a promissory note, mortgage, installment contract or similar instrument is an available countable resource.
 - ii) In order to determine the fair market value, the applicant shall obtain three estimates of fair market value from a private note broker, who is engaged in the business of purchasing such notes. In order to obtain the estimates and locate willing buyers, the note shall be advertised in a newspaper with state wide circulation under business or investment opportunities.
 - iii) A note or similar instrument which transferred funds or assets for less than fair consideration shall be considered as a transfer for less than fair consideration and a period of ineligibility shall be imposed.
 - n. Promissory notes established on or after April 1, 2006 and before March 1, 2007 are treated as follows:
 - i) The value of a promissory note, loan or mortgage is an available countable resource unless the note, loan or mortgage:
 - 1) Has a repayment term that is actuarially sound based on the individual's life expectancy, found in the tables at 8.100.7.J, for annuities purchased on or after February 8, 2006;
 - 2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
 - 3) Prohibits the cancellation of the balance upon the death of the lender.

- ii) The value of a promissory note, loan or mortgage which does not meet the criteria in outlined in 8.100.5.M.3.n.i)1)-3) is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is subject to the transfer of assets without fair consideration provisions as outlined in section 8.100.7.F.
- o. Promissory notes established on or after March 1, 2007 are treated as follows:
 - i) The value of a promissory note, loan or mortgage is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is an available countable resource, and
 - ii) A promissory note, loan or mortgage which does not meet the following criteria shall be considered to be a transfer without fair consideration and shall be subject to the provisions outlined at 8.100.7.F.
 - 1) Has a repayment term that is actuarially sound based on the individual's life expectancy as found in the tables in section 8.100.7.J for annuities purchased on or after February 8, 2006;
 - 2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
 - 3) Prohibits the cancellation of the balance upon the death of the lender.
- p. Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.
 - i) Ownership of land and mineral rights. If the individual owns the land to which the mineral rights pertain, the current market value of the land generally includes the value of the mineral rights.
 - ii) If the individual does not own the land to which the mineral rights pertain, the individual should obtain a current market value estimate from a knowledgeable source. Such sources may include:
 - 1) any mining company that holds leases;
 - 2) the Bureau of Land Management;
 - 3) the U.S. Geological Survey.

8.100.5.N. Treatment of Self-Funded Retirement Accounts

- 1. The following regulations apply to self-funded retirement accounts such as an Individual Retirement Account (IRA), Keogh Plan, 401(k), 403(b) and any other self-funded retirement account.
- 2. Self-funded retirement accounts in the name of the applicant are countable as a resource to the applicant.
- 3. Self-funded retirement accounts in the name of the applicant's spouse who is living with the applicant are exempt in determining eligibility for the applicant, except as set forth in 4. below.

4. Self-funded retirement accounts in the name of a community spouse who is married to an applicant who is applying for Long Term Care in a Long Term Care institution, HCBS or PACE, are countable as a resource to the applicant and may be included in the Community Spouse Resource Allowance (CSRA) up to the maximum amount allowable. The terms community spouse and CSRA are further defined in the regulations on Spousal Protection in this volume.
5. The value of a self-funded retirement account is determined as follows:
 - a. The gross value of the account, less any taxes due, is the amount that is countable as a resource, regardless of whether any monthly income is being received from the account.
 - b. If the applicant is not able to provide the amount of taxes that are due, the value shall be determined by deducting 20% from the gross value of the account.

8.100.5.O. Treatment of Inheritances

1. An inheritance is cash, other liquid resources, non-cash items, or any right in real or personal property received at the death of another.
2. If an Individual or individual's spouse is the beneficiary of a will, the inheritance is presumed to be available at the conclusion of the probate process or within 6 months if the estate is not in probate.
3. If an individual or individual's spouse is eligible for a family allowance in a probate proceeding, that allowance will be considered available three months after death or when actually available, whichever is sooner.
4. Evidence demonstrating that the inheritance is not available due to probate or other legal restrictions must be provided to rebut the presumption.

8.100.5.P. Treatment of Proceeds from Disposition of Resources

Treatment of proceeds from disposition of resources is determined as follows:

1. The net proceeds from the sale of exempt or non-exempt resources are considered available resources.
2. The net proceeds are the selling price less any valid encumbrances and costs of sale.
3. After deducting any amount necessary to raise the individual's and spouse's resources to the applicable limits, the balance of the net proceeds, in excess of the resource limits, shall be considered available resources. In lieu of terminating eligibility due to excess resources, the client may request that the proceeds be used to reimburse the Medical Assistance Program for previous payments for Medical Assistance.
4. The proceeds from the sale of an exempt home will be excluded to the extent they are intended to be used and are, in fact, used to purchase another home in which the individual, a spouse or dependent child resides, within three months of the date of the sale of the home.

8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility

8.100.6.A. Aged, Blind, and Disabled (ABD) General Information

1. Medical Assistance for ABD includes SSI eligible individuals, OAP recipients, and the Medicare Savings Program (MSP) individuals. Refer to section 8.100.5 of this volume for income and resource criteria for these categories of assistance.

8.100.6.B. Disability Determinations

1. Beginning on July 1, 2001, the Department or its contractor shall determine whether the client is disabled or blind in accordance with the requirements and procedures set forth elsewhere in this volume and according to Federal regulations regarding disability determinations.
2. A client who disagrees with the decision on disability or blindness shall have the right to appeal that decision to a state-level fair hearing in accordance with the procedures at 8.057.

8.100.6.C. SSI Eligibles

1. Benefits of the Colorado Medical Assistance Program must be provided to the following:
 - a. persons receiving financial assistance under SSI;
 - b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;
 - c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.
2. The Department has entered into an agreement with SSA in which SSA shall determine Medical Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving SSI benefits as determined by SSA to be eligible for Medical Assistance.
3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the eligibility site to authorize Medical Assistance.
4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.
5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical Assistance.
6. The SISC Code for this type of assistance is B.
7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later overturned, must be approved from the original SSI eligibility date.
8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive Medical Assistance benefits. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income.

9. If the eligibility site obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.
10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.
 - a. Special Provisions for Infants
 - i) For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:
 - 1) the infant was born in a hospital;
 - 2) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and
 - 3) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI

8.100.6.D. Pickle Amendment

1. Beginning July 1977, Medical Assistance must be provided to an individual if their countable income is below the current years SSI standard after a cost of living adjustment (COLA) disregard is applied to their OASDI (excluding Railroad Retirement Benefits) and they meet all other eligibility criteria. This is referred to as Pickle Disregard.
2. The Pickle Disregard applies to an individual who:
 - a. lost SSI and/or OAP because of a cost of living adjustment to his/her own OASDI benefits.
 - b. lost SSI and/or OAP because a cost of living adjustment to OASDI income deemed from a parent or spouse.
 - c. lost OAP and/or SSI due to the receipt of, or increase to, OASDI, and would be eligible for OAP and/or SSI if all COLA'S on the amount that caused them to lose eligibility is disregarded from their current OASDI amount.

8.100.6.E. Pickle Determination

1. To determine eligibility of Medical Assistance recipients to whom the Pickle disregards apply, the eligibility site must:
 - a. establish whether the person was eligible for SSI or OAP and, for the same month, was entitled to OASDI;
 - b. determine the previous amount of the OASDI that caused them to lose SSI and/or OAP;
 - c. determine the current OASDI income;
 - d. subtract the previous OASDI income from the current OASDI income to find the cumulative OASDI COLAs since SSI and/or OAP was lost. This is the Pickle Disregard amount;

- e. subtract the Pickle Disregard amount from the current OASDI income to get the countable OASDI income.
2. If the countable OASDI income and all other countable income is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria then medical eligibility must continue or be reinstated.
3. This disregard must also be applied to any OASDI cost of living increases paid to any financially responsible individual such as a parent or spouse whose income is considered in determining the person's continued eligibility for Medical Assistance.
4. The cost of living increase disregard specified in the preceding action must continue to be applied at each eligibility redetermination.
5. An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be contacted by the eligibility site to determine if the individual would continue to remain eligible for Medical Assistance under the provisions for SSI related cases. The individual must complete an application for assistance to continue receiving benefits.

8.100.6.F. 1972 Disregard Individuals

1. Medical Assistance must be provided to a person who was receiving financial assistance under AND or Aid to the Blind (AB) for August 1972 and who – except for the October 1972 Social Security (includes RRB) 20% increase amount would currently be eligible for financial assistance. This disregard must also be applied to a person receiving Medical Assistance in August 1972 who was eligible for financial assistance but was not receiving the money payment and to a person receiving Medical Assistance as a resident in a medical institution in August 1972.
2. To redetermine the eligibility of Medical Assistance recipients to whom the 1972 disregard applies, the eligibility site must:
 - a. review the case against the current applicable program definitions and requirements;
 - b. apply the resource and income criteria specified in section 8.100.5;
 - c. subtract the 1972 disregard amount from the income;
 - d. consider the remainder against the current appropriate SSI benefit level.

8.100.6.G. Individuals Eligible in 1973

1. Medical Assistance must be provided to ABD persons who are receiving mandatory state supplementary payments (SSP). Such persons are those with income below their December 1973 minimum income level (MIL).
2. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an inpatient of a medical facility, who continues to meet the December 1973 eligibility criteria for institutionalized persons and who remains institutionalized.
3. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an “essential spouse” of an AND or AB financial assistance recipient, and who continues to be in the grant and continues to meet the December 1973 eligibility criteria. Except for such persons who were grandfathered-in for continued assistance, essential spouses included in assistance grants after December 1973 are not eligible for Medical Assistance.

8.100.6.H. Eligibility for Certain Disabled Widow(er)s

1. Medical Assistance shall be provided retroactive to July 1, 1986, to qualified disabled widow(er)s who lost SSI and/or state supplementation due to the 1983 change in the actuarial reduction formula prescribed in section 134 of P.L. No. 98 21.

In order for these widow(er)s to qualify, these individuals must:

- a. have been continuously entitled to Title II benefits since December 1983;
- b. have been disabled widow(er)s in January 1984;
- c. have established entitlement to Title II benefits prior to age 60;
- d. have been eligible for SSI/SSP benefits prior to application of the revised actuarial reduction formula;
- e. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial table; and
- f. reapply for assistance prior to July 1, 1987.

8.100.6.I. Eligibility for Disabled Widow(er)s

1. Effective January 1, 1991, Medical Assistance shall be provided to disabled widow(er)s age 50 through 64 who lost SSI and/or OAP due to the receipt of Social Security benefits as a disabled widow(er). The individual shall remain eligible for Medical Assistance until he/she becomes eligible for Part A of Medicare (hospital insurance).

To qualify these individuals must:

- a. be a widow(er);
- b. have received SSI in the past;
- c. be at least 50 years old but not 65 years old;
- d. no longer receive SSI payments because of Social Security payments;
- e. not have hospital insurance under Medicare; and,
- f. meet all other Medical Assistance requirements.

8.100.6.J. Disabled Adult Children

1. Medical Assistance shall be provided to an individual aged 18 or older who loses SSI due to the receipt of OASDI drawn from his/her parents' Social Security Number; and:
 - a. who was determined disabled prior to the age of 22; and
 - b. who is currently receiving OASDI income as a Disabled Adult Child; and
 - c. who would continue to be eligible for SSI if:
 - i) the current OASDI income of the applicant is disregarded; and

- ii) the resources are below the applicable limit as listed at 8.100.5.M; and
 - iii) other countable income is below the current years SSI FBR.
2. Disabled Adult Children are identified by the OASDI Beneficiary Identification Code (BIC) of "C".

8.100.6.K. Old Age Pension (OAP) Eligibles

1. Individuals that are 65 and over are defined as the OAP-A category. Individuals who attain the age of 60 but not yet 65 are defined as the OAP-B category.
2. Medical Assistance must be provided to persons receiving OAP-A or OAP-B and SSI (SISC B).
3. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria but are not receiving a money payment (SISC-B).
4. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria except for the level of their income (SISC-B).
5. Medical Assistance must be provided to persons in a facility eligible for Medical Assistance reimbursement whose income is under 300% of the SSI benefit level and who, but for the level of their income, would be eligible for OAP "A" or OAP "B" and SSI financial assistance. This group includes persons 65 years of age or older receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement (SISC A). This population is referenced as Psych >65.
6. The OAP B individual included in AFDC assistance unit shall receive Medical Assistance as a member of the AFDC household (SISC B).
7. The OAP State Only Medical Assistance Program provides Medical Assistance to OAP-A, OAP-B or OAP Refugees who lost their OAP financial assistance because of a cost of living adjustment other than OASDI. Examples of other sources of income are VA, RRB, PERA, etc. (SISC C).
8. For the purpose of identifying the proper SISC code for persons receiving assistance under OAP "A" or OAP "B", if the person:
 - a. receives an SSI payment (SISC B);
 - b. does not receive an SSI payment but is receiving assistance under OAP "A", a second evaluation of resources must be made using the same resource criteria as specified in section 8.100.5.M for those who meet this criteria the SISC code is B for money payment and "disregard" case, A for institutional cases;
 - c. does not receive an SSI payment and does not otherwise qualify under SISC code B or A as described in item b. above (SISC C).

8.100.6.L. Qualified Medicare Beneficiaries (QMB)

1. Medical Assistance coverage for QMB clients is payment of Medicare part B premiums, co-insurance and deductibles.
2. Effective July 1, 1989, a Qualified Medicare Beneficiary is an individual who:
 - a. is entitled to Part A Medicare; and

- b. resources may not exceed the standard for an individual or couple who have resources, as described in section 8.100.5.M; and
 - c. has income at or below the percentage of the federal poverty level for the size family as mandated for QMB by federal regulations. Poverty level is established by the Executive Office of Management and Budget.
- 3. For QMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for QMB.
- 4. For QMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the \$65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.
- 5. Medicare cost sharing expenses must be provided to qualified Medicare beneficiaries. This limited Medical Assistance package of Medicare cost sharing expenses only includes:
 - a. payment of Part A Medicare premiums where applicable;
 - b. payment of Part B Medicare premiums; and
 - c. payment of coinsurance and deductibles for Medicare services whether or not a benefit of Medical Assistance up to the full Medicare rate or reasonable rates as established in the State Plan.
- 6. Individuals may be QMB recipients only or the individual may be classified as a dual eligible. A dual eligible is a Medicare recipient who is otherwise eligible for Medical Assistance.
- 7. A QMB-only recipient is an individual who is not eligible for other categorical assistance program due to their income and/or resources but who meets the eligibility criteria for QMB described above.
- 8. Individuals who apply for QMB assistance have the right to have their eligibility determined under all categories of assistance for which they may qualify.
- 9. All other general non-financial requirements or conditions of eligibility must also be met such as age, citizenship, residency requirements as well as reporting and redetermination requirements. These criteria are defined in section 8.100.3 of this volume.
- 10. Eligibility for QMB benefits shall be effective the month following the month of determination. Beneficiaries who submit and complete an application within the 45-day standard shall be eligible for benefits no later than the first of the month following the 45th day of application. Administrative delays shall not postpone the effective date of eligibility.
- 11. QMB benefits are not retroactive and the three month retroactive Medical Assistance rule does not apply to QMB benefits.
- 12. Clients who would lose their QMB entitlement due to annual social security COLA will remain eligible for QMB coverage under Medical Assistance, as income disregard cases, until the next year's federal poverty guidelines are published.

8.100.6.M. Specified Low Income Medicare Beneficiaries

1. Medical Assistance coverage for SLMB clients is limited to payment of monthly Medicare Part B (Supplemental Medical Insurance Benefits) premiums.
2. Effective January 1, 1993, a Specified Low Income Medicare Beneficiary (SLMB) is an individual who:
 - a. is entitled to Medicare Part A;
 - b. resources may not exceed the standard for an individual or couple who has resources as described in section 8.100.5.M of this volume.
 - c. has income at or below a percentage of the federal poverty level for the family size as mandated by federal regulations for SLMB. Income limits have been defined through CY 1995, as follows: CY 1993 and 1994 100-110% of FPL, CY 1995 100-120% of FPL.
3. For SLMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for SLMB.
4. For SLMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the \$65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.
5. SLMB eligibility starts on the date of application or up to three month prior to the application date for retroactive Medical Assistance.
6. Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.
7. Clients who would lose their SLMB entitlement due to annual SSA COLA will remain eligible for SLMB coverage, as income disregard cases, through the month following the month in which the annual federal poverty levels (FPL) update is published.

8.100.6.N. Medicare Qualifying Individuals 1 (QI1)

1. Medical Assistance coverage is limited to monthly payment of Medicare Part B premiums. Payment of the premium shall be made by the Department on behalf of the individual.
2. Eligibility for this benefit is limited by the availability of the allocation set by CMS. Once the state allocation is met, no further benefits under this category shall be paid and a waiting list of eligible individuals shall be maintained.
3. Eligibility for QI1 benefits shall be effective the month in which application is made and the individual is eligible for benefits. Eligibility may be retroactive up to three months from the date of application, but not prior to January 1, 1998.
4. In order to qualify as a Medicare Qualifying Individual 1, the individual must meet the following:
 - a. be entitled to Part A of Medicare,
 - b. income of at least 120%, but less than 135% of the FPL.
 - c. resources may not exceed the standard as described in section 8.100.5.M, and

- d. he/she cannot otherwise be eligible for Medical Assistance.
- 5. For QI1 purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the \$65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.
- 6. Clients who would lose QI-1 entitlement due to annual social security COLA will remain eligible for QI-1 coverage under Medical Assistance, as an income disregard case, until the next year's federal poverty guidelines are published.

8.100.6.O. Qualified Disabled And Working Individuals

- 1. Medical Assistance coverage is limited to monthly payment of Medicare Part A premiums, and any other Medicare cost sharing expenses determined necessary by CMS.
- 2. Effective July 1, 1990, a Qualified Disabled and Working Individual (QDWI) is an individual who:
 - a. was a recipient of federal Social Security Disability Insurance (SSDI) benefits, who continues to be disabled but lost SSDI entitlement due to earned income in excess of the Social Security Administration's Substantial Gainful Activity (SGA) threshold, and;
 - b. has exhausted SSA's allowed extension of "premium free" Medicare Part A coverage under SSDI, and;
 - c. has resources at or below twice the SSI resource limit as described in section 8.100.5., and;
 - d. has income less than 200% of FPL.
- 3. For QDWI purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the \$65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.
- 4. An individual may be eligible under this section only if he/she is not otherwise eligible under another Medical Assistance category of eligibility.
- 5. Eligibility for QDWI benefits shall be effective the month of determination of entitlement.
- 6. Eligibility may be retroactive only to the date as of which SSA approves an individual's application for coverage as a "Qualified Disabled and Working Individual". However, eligibility may not begin prior to 07/01/90.

8.100.6.P. Medicaid Buy-In Program for Working Adults with Disabilities.

- 1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:
 - a. Applicants must be at least age 16.
 - b. Income must be less than or equal to 450% of FPL after income allocations and disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income allocations and disregards. Only the applicant's income will be considered.
 - c. Resources are not counted in determining eligibility.

- d. Individuals must have a disability as defined by Social Security Administration medical listing or a limited disability as determined by a state contractor.
- e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.
 - i) Due to the federal COVID-19 Public Health Emergency, and required by the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program until the end of the federal Public Health Emergency. At the end of the federal Public Health Emergency, members will be redetermined based on their current employment status. New applicants enrolled will still need to meet the work requirement.
- f. Individuals will be required to pay monthly premiums on a sliding scale based on income.
 - i) The amount of premiums cannot exceed 7.5% of the individual's income.
 - ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.
 - iii) Premium amounts are as follows:
 - 1) There is no monthly premium for individuals with income at or below 40% FPL.
 - 2) A monthly premium of \$25 is applied to individuals with income above 40% of FPL but at or below 133% of FPL.
 - 3) A monthly premium of \$90 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.
 - 4) A monthly premium of \$130 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.
 - 5) A monthly premium of \$200 is applied to individuals with income above 300% of FPL but at or below 450% of FPL./
 - iv) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by \$10 or more.
 - v) A change in a member's net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in the member's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due. The Department will waive premiums for the Medicaid Buy-In for Working Adults with Disability Program for member's who are within their 12 months postpartum period.
 - vi) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Medicaid Buy-In for Working Adults with Disability Program during the federal COVID-19 emergency declaration. Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation
3. Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Working Adults with Disabilities. This is also called “opt out.”

8.100.6.Q. Medicaid Buy-In Program for Children with Disabilities

1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:
 - a. Applicants must be age 18 or younger.
 - b. Household income will be considered and must be less than or equal to 300% of FPL after income disregards. The following rules apply:
 - i) 8.100.4.E - MAGI Household Requirements
 - ii) 8.100.5.F - Income Requirements
 - iii) 8.100.5.F.6 - Income Exemptions
 - iv) An earned income of \$90 shall be disregarded from the gross wages of each individual who is employed
 - v) A disregard of a 33% (.3333) reduction will be applied to the household's net income.
 - c. Resources are not counted in determining eligibility.
 - d. Individuals must have a disability as defined by Social Security Administration medical listing.
 - e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18 shall be determined for eligibility through the Medicaid Buy-In Program for Working Adults with Disabilities.
 - f. Families will be required to pay monthly premiums on a sliding scale based on household size and income.
 - i) For families whose income does not exceed 200% of FPL, the amount of premiums and cost-sharing charges cannot exceed 5% of the family's adjusted gross income. For families whose income exceeds 200% of FPL but does not exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot exceed 7.5% of the family's adjusted gross income.
 - ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.
 - iii) For households with two or more children eligible for the Medicaid Buy-In Program for Children with Disabilities, the total premium shall be the amount due for one eligible child.
 - iv) Premium amounts are as follows:

- 1) There is no monthly premium for households with income at or below 133% of FPL.
 - 2) A monthly premium of \$70 is applied to households with income above 133% of FPL but at or below 185% of FPL.
 - 3) A monthly premium of \$90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL.
 - 4) A monthly premium of \$120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.
 - v) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by \$10 or more.
 - vi) A change in household net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in a member's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due. The Department will waive premiums for the Children with Disabilities Program members who are within their 12 months postpartum period.
 - vii) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Department's Children with Disabilities Program during the federal emergency declaration. Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume.
2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.
 3. Verification requirements will follow the MAGI Category Verification Requirements found at 8.100.4.B.
 4. Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Children with Disabilities. This is also called "opt out."

8.100.7 Long-Term Care Medical Assistance Eligibility

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

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

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

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

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

2. Eligibility under the 300% Institutionalized Special Income category will be provided to applicants who:
 - a. Have attained the age of 65 years or;
 - b. Have met the requirements according to the definition of disability or blindness applicable to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)
 - c. Have been institutionalized for at least 30 consecutive full days in a Long-Term Care institution. The 30 consecutive full day stay may be a combination of days in a hospital, Long-Term Care institution, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE).

Supporting documentation must be provided which verifies the 30 consecutive full days. This documentation shall include the Long-Term Services and Supports Level of Care Eligibility Determination and/or medical records which must be verified by a physician or case manager.

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

- i) There is a statement from a physician, or case manager that declares if the client had not died, he/she would have been institutionalized for 30 consecutive full days, and;
 - ii) The statement is verified by supporting documentation from the beginning of the institutionalized period, which is the first 15 days, or prior to the death of the client, whichever is earliest.
 - iii) Once the 30 consecutive days of institutionalization requirement has been met, Medical Assistance benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date.
 - d. Are in a facility eligible for Medical Assistance Program reimbursement if the individual is in a hospital or Long-Term Care institution; and
 - e. Have gross income that does not exceed 300% of the current individual SSI benefit level or;

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

- i) This special income standard must be applied for:

- 1) A person 65 years of age or older, or disabled or blind receiving care in a hospital, nursing facility; or
 - 2) A person who is not SSI eligible needing Long-Term Care from HCBS or PACE; or
 - 3) A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement; and
- f. Have resources that conform with the regulations regarding resource limits and exemptions set forth in section 8.100.5 of this volume; and
- g. If married, Income and resources conform to rules set forth at 8.100.7.C and 8.100.7.K; and
- h. Have not transferred assets without fair consideration on or after the look-back date defined in section 8.100.7.F.2.d. which would incur a penalty period of ineligibility in accordance with the regulations on transfers without fair consideration in section 8.100.7 of this volume; and
- i. Have submitted trust documents to the Department if the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of trust. The Department shall determine the effect of the trust on Medical Assistance Program eligibility.
- j. Have submitted documents verifying that an annuity conforms to the regulations regarding Annuities at 8.100.7.I.
3. An appeal process is available to children identified by C.R.S. 27-10.3-101 to 108, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Department of Human Services (9 CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to Medical Assistance eligibility

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

1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry Point/Case Management Agency to have met the institutional level of care and will remain in the community by receiving HCBS or PACE; and
 - a. are SSI (including 1619b) or OAP Medicaid eligible; or
 - b. are eligible under the Institutionalized 300% Special Income category described at 8.100.7.A; or
 - c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P. For this group, access to HCBS:
 - i) Is limited to the Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI) and Supported Living Services (SLS) waivers; and

- ii) Is contingent on the Department receiving all necessary federal approval for the waiver amendments that extend access to HCBS to the Working Adults with Disabilities population described at 8.100.6.P.
- 2. A client who is already Medicaid eligible does not need to submit a new application. The client must request the need for Long-Term Care services and the Eligibility Site must redetermine the client's eligibility.
 - a. All individuals applying for or requesting Long-Term Care services must disclose and provide documentation of:
 - i) any transfer of assets without fair consideration as described at 8.100.7.F; and
 - ii) any interest in an annuity as described at 8.100.7.I; and
 - iii) any interest in a trust as described at 8.100.7.E.
 - b. Failure to disclose and provide documentation of the assets described at 8.100.7.B.2.a may result in the denial of Long-Term Care services.
 - c. The requirements at 8.100.7.B.2.a and 8.100.7.B.2.b do not apply to individuals who have been determined eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P.
- 3. For individuals served in Alternative Care Facilities (ACF), income in excess of the personal needs allowance and room and board amount for the ACF shall be applied to the Medical Assistance charges for ACF services. The total amount allowed for personal need and room and board cannot exceed the State's Old Age Pension Standard.

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

- 1. The income of a community spouse is not deemed to the institutionalized spouse in determining eligibility. If both spouses are institutionalized, their individual income is counted in determining their own eligibility. The income of one institutionalized spouse is not deemed to the other institutionalized spouse when determining eligibility.
- 2. The income and resources of both spouses are counted in determining eligibility for either or both spouses with the following exceptions:
 - a. If spouses share the same room in an institution, the income of the individual spouse is counted in determining his or her eligibility, and each spouse is allowed the \$2000 limit for resources.
 - b. Beginning the first month following the month the couple ceases to live together, only the income of the individual spouse is counted in determining his or her eligibility.
 - c. If one spouse is applying for Long-Term Care in a Long-Term Care institution or Home and Community Based Services (HCBS), refer to the rules on Treatment of Income and Resources for Institutionalized Spouses.
- 3. Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the Long-Term Care institution.

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

Long-Term Care

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

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

8.100.7.E Consideration of Trusts in Determining Medical Assistance Eligibility

1. Trusts established before August 11, 1993:
 - a. Medical Assistance Qualifying Trust (MQT)
 - i) In the case of a Medical Assistance qualifying trust, as defined in 42 U.S.C. Sec. 1396a(k), the amount of the trust property that is considered available to the applicant/recipient who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual assuming the full exercise of discretion by the trustee(s) for the distribution of the maximum amount to the applicant/recipient. This amount of property is deemed available resources to the individual, whether or not is actually received.
 - ii) 42 U.S.C. Sec. 1396a(k) was repealed in 1993 and is reprinted here exclusively for purposes of trusts established before August 11, 1993. 42 U.S.C. Sec. 1396a(k) defines a Medical Assistance qualifying trust as "a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual."
 - b. This provision does not apply to any trust or initial decrees established before April 7, 1986, solely for the benefit of a developmentally disabled individual who resides in an Long Term Care Institution for the developmentally disabled.
 - c. This provision does not apply to individuals who are receiving SSI.
2. Trusts established on or after July 1, 1994:

Assets include all income and resources of the individual and the individual's spouse, including all income and resources which the individual or the individual's spouse is entitled to but does not receive because of action by any of the following:

 - a. The individual or the individual's spouse,
 - b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse, or
 - c. Any person court or administrative body acting at the direction of or upon the request of the individual or the individual's spouse.

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3. In determining an individual's eligibility for Medical Assistance, the following regulations apply to a trust established by an individual:
- a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust, other than by will:
 - i) The individual or the individual's spouse
 - ii) A person, including a court or administrative body, with legal authority to act in place of, or on the behalf of, the individual or the individual's spouse;
 - iii) A person, including a court or administrative body acting at the direction or upon the request of the individual or the individual's spouse.
 - b. In the case of a trust, the corpus of which includes assets of an individual and the assets of any other person(s), this regulation shall apply to the portion of the trust attributable to the assets of the individual.
 - c. These regulations apply without regard to the following:
 - i) The purposes for which a trust is established;
 - ii) Whether the trustees have or exercise any discretion under the trust;
 - iii) Any restrictions on when or whether distributions may be made from the trust; or
 - iv) Any restrictions on the use of distributions from the trust.
4. Revocable Trusts are considered as follows:
- a. The corpus of the trust shall be considered resources available to the individual.
 - b. Payments from the trust to or for the benefit of the individual shall be considered income to the individual, and
 - c. Any other payments from the trust shall be considered assets transferred by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.
5. Irrevocable Trusts
- If there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the following shall apply:
- a) The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.
 - b) Payments from that portion of the corpus, or income to or for the benefit of the individual, shall be considered income to the individual.

- c) Payments from that portion of the corpus or income for any other purpose shall be considered as a transfer of assets by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.
 - d) Any portion of the trust from which, or any income on the corpus from which no payment could be made to the individual under any circumstances, shall be considered as a transfer of assets for less than fair market value and shall be subject to a 60 month look back period and penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume. The transfer will be effective as of the date of the establishment of the trust, or the date on which payment to the individual from the trust was foreclosed, if later. The value of the trust shall be determined by including the amount of any payments made from such portion of the trust after such date.
6. The preceding regulations for trusts established on or after July 1, 1994, do not apply to the following:
- a. Income Trusts
 - i) A trust consisting only of the individual's pension income, social security income and other monthly income that is established for the purpose of establishing income eligibility for Long Term Care institution care or Home and Community Based Services (HCBS). To be valid, the trust must meet the following criteria:
 - a) The individual's gross monthly income must be above the 300%-SSI limit but below the average cost of private Long Term Care institution care in the geographic region in which the individual resides and intends to remain. The Colorado Department of Health Care Policy and Financing shall calculate the average rates for such regions on an annual, calendar-year basis. The geographic regions which are used for calculating the average private pay rate for Long Term Care institution care shall be based on the Bureau of Economic Analysis Regions and consist of the following counties:

REGION I: (Adams, Arapahoe, Boulder, Broomfield, Denver, Jefferson)

REGION II: (Cheyenne, Clear Creek, Douglas, Elbert, Gilpin, Grand, Jackson, Kit Carson, Larimer, Logan, Morgan, Park, Phillips, Sedgwick, Summit, Washington, Weld, Yuma)

REGION III: (Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, El Paso, Fremont, Huerfano, Kiowa, Lake, Las Animas, Lincoln, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache, Teller)

REGION IV: (Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison, Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel)
 - b) For Long Term Care institution clients, each month the trustee shall distribute the entire amount of income which is transferred into the trust. An amount not to exceed \$20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust.

- c) The only deductions from the monthly trust distribution to the Long Term Care institution are the allowable deductions which are permitted for Medical Assistance-eligible persons who do not have income trusts. Allowable deductions include only the following:
 - i) Personal need allowance
 - ii) Spousal income payments
 - iii) Approved PETI payments
- d) Any funds remaining after the allowable deductions shall be paid solely to the cost of the Long Term Care institution care in an amount not to exceed the Medical Assistance reimbursement rate. Any excess income which is not distributed shall accumulate in the trust.
- e) No other deductions or expenses may be paid from the trust. Expenses which cannot be paid from the trust include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past-due medical bills and other debts. Trustee fees which were ordered prior to April 1, 1996 may continue until the trust terminates.
- f) For HCBS clients, the amount distributed each month shall be limited to the 300% of the SSI limit. Any monthly income above that amount shall remain in the trust. An amount not to exceed \$20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust. No other trust expenses or deductions may be paid from the trust. For the purpose of calculating Individual Cost Containment or client payment (PETI), the client's monthly income will be 300% of the SSI limit. Upon termination, the funds which have accumulated in the trust shall be paid to the Department up to the total amount of Medical Assistance paid on behalf of the individual.
- g) For a court-approved trust, notice of the time and place of the hearing, with the petition and trust attached, shall be given to the eligibility site and the Department in the manner prescribed by law.
- h) The sole beneficiaries of the trust are the individual for whose benefit the trust is established and the Department. The trust terminates upon the death of the individual or if the trust is not required for Medical Assistance eligibility in Colorado.
- i) The trust must provide that upon the death of the individual or termination of the trust, whichever occurs sooner, the Department shall receive all amounts remaining in the trust up to the total amount of Medical Assistance paid on behalf of the individual.
- j) The trust must include the name and mailing address of the trustee. The trustee must notify the Department of any trustee address changes or change of trustee(s) within 30 calendar days.

- k) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the eligibility site or to the Department upon reasonable request or upon any change of trustee.
- l) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.
- m) The regulations in this section for income trusts shall also apply to income trusts established after January 1, 1992, under the undue hardship provisions in 26-4-506.3(3), C.R.S. and 15-14-412.5, C.R.S.

b. Disability Trusts

- i) A trust that is established solely for the benefit of a disabled individual under the age of 65, which consists of the assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the individual's resource eligibility for Medical Assistance and which meets the following criteria:
 - a) The individual for whom the trust is established must meet the disability criteria of Social Security.
 - b) [Removed and Reserved]
 - c) The trust is established solely for the benefit of the disabled individual by the individual, the individual's parent, the individual's grandparent, the individual's legal guardian, or by the court.
 - d) The sole lifetime beneficiaries of the trust are the individual for whose benefit the trust is established, the Colorado Department of Health Care Policy and Financing, and any other state that provides medical assistance to the individual under such state's Medicaid program.
 - e) The trust terminates upon the death of the individual or if the trust is no longer required for Medical Assistance eligibility.
 - i) If the individual becomes ineligible for Medical Assistance in Colorado or any other state due to a change in residency, then the trust shall terminate unless the Department receives proof that: (1) the individual is receiving medical assistance under another state's Medicaid program; and (2) the trust is required for the individual to receive those medical assistance benefits. The trustee must submit the required proof no later than sixty (60) calendar days from the date the trustee acquires knowledge of the change in residency. An extension of time may be granted upon submission of a written request to the Department by the trustee.
 - ii) The trustee must provide the Department with notice of the individual's death, loss of Medicaid eligibility, or change in residency no later than sixty (60) calendar days from the date the trustee acquires knowledge of such event.

- f) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the trust and approval of the trust.
- g) If the trust is funded with an annuity or other periodic payments, the trust shall be named on the contract or settlement as the remainder beneficiary or the Department and any other state that provided medical assistance to the individual under such state's Medicaid program may be named as remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual.
- h) The trust shall provide that, upon the death of the beneficiary or termination of the trust, the Department and any other state that provided medical assistance to the individual under such state's Medicaid program shall receive all amounts remaining in the trust up to the amount of total medical assistance paid on behalf of the individual. If the trust does not have sufficient funds to reimburse each state in full, the amount remaining in the trust shall be distributed based on each state's proportionate share of the total amount of medical assistance benefits paid by all of the states on the individual's behalf.
- i) No expenditures may be made after the death of the beneficiary, except for federal and state taxes. However, prior to the death of the individual beneficiary, trust funds may be used to purchase a burial fund for the beneficiary.
- j) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.
- k) The trust fund shall not be considered as a countable resource in determining eligibility for Medical Assistance.
- l) [Rule 8.110.52 B 5. b. 1) I), adopted or amended on or after November 1, 2000 and before November 1, 2001 was not extended by HB 02-1203, and therefore expired May 15, 2002.]
- m) Distributions from the trust may be made only to or for the benefit of the individual beneficiary. Cash distributions from the trust shall be considered income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.
- n) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward eligibility.
- o) The trust must include the name and mailing address of the trustee. The Department must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.

- p) The trust must provide that an accounting of trust income and expenditures and statement of trust assets shall be submitted to the eligibility site and to the Department on an annual basis and upon reasonable request or any change of trustee. Further, the trust must provide that the trustee is required to give the Department notice of any distribution in excess of \$5,000 no later than thirty (30) days after such distribution. The Department shall acknowledge receipt within thirty (30) days of receiving the notice.
 - q) Prior to the establishment or funding of a disability trust, the trust shall be submitted for review to the Department, along with proof that the individual beneficiary is disabled according to Social Security criteria. No disability trust shall be valid unless the Department has reviewed the trust and determined that the trust conforms to the requirements of 15-14-412.8, C.R.S., as amended, and any rules adopted by the Medical Services Board..
- c. Pooled Trusts
 - i) A trust consisting of individual accounts established for disabled individuals for the purpose of establishing resource eligibility for Medical Assistance. A valid pooled trust shall meet the following criteria:
 - a) The individual for whom the trust is established must meet the disability criteria of Social Security.
 - b) The trust is established and managed by a non-profit association which has been approved by the Internal Revenue Service.
 - c) A separate account is maintained for each beneficiary; however, the trust pools the accounts for the purposes of investment and management of the funds.
 - d) The sole lifetime beneficiaries of each trust account are the individual for whom the trust is established and the Department.
 - e) If the trust is funded with an annuity or other periodic payments, the Department or the pooled trust shall be named as remainder beneficiary.
 - f) The trust account shall be established by the disabled individual, parent, grandparent, legal guardian, or the court.
 - g) The only assets used to fund each trust account are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under *Sullivan v. Zeblev*. (This provision is applicable to pooled trusts established from July 1, 1994 to December 31, 2000.)
 - h) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the individual's trust account and approval of the joinder agreement.

- i) Following the disabled individual's death or termination of the trust account, whichever occurs sooner, to the extent that the remaining funds in the trust account are not retained by the pooled trust, the Department shall receive any amount remaining in the individual's trust account up to the total amount of Medical Assistance paid on behalf of the individual.
 - j) The pooled trust account shall not be considered as a countable resource in determining Medical Assistance eligibility.
 - k) Distributions from the trust account may be made only to or for the benefit of the individual. Cash distributions to the individual from the trust shall be considered as income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.
 - l) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward resource eligibility.
 - ii) If an institutionalized individual for whom a pooled trust is established is 65 years of age or older, the transfer of assets into the pooled trust creates a rebuttable presumption that the assets were transferred without fair consideration and shall be analyzed in accordance with the rules on transfers without fair consideration in this volume. This regulation is effective for transfers to pooled trusts after January 1, 2001.
 - iii) When the individual beneficiary of an income, disability or pooled trust dies or the trust is terminated, the trustee shall promptly notify the eligibility site and the Department. To the extent required by these rules the trustee shall promptly forward the remainder of the trust property to the Department, up to the amount of Medical Assistance paid on behalf of the individual beneficiary.
- d. Third Party Trusts
- i) Third party trusts are trusts which are established with assets which are contributed by individuals other than the applicant or the applicant's spouse for the benefit of an applicant or client
 - ii) The terms of the trust will determine whether the trust fund is countable as a resource or income for Medical Assistance eligibility.
 - iii) Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource. If distributions are made for income or resources, such distributions are countable as such for eligibility.
 - iv) If the trust requires income distributions, the amount of the income shall be countable as income in determining eligibility.
 - v) If the trust requires principal distributions, that amount shall be considered as a countable resource.
 - vi) If the trustee may exercise discretion in distributing income or resources, the income or resources are not countable in determining eligibility. If distributions are made for income or resources, such distributions are countable as such for eligibility.

- e. Federally Approved Trusts
 - i) If an SSI recipient has a trust which has been approved by the Social Security Administration, eligibility for Medical Assistance cannot be delayed or denied. Individuals on SSI are automatically eligible for Medical Assistance despite the existence of a federally approved trust.
 - ii) If the eligibility site has a copy of a federally approved trust, the eligibility site must send a copy to the Department.
- 7. Submission of Trust Documents and Records
 - a. The trustee of a trust which was established by or which benefits a Medical Assistance Applicant or client shall submit trust documents and records to the eligibility site and to the Department.
 - b. This requirement includes documents and records for income trusts, disability trusts and the joinder agreement for each pooled trust account.
 - c. The eligibility site shall submit any trust which is submitted with an application or at redetermination to The Department. The eligibility site shall determine Medical Assistance eligibility based on the determination of The Department as to the effect of the trust on eligibility.

8.100.7.F. Transfers of Assets Without Fair Consideration

- 1. Definitions. The following definitions apply to transfers of assets without fair considerations:
 - a. "Assets" include all income and resources of the individual and such individual's spouse, including any interest in income or a resource as well as all income or resources which the individual or such individual's spouse is entitled to but does not receive because of action by any of the following:
 - i) The individual or such individual's spouse,
 - ii) A person, a court, or administrative body with legal authority to act on behalf of the individual or such individual's spouse, or
 - iii) Any person, court or administrative body acting at the direction of or upon the request of the individual or such individual's spouse.
 - b. "Fair market value" is the value of the asset if sold at the prevailing price at the time it was transferred.
 - c. "Fair consideration" is the amount the individual receives in exchange for the asset that is transferred, which is equal to or greater than the value of the transferred asset.
 - d. "Look-back period" means the number of months prior to the month of application for long-term care services that the Department will consider for transfer of assets.
 - e. "Penalty period" means a period of time for which an applicant or client will not be eligible to receive long-term care services.

- f. "Uncompensated value" shall mean the fair market value of an asset at the time of the transfer minus the value of compensation the individual receives in exchange for the asset.
- g. "Valuable consideration" shall mean what an individual receives in exchange for his or her right or interest in an asset which has a tangible and/or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset.

2. General Provisions

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

- a. For transfers made before February 8, 2006, the look-back period is 36 months prior to the date of application. For transfers made on or after February 8, 2006, the look-back date is 60 months prior to the date of application.
- b. An institutionalized individual is one who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).
- c. If an institutionalized individual or such individual's spouse transfers assets without fair consideration on or after the look-back period, the transfer shall be evaluated as follows:
 - i) The fair market value of the transferred asset, less the actual amount received, if any, shall be divided by the average of the regions, defined at 8.100.7.E, monthly private pay cost for Long-Term Care institution care in the state of Colorado at the time of application.
 - ii) The resulting number is the number of months that the individual shall be ineligible for Medical Assistance. For transfers made before February 8, 2006, the period of ineligibility shall begin with the first day of the month following the month in which the transfer occurred. For transfers made on or after February 8, 2006, the period of ineligibility shall begin on the later of the following dates:
 - a) The first day of the month following the month in which the transfer occurred or is discovered. For transfers discovered after the date the transfer occurred, the date of transfer shall be the discovery date.

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

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

- d. The period of ineligibility shall also include partial months, which shall be calculated by multiplying 30 days by the decimal fractional share of the partial month. The result is the number of days of ineligibility. For transfers occurring on or after April 1, 2006, the result shall be rounded up to the nearest whole number.
- e. There is no maximum period of ineligibility.
- f. For transfers prior to February 8, 2006, the total amount of all of the transfers are added together and the period of ineligibility begins the first day of the month following the month in which the resources are transferred.
 - i) If the previous penalty period has completely expired, the transfers are not added together.
 - ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.
- g. For transfers on or after February 8, 2006, the total amounts of all of the transfers are added together and the penalty period is assessed as outlined in section 8.100.7.F.2.c-d above.
 - i) If the previous penalty period has completely expired, the transfers are not added together.
 - ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.
- h. The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and basic Medical Assistance services, but shall not be eligible for Medical Assistance for Long-Term Care institution services, Home and Community Based Services or the Program of All Inclusive Care for the Elderly due to the transfer without fair consideration.
- i. If a transfer without fair consideration is made during a period of eligibility, a period of ineligibility shall be assessed in the same manner as stated above.
- j. Actions that prevent income or resources from being received, or reduce an individual's ownership, right or interest in an asset such that the individual does not receive valuable consideration as set forth on the following list, which is not exclusive, shall create a rebuttable presumption that the transfer was without fair consideration:
 - i) Waiving pension income.
 - ii) Waiving a right to receive an inheritance.
 - iii) Preventing access to assets to which an individual is entitled by diverting them to a trust or similar device. This is not applicable to valid income trusts, disability trusts and pooled trusts for individuals under the age of 65 years.
 - iv) Failure of a surviving spouse to elect a share of a spouse's estate or failure to open an estate within 6 months after a spouse's death.

- v) Failure to obtain a family allowance or exempt property allowance from an estate of a deceased spouse or parent. Such allowances are presumed to be available 3 months after death.
- vi) Not accepting or accessing a personal injury settlement.
- vii) Transferring assets into an irrevocable private annuity which was not purchased from a commercial company.
- viii) Transferring assets into an irrevocable entity such as a Family Limited Partnership which eliminates or restricts the individual's access to the assets.
- ix) Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony, if the benefit outweighs the cost.
- x) Failure to exercise rights in a Dissolution of Marriage case, which insure an equitable distribution of marital property and income.
- xi) Purchasing a single-premium life insurance policy, endowment policy or similar instrument within the look-back period, which has no cash value, and for which the individual receives no valuable consideration shall be considered an uncompensated transfer. The total amount of the purchase price shall be considered a transfer without fair consideration.

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

1. Promissory notes established before April 1, 2006:
 - a. The fair market value of promissory notes is a countable resource and must be evaluated in accordance with the regulations on consideration of resources in this volume.
 - b. Promissory notes with one or more of the following provisions, indicating they have little or no market value, shall create a rebuttable presumption of a transfer without fair consideration:
 - i) An interest rate lower than the prevailing market rate.
 - ii) A term for repayment longer than the life expectancy of the holder of the note, as determined by the tables at 8.100.7.J. for annuities purchased on or after February 8, 2006.
 - iii) Low payments.
 - iv) Cancellation at the death of the note holder.
 - c. Promissory notes which have been appraised by a note broker as having little or no value shall create a rebuttable presumption of a transfer without fair consideration.
2. Promissory notes established on or after April 1, 2006 but before March 1, 2007
 - a. Subject to the look-back date described in section 8.100.7.F.2.b for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.n. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c.

3. Promissory notes established on or after March 1, 2007
 - a. Subject to the look-back date described in section 8.100.7.F.2.b, for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.o. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c..
4. Personal care services
 - a. Effective for agreements that were signed and notarized prior to March 1, 2007, family members who provide assistance or services are presumed to do so for love and affection, and compensation for past assistance or services shall create a rebuttable presumption of a transfer without fair consideration unless the compensation is in accordance with the following:
 - i) A written agreement must be executed prior to the delivery of services.
 - ii) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement.
 - iii) The agreement must be dated and the signature must be notarized; and
 - iv) Compensation for services rendered must be comparable to what is received in the open market.
 - b. Effective for agreements that are signed and notarized on or after March 1, 2007, compensation under personal service agreements will be deemed to be a transfer without fair consideration unless the following requirements are met:
 - i) A written agreement was executed prior to the delivery of services; and
 - a) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement; and
 - b) The legally authorized representative, agent, guardian, conservator, or other representative of the applicant's estate may not be a beneficiary of a care agreement; and
 - c) The agreement specifies the type, frequency and time to be spent providing the services agreed to in exchange for the payment or transferred item; and
 - d) The agreement provides for payment of services on a regular basis, no less frequently than monthly, while the services are being provided; and
 - ii) Compensation for services rendered must be comparable to what is received in the open market. The burden is on the applicant to prove that the compensation is reasonable and comparable; and

- iii) A record or log is provided which details the actual services rendered. The services cannot be services that duplicate services that another party is being paid to provide or which another party is responsible to provide.
 - c. Payment for services, which were rendered previously and for which no compensation was made, shall be considered as a transfer without fair consideration.
 - d. Assets transferred in exchange for a contract for personal services for future assistance after the date of application are considered available resources.
 - e. A care agreement must be entered into, signed, and notarized prior to providing any services for which a beneficiary will be compensated.
- 5. Transfers of real property into joint tenancy without fair consideration
 - a. If real property is transferred into joint tenancy with right of survivorship with one or more joint tenants, the amount transferred depends on the number of joint tenants to whom the property is transferred. The following are examples:
 - i) If the transfer is to one joint tenant, the amount transferred is equal to one-half of the value of the property at the time of the transfer.
 - ii) If the transfer is to two joint tenants, the amount transferred is equal to two-thirds of the value.
 - iii) If the transfer is to three joint tenants, the amount transferred is equal to three-fourths of the value of the property at the time of the transfer.
 - b. If the transfer is completed with two deeds or transactions, the first of which transfers a fractional share of the property into tenancy in common, and the second into joint tenancy, the amount transferred shall be determined in the same manner as set forth above.
- 6. No period of ineligibility will be imposed if the individual transferred the assets under any of following circumstances:
 - a. The asset transferred was a home and title to the home was transferred to:
 - i) The spouse of such individual;
 - ii) A child of such individual who is either
 - 1) Under the age of 21 years, or
 - 2) Is blind or totally and permanently disabled as determined by the Social Security Administration.
 - iii) A brother or sister
 - 1) Who has an equity interest in the home and
 - 2) Who was residing in such individual's home for at least one year immediately before the date that the individual becomes institutionalized.
 - iv) A son or a daughter of such individual

- 1) Who was residing in the home for a period of at least two years immediately before the date the individual becomes institutionalized and
 - 2) Who provided care to such individual by objective evidence, that permitted such individual to reside at home rather than in an institution.
 - 3) Documentation shall be submitted proving that the son or daughter's sole residence was the home of the parent. The parent's attending physician(s) or professional health provider(s) during the past two years must substantiate in writing that the care was provided, and that the care prevented the parent from requiring placement in a Long-Term Care institution.
- b. The assets were transferred:
- i) To the individual's spouse or to another for the sole benefit of the individual's spouse.
 - ii) From the individual's spouse to another for the sole benefit of the individual's spouse.
 - iii) To a trust which is established solely for benefit of the individual's child who is determined to be blind or totally disabled by the Social Security Administration or to that child directly for the sole benefit of the child.
 - iv) To a trust established solely for the benefit of an individual under 65 years of age who is determined to be blind or totally disabled by the Social Security Administration.
- c. Definition of the term "for the sole benefit of," as used in the preceding exceptions to the transfer penalty rules:
- i). A transfer or a trust is considered to be for the sole benefit of the spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.
 - ii). To insure that the asset transferred is for the sole benefit of the spouse, blind or disabled child or disabled individual, the following criteria must be met:
 - 1) The transfer must be accomplished by a written instrument which legally binds the parties to a specified course of action and sets forth:
 - a) The conditions under which the transfer was made, and
 - b) A statement as to whom can benefit from the transfer.
 - 2) The written instrument must provide for the spending of funds or use of the transferred assets for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual.

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- 3) Disability trusts and income trusts, which designate the Colorado Department of Health Care Policy and Financing as the remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual, are exempt from this requirement.
 - 4) A community spouse to whom a Community Spouse Resource Allowance has been transferred does not have to provide a written document or comply with the requirement that the transfer is actuarially sound. However, the Community Spouse Resource Allowance must be for the sole benefit of the community spouse to whom it is transferred. Upon the death of the community spouse, those resources shall be made available to the surviving spouse, at least up to the amount of the elective share of the augmented estate, the family allowance and the exempt property allowance.
7. There is a rebuttable presumption the transfer without fair consideration was made for purposes of Medical Assistance eligibility or avoiding the medical assistance estate recovery program.
- a. The presumption that an asset was transferred to establish or maintain Medicaid eligibility or to avoid the medical assistance estate recovery program is rebutted only if the individual or individual's spouse demonstrates by providing convincing evidence that the asset was transferred exclusively for some other purpose and the reason for the transfer did not include Medical Assistance eligibility or avoidance of medical assistance estate recovery..
 - b. A subjective statement of intent or ignorance of the transfer penalty or verbal assurances that the individual was not considering Medical Assistance eligibility when the transfer was made are not sufficient.
 - c. There is a rebuttable presumption that transfers without fair consideration were made for the purpose of Medical Assistance eligibility in the following cases:
 - i) In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer total an amount insufficient to meet all living expenses and medical expenses reasonably expected to be incurred by the individual or the individual's spouse in the sixty (60) months following the transfer. Medical expenses include the cost of Long-Term Care unless the future necessity of such care could have been absolutely precluded because of the particular circumstances.
 - ii) In any case where:
 - 1) the transfer was made on behalf of the individual or the individual's spouse;
 - 2) the transfer was made by:
 - a) the individual or individual's spouse
 - b) a guardian,
 - c) a conservator, or
 - d) agent under a power of attorney; and

- 3) the transfer was made to:
 - a) anyone related to the individual or individual's spouse by birth, adoption or marriage, other than between the individual and the individual's spouse; or to
 - b) anyone related to the guardian, conservator, or agent under a power of attorney by birth, adoption or marriage.
- d. Convincing evidence may include, but is not limited to, verification which establishes:
 - i) That at the time of the transfer the individual could not have anticipated needing long term Medical Assistance due to the existence of other circumstances which would have precluded the need.
 - ii) Other assets were available at the time of the transfer to meet current and future needs of the individual, including the cost of Long-Term Care institution or other institutionalized care for a period of sixty (60) months.
 - iii) The specific purpose for which the assets were transferred and the reason the transfer was necessary and the reason there was no alternative but to transfer the assets without fair consideration.
- 8. Apportionment of penalty period between spouses
 - a. If a transfer results in a period of ineligibility for an individual, and the individual's spouse becomes institutionalized and is otherwise eligible for Medical Assistance, the period of ineligibility shall be apportioned equally between the spouses.
 - b. If one spouse dies or is no longer institutionalized, any months remaining in the period of ineligibility shall be assigned to the spouse who remains institutionalized.
- 9. If the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of a trust, the trust document shall be submitted to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on Medical Assistance eligibility.
- 10. Notice
 - a. The Colorado Department of Health Care Policy and Financing is an interested person according to 15-14-406, C.R.S. or a successor statute.
 - b. As an interested party, the department shall be given notice of a hearing in cases in which Medical Assistance planning or Medical Assistance eligibility is set forth in the petition as a factor for requesting court authority to transfer property.
- 11. Undue Hardship
 - a. The period of ineligibility resulting from the imposition of the transfer or the trust provisions may be waived if denial of eligibility would create an undue hardship for an individual who is otherwise eligible. Undue hardship can be established if application of the transfer penalty would:
 - i) deprive the individual of medical care such that the individual's health or life would be endangered; or

- ii) deprive the individual of food, clothing, shelter or other necessities of life.
- b. Undue hardship shall not exist when the application of the trust or transfer rules merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.
- c. Notice of an undue hardship exception shall be given to the applicant or client. The Eligibility Site shall make a determination on the request within 15 working days from when the request is received. The Eligibility Site shall issue a notice of action on the determination of hardship. An adverse determination may be appealed in accordance with the appeal process as described at Section 8.057 of this volume.
- d. The facility in which an institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual with the individual's or his or her personal representative's consent. Where the individual is unable to give consent and where the personal representative of the individual has a conflict of interest concerning the particular circumstance giving rise to the period of ineligibility, the facility may request an undue hardship on behalf of the individual. An example of such a conflict of interest would be a situation where the personal representative who is also an agent under a power of attorney transfers property to himself or herself. The facility shall submit the undue hardship request to the Eligibility Site and give sufficient detail of the circumstance surrounding the conflict of interest and the information required below to the Eligibility Site. These provisions are not intended to change the Department's requirements under Section 8.057 of the Department's regulations as to who has standing to file an appeal.
- e. An individual or representative may request that the Eligibility Site waive a transfer penalty on the basis of undue hardship. The request shall be made in writing to the applicant's or client's Eligibility Site case worker. The individual making the request has the burden of proof and must provide clear and convincing evidence to substantiate the circumstances surrounding the transfer, attempts to recover the assets, and the impact of the denial of Medicaid payments for Long-Term Care services. The request and documentation shall include all of the following:
 - i) the reason(s) for the transfer including the individual's participation in the transfer or grant of legal authority to another that gave rise to the transfer, and the relationship between the transferor and transferee;
 - ii) evidence to prove that the assets have been irretrievably lost and that all reasonable attempts made to recover the asset(s), including any legal actions and the results of the attempts, including but not limited to a request for an adult protection investigation (such as in a case of financial exploitation), filing a police report, or filing a civil action have been exhausted or have been or are being pursued; and,
 - iii) documentation such as a notice of discharge or pending discharge from the facility and a physician's statement detailing how the inability to receive nursing facility or community based services would result in the individual's inability to obtain life-sustaining medical care or that the individual would not be able to obtain food, clothing or shelter.
- f. To the extent that the transferred assets are recovered pursuant to the attempts in (e)(ii) above, the individual shall reimburse Medicaid for the funds expended as a result of an approved undue hardship request.

- g. If the transferee and the transferor of the assets for which the transfer penalty is being imposed are related parties there shall be a rebuttable presumption that the transferred assets are not irretrievably lost as required under (e)(ii) above. Related parties are described in Section 8.100.7.G.7.c.ii of these regulations.
- 12. No period of ineligibility shall be assessed in any of the following circumstances:
 - a. Convincing and objective evidence is provided that the individual intended to dispose of the resources either at fair market value or for other fair consideration.
 - b. Convincing and objective evidence is presented proving that the resources were transferred exclusively for a purpose other than to qualify or remain eligible for Medical Assistance.
 - c. All of the resources transferred without fair consideration have been returned to the individual.
 - d. For assets transferred before February 8, 2006, the assets were transferred more than 36 months prior to the date of application.
 - e. For assets transferred before February 8, 2006, the penalty period has expired based on the following formula: The fair market value of the transferred asset is divided by the average cost of Long Term Care institution care in the state at the time of application and the resulting number of months of ineligibility has ended prior to the date of application.

8.100.7.H. Life Estates

- 1. Definitions
 - a. "Fair Market Value" means the amount for which a property or interest in a property could reasonably be expected to sell on the open market.
 - b. "Life Estate." A life estate conveys upon a grantee certain rights in property measured by the life of the life estate holder or of some other person. The owner of a life estate has the right to possess the property, the right to use the property, the right to obtain profits from the property, and the right to sell the life estate interest in the property. The establishment of a life estate on a property results in the creation of two interests: a life estate interest and a remainder interest.
 - c. "Remainder Interest" means an interest in property created at the time a life estate is established which gives the holder of the interest the right to ownership of the property upon the death of the life estate holder. An individual holding a remainder interest is free to sell his or her interest in the property unless the sale is restricted by the terms of the instrument which established the remainder interest.
- 2. General Provisions
 - a. Life Estates Established before July 1, 1995
 - i) Transfer without fair consideration Treatment
 - 1) The establishment of a life estate before July 1, 1995 by an individual or individual's spouse shall not be considered a transfer without fair consideration.

- ii) Resource Treatment
 - 1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered to be an exempt resource.
 - 2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.
 - i) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.
 - 3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.
 - 4) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource
 - i) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.a.
- b. Life Estates Established on or after July 1, 1995
 - i) Transfer without fair consideration Treatment
 - 1) The establishment of a life estate on or after July 1, 1995 on property owned by an individual or individual's spouse shall be considered a transfer without fair consideration if the life estate was established within the look-back period described at 8.100.7.F.2.b.
 - a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be based on the value of the remainder interest, as calculated using the methodology described at 8.100.7.H.4.a.
 - 2) The purchase of a life estate interest in a home not owned by an individual or individual's spouse on or after April 1, 2006 within the look-back period described at 8.100.7.F.2.b. shall be considered a transfer without fair consideration unless the purchaser lives in the home for a period of at least twelve (12) consecutive months after the date of the purchase.
 - a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be the entire amount used to purchase the life estate.
 - b) If the payment for the life estate exceeds the value of the life estate, as calculated using the methodology described at 8.100.7.H.3, then the difference between the amount paid and the value of the life estate shall be considered to be a transfer without fair consideration.

ii) Resource Treatment

- 1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered an exempt resource.
- 2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.
 - a) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.a.
- 3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.
- 5) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource
 - a) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.

3. Determining the Value of a Life Estate

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

- i) Determine the fair market value of the property on which the life estate was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the actual value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.
- ii) Multiply the fair market value of the property by the "Life Estate" factor in Column 1 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the life estate interest.

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

4. Determining the Value of a Remainder Interest

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

- i) Determine the fair market value of the property on which the remainder interest was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the market value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.
- ii) Multiply the fair market value of the property by the "Remainder" factor in Column 2 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the remainder interest.

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

5. Life Estate Table

This rule incorporates by reference the Social Security life estate and remainder interest table effective April 1999 to the present. The incorporation of the table excludes later amendments, or editions of, the referenced material.

The Social Security life estate and remainder interest tables are available at <http://policy.ssa.gov/poms.nsf/lnx/0501140120>

Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.7.I. Annuities

1. DEFINITIONS

- a. “Annuity” means a contract between an individual and a commercial company in which the individual invests funds and in return receives installments for life or for a specified number of years.
- b. “Annuitant” means an individual who is entitled to receive payments from an annuity.
- c. “Annuitization Period” means the period of time during which an annuity makes payments to an annuitant.
- d. “Annuitized” means an annuity that has become irrevocable and is making payments to an annuitant.
- e. “Assignable” means an annuity that can have its owner and/or annuitant changed.
- f. “Balloon Payment” means a lump sum equal to the initial annuity premium less any distributions paid out before the end of an annuitization period.
- g. “Beneficiary” means an individual or individuals entitled to receive any remaining payments from an annuity upon the death of the annuitant.
- h. “Department” means the Department of Health Care Policy and Financing, its successor(s), or its designee(s).
- i. “Irrevocable” means an annuity that cannot be canceled, revoked, terminated, or surrendered under any circumstances.
- j. “Non-assignable” means an annuity that cannot have its owner and/or annuitant changed under any circumstances.
- k. “Owner” means the person who may exercise the rights provided in an annuity contract during the life of the annuitant. An owner can generally name himself or herself or another person as the annuitant.

- I. "Revocable" means an annuity that can be canceled, revoked, terminated, or surrendered.
 - m. "Transaction" means:
 - i) The purchase of an annuity;
 - ii) The addition of principal to an annuity;
 - iii) Elective withdrawals from an annuity;
 - iv) Requests to change the distributions from an annuity;
 - v) Elections to annuitize an annuity contract; or
 - vi) Any other action taken by an individual that changes the course of payments made by an annuity or the treatment of income or principal of an annuity.
- 2. Annuities purchased on or before June 30, 1995
 - a. A revocable or irrevocable annuity established on or before June 30, 1995 is not a countable resource if it is annuitized and regular returns are being received by the annuitant.
 - i) Payments from the annuity to the individual or individual's spouse are income in the month received.
 - b. A revocable or irrevocable annuity established on or before June 30, 1995 is a countable resource if it has not been annuitized.
- 3. Annuities Established on or after July 1, 1995 but before February 8, 2006
 - a. The purchase of an annuity shall be considered to be a transfer without fair consideration unless the following criteria are met:
 - i) The annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business;
 - ii) The annuity is annuitized for the individual or individual's spouse;
 - iii) The annuity is purchased on the life of the individual or individual's spouse; and
 - iv) The annuity provides payments for a period not exceeding the annuitant's projected life expectancy based on life expectancy tables described at 8.100.7.J.
 - b. To determine if a transfer without fair consideration has occurred in the purchase of an annuity, the Eligibility Site shall:
 - i) Determine the date on which the annuity was purchased;
 - ii) Determine the amount of money used to purchase the annuity and the length of the annuitization period;
 - iii) Determine the age of the annuitant at the time the annuity was purchased; and

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- iv) Determine the life expectancy of the annuitant at the time the annuity was purchased using the appropriate life expectancy table described at 8.100.7.J.
 - 1) If the length of the annuitization period exceeds the annuitant's life expectancy, then a transfer without fair consideration exists for the portion of the annuitization period that exceeds the annuitant's life expectancy.
 - 2) If the total value of the annuity's payments during the annuitization period is less than the original purchase price of the annuity, then the difference shall be considered to be a transfer without fair consideration.
 - 3) If the total value of the annuity's payments during the annuitization period is equal to or greater than the original purchase price of the annuity, then the purchase of the annuity shall not be considered to be a transfer without fair consideration. However, any payments made by the annuity shall be considered to be countable income in the month received.
 - 4) If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period. However, any payments made by the annuity shall be considered to be countable income in the month received.
 - 4. Annuities Established on or after April 1, 1998 but before February 8, 2006
 - a. The Eligibility Site shall determine the Minimum Monthly Maintenance Needs Allowance (MMMNA) of the community spouse, if applicable.
 - i) If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, then the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered to be a transfer without fair consideration in determining the institutionalized spouse's eligibility. This applies only to the extent that the transferred amount causes the Community Spouse Resource Allowance to exceed the maximum.
 - b. The Eligibility Site shall determine if the Individual is receiving substantially equal installments from the annuity for the annuitization period of the annuity.
 - i) If the annuity is not paid in substantially equal installments, then the original purchase price of the annuity shall be considered to be a transfer without fair consideration.
 - c. If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period.
 - i) Any payments made by the annuity shall be considered to be countable income in the month received.
 - 5. Annuities Purchased on or after February 8, 2006
 - a. As a condition of Medicaid eligibility, at the time of application or redetermination, an applicant or his or her spouse for Medicaid Long-Term Care services shall disclose any interest that the Medicaid applicant or his or her spouse has in an annuity.
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- i) A complete copy of the annuity contract, including the most recent beneficiary designation, shall be provided to the eligibility site.
- b. By providing Medicaid Long-Term Care services, the Department shall be a remainder beneficiary of any annuity in which an individual or individual's spouse has an interest. The purchase of the annuity shall not be considered to be a transfer without fair consideration if:
 - i) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or
 - ii) The Department is named as the remainder beneficiary in the next position after the community spouse or minor or disabled child.
 - iii) This provision shall not apply to annuities that are revocable and/or assignable.
- c. The Eligibility Site shall notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity for medical assistance provided to the institutionalized individual. This notice shall include a statement requiring the issuer to notify the Eligibility Site of any changes in the amount of income or principal that is being withdrawn from the annuity or any other transactions, as defined at 8.100.7.1.1., regardless of when the annuity was purchased.
- d. If the Department is not named on the annuity as a remainder beneficiary, then the value of funds used to purchase the annuity shall be deemed a transfer without fair consideration and shall be subject to the penalty period provisions described at 8.100.7.F.
 - i) This provision shall not apply to annuities that are revocable and/or assignable.
- e. Revocable Annuities
 - i) A revocable annuity is a countable resource. The value of the annuity is the total value of the annuity principal plus any accumulated interest.
 - a) If the annuity includes a surrender charge or other financial penalty (other than tax withholding or a tax penalty) for withdrawing funds from the annuity, then the value of the annuity is the net amount the individual would receive upon full surrender of the annuity.
 - ii) Payments from a revocable annuity are not countable as income.
- f. Irrevocable Assignable Annuities
 - i) An irrevocable assignable annuity is a countable resource. The value of the annuity is presumed to be the total value of the annuity principal plus any accumulated interest.
 - a) An individual or individual's spouse can rebut the presumption by providing documented offers from at least three companies who are active in the market for buying and selling annuities an annuity income streams. The value of the annuity shall then be the highest of the offers.
 - b) Any payments from an irrevocable assignable annuity that is considered to be a countable resource are not considered to be countable income.

- ii) An individual or individual's spouse can rebut the presumption that an irrevocable assignable annuity is not a countable resource by providing documented offers from at least three companies who are active in the market for buying and selling annuities and annuity income streams stating their unwillingness or inability to purchase the annuity or annuity income stream.
 - a) Any payments from an irrevocable assignable annuity that is not considered to be a countable resource are considered to be countable income in the month received.
- g. Irrevocable Non-Assignable Annuities
 - i) An irrevocable non-assignable annuity is not considered to be a countable resource.
 - ii) Payments from an irrevocable non-assignable annuity are considered countable income in the month received.
 - iii) An irrevocable non-assignable annuity purchased by or for the benefit of a community spouse shall not be considered to be a transfer without fair consideration if:
 - 1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or
 - 2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.
 - iv) An irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if:
 - 1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or
 - 2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.
 - v) In addition to the requirements listed at 8.100.7.1.5.g.iv) for naming the Department as remainder beneficiary, an irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if the annuity meets any one of the following conditions:
 - 1) The annuity is considered either:
 - a) An Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or

- b) A deemed Individual Retirement Account under a qualified employer plan described in Section 408(q) of the Internal Revenue Code of 1986; or
 - 2) The annuity is purchased with proceeds from one of the following:
 - a) An Individual Retirement Account as described in Section 408(a) of the Internal Revenue Code of 1986; or
 - b) An account established by an employer or association of employers as described in Section 408(c) of the Internal Revenue Code of 1986; or
 - c) A simple retirement account as described in Section 408(p) of the Internal Revenue Code of 1986; or
 - d) A simplified employee pension plan as described in Section 408(k) of the Internal Revenue Code of 1986; or
 - e) A Roth IRA as described in Section 408A of the Internal Revenue Code of 1986; or
 - 3) The annuity meets all of the following requirements:
 - a) The annuity is irrevocable and non-assignable; and
 - b) The annuity is actuarially sound based on the life expectancy tables described at 8.100.7.J.; and
 - c) The annuity provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.
 - vi) If an irrevocable non-assignable annuity is considered to be a transfer without fair consideration, then, for the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount of funds used to purchase the annuity.
- h. Annuity Transactions
- i) If an Individual or individual's spouse undertakes any transaction, as defined at 8.100.7.I.1. which has the effect of changing the course of payments to be made by an annuity or the treatment of income or principal of the annuity, such a transaction shall be deemed to be a transfer without fair consideration, regardless of when the annuity was originally purchased. For the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount used to purchase the annuity.
 - a) Routine changes such as a notification of an address change or death or divorce of a remainder beneficiary are excluded from treatment as a transfer without fair consideration.

- b) Changes which occur based on the terms of the annuity which existed before February 8, 2006 and which do not require a decision, election, or action to take effect are excluded from treatment as a transfer without fair consideration.
- c) Changes which are beyond the control of the individual, such as a change in law, a change in the policies of the annuity issuer, or a change in terms based on other factors, such as the annuity issuer's financial condition, are excluded from treatment as a transfer without fair consideration.

8.100.7.J. Life Expectancy Tables

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

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

Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

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

1. The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community. Being a community spouse does not prohibit Medicaid eligibility if all criteria are met. The community spouse resource allowance does not supersede the Medicaid eligibility criteria.
2. For purposes of spousal protection, an institutionalized spouse is an individual who:
 - a. Begins a stay in a medical institution or nursing facility on or after September 30, 1989, or
 - b. Is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or
 - c. Receives Home and Community Based Services on or after July 1, 1999; and
 - d. Is married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraphs 8.100.7.K.2.a thru c for at least 30 consecutive days.
3. A community spouse is defined as the spouse of an institutionalized spouse.

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

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

8.100.7.M. Calculation of the Community Spouse Resource Allowance

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

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

- a. The total resources of the couple but no more than the current maximum allowance which, changes each year beginning January 1st.; or
 - b. The increased CSRA calculated pursuant to section 8.100.7.S; or
 - c. The amount a court has ordered the institutionalized spouse to transfer to the community spouse for monthly support of the community spouse or a dependent family member.
2. The resources allotted to the community spouse as the CSRA shall be transferred into the name of the community spouse and shall not be considered available to the institutionalized spouse. After the transfer of the CSRA to the community spouse, the income from these resources shall be attributed to the community spouse.
 3. The transfer of the CSRA shall be completed as soon as possible, but no later than the next redetermination when the community spouse becomes institutionalizes; whichever is earlier. If the transfer is not completed within this time period, the resources shall be attributed to the institutionalized spouse and shall affect his/her Medical Assistance eligibility. Verification of the transfer of assets to the community spouse shall be provided to the eligibility site.

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

4. If the community spouse is in control of resources attributed to the institutionalized spouse, but fails to make such resources available for his/her cost of care, this fact shall not make the institutionalized spouse ineligible for Medical Assistance, where:
 - a. The institutionalized spouse has assigned The Department any rights to support from the community spouse; or
 - b. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but The Department has the right to bring a support proceeding against the community spouse without such assignment; or

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

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

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

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

1. The institutionalized spouse is resource eligible for Medical Assistance when the total resources owned by the couple are at or below the amount of the Community Spouse Resource Allowance plus the Medical Assistance resource allowance for an individual of \$2,000.
2. The eligibility site shall determine whether the institutionalized spouse is income eligible for Medical Assistance. The institutionalized spouse shall be income eligible if his/her gross income is at or below the Medical Assistance income limit for recipients of long-term care. If an income trust is used the trust must be established before the MIA is calculated.

8.100.7.P. Attribution of Income

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

1. If payment of income from resources is made solely in the name of either the institutionalized spouse or the community spouse, the income shall be considered available only to the named spouse.
2. If payment of income from resources is made in the names of both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each spouse.
3. If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.
4. The above regulations of attribution of income are superseded if the institutionalized spouse can establish by a preponderance of the evidence that the ownership interests in the income are other than that provided in the regulations.

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

1. The community spouse's total minimum monthly needs shall be determined as follows:
 - a. The current minimum monthly maintenance needs allowance (MMMNA), which is equal to 150% of the federal poverty level for a family of two and is adjusted in July of each year;
 - b. An excess shelter allowance, in cases where the community spouse's expenses for shelter exceed 30% of the MMMNA. The excess shelter allowance is computed by adding (a) and (b) together:

- i) The community spouse's expenses for rent or mortgage payment including principal and interest, taxes and insurance, and, in the case of a condominium or cooperative, any required maintenance fee, for the community spouse's principal residence; and
 - ii) The larger of the following amounts: the standard utility allowance used by Colorado under U.S.C. 2014(e) of Title 7; or the community spouse's actual, verified, utility expenses. A utility allowance shall not be allowed if the utility expenses are included in the rent or maintenance charge, which is paid by the community spouse.
 - iii) The excess shelter allowance is the amount, if any, that exceeds 30% of the MMMNA.
- 2. An additional amount may be approved for the following expenses:
 - a. Medical expenses of the community spouse or dependent family member for necessary medical or remedial care. Each medical or remedial care expense claimed for deduction must be documented in a manner that describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider. An expense may be deducted only if it is:
 - i) Provided by a medical practitioner licensed to furnish the care;
 - ii) Not subject to payment by any third party, including Medical Assistance and Medicare;
 - b. The cost of Medicare, Long Term Care insurance, and health insurance premiums. A health insurance premium may be allowed in the month the premium is paid or may be prorated and allowed for the months the premium covers. This allowance does not include payments made for coverage which is:
 - i) Limited to disability or income protection coverage;
 - ii) Automobile medical payment coverage;
 - iii) Supplemental to liability insurance;
 - iv) Designed solely to provide payments on a per diem basis, daily indemnity or non-expense-incurred basis; or
 - v) Credit life and/or accident and health insurance.
- 3. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.
- 4. The total that results from adding the current MMMNA and the excess shelter allowance shall not exceed the current maximum MMMNA which is \$2,175.00 for the year 2001 and is adjusted by the Health Care Financing Administration in January of each year.

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

1. The Monthly Income Allowance (MIA) is the amount of money necessary to raise the community spouse's income to the level of his/her monthly needs, and shall be obtained from the monthly income of the institutionalized spouse. For individuals who become institutionalized on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse must be considered to have been made available to the community spouse before an MIA is allocated to the community spouse.
2. The MIA shall be the amount by which the community spouse's minimum monthly needs, which is the MMMNA, exceed his/her income from sources other than the institutionalized spouse. The community spouse's income shall be calculated by using the gross income less mandatory deductions for FICA and Medicare tax.
3. If a court has entered an order against the institutionalized spouse for monthly support of the community spouse, the MIA shall not be less than the monthly amount ordered by the court.
4. The eligibility site shall make adjustments to the MMMNA and/or the MIA on a monthly basis for any continuing change in circumstances that exceeds \$50 a month. Continuing changes of less than \$50 in a month, and any infrequent or irregular changes, shall be considered at redetermination.

8.100.7.S. Increasing the Community Spouse Resource Allowance

1. The CSRA shall be increased above the maximum amount if additional resources are needed to raise the community spouse's monthly income to the level of the Minimum Monthly Maintenance Needs Allowance (MMMNA). In making this determination the items listed below are calculated in the following order:
 - a. The community spouse's MMMNA;
 - b. The community spouse's own income; and
 - c. The Monthly Income Allowance (MIA) contribution that the community spouse is eligible to receive from the institutionalized spouse.
 - d. If the community spouse's own income, and the Monthly Income Allowance contribution from the institutionalized spouse's income is less than the Minimum Monthly Maintenance Needs Allowance, additional available resources shall be shifted to the community spouse to bring his/her income up to the level of the MMMNA. The additional resources necessary to raise the community spouse's monthly income to the level of the MMMNA shall be based upon the cost of a single-premium lifetime annuity with monthly payments equal to the difference between the MMMNA and the community spouse's income. The following steps shall be followed to determine the amount of resources to be shifted:
 - i) The applicant shall obtain three estimates of the cost of an annuity that would generate enough income to make up the difference between the MMMNA and the combined community spouse's income as described above.
 - ii) The amount of the lowest estimate shall be used as the amount of resources to increase the CSRA.
 - iii) The applicant shall not be required to purchase the annuity in order to have the CSRA increased.

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

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

1. During each month after the institutionalized spouse becomes Medical Assistance eligible, deductions shall be made from the institutionalized spouse's monthly income in the following order.
 - a. A personal needs allowance or the client maintenance allowance as allowed by program eligibility.
 - b. A Monthly Income Allowance (MIA) for the community spouse, but only to the extent that income of the institutionalized spouse is actually made available to, or for the benefit of, the community spouse;
 - c. A family allowance for each dependent family member who lives with the community spouse.
 - i) The allowance for each dependent family member shall be equal to one third of the amount of the MMMNA and shall be reduced by the monthly income of that family member.
 - ii) Family member means dependent children (minor or adult), dependent parents or dependent siblings of either spouse that are residing with the community spouse and can be claimed by either the institutionalized or community spouse as a dependent for federal income tax purposes.
 - d. Allowable deductions identified in section 8.100.7.V.
 - e. If the institutionalized spouse fails to make his/her income available to the community spouse or eligible dependent family members in accordance with these regulations, that income shall be applied to the cost of care for the institutionalized spouse.
 - f. No other deductions shall be allowed.

8.100.7.U. Right to Appeal

1. Both spouses shall be informed of the following:
 - a. The amount and method by which the eligibility site calculated the community spouse resource allowance (CSRA), community spouse monthly income allowance (MIA), and any family allowance;
 - b. The spouses' right to a fair hearing concerning these calculations;
 - c. The eligibility site conclusions with respect to the spouses' ownership and availability of income and resources, and the spouses' right to a fair hearing concerning these conclusions.
2. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

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

8.100.7.V. Long-Term Care Institution Recipient Income

1. Determination of Income and Communication between the Long-Term Care institution and the Eligibility Site Using the AP-5615 Form for Patient Payment
 - a. Sections I, II and IV of the AP-5615 form are to be completed by the Long-Term Care institution for all admissions, readmissions, transfers to and from another payer source, including private pay and Medicare, discharges, deaths, changes in income and/or patient payment, medical leaves of absence and non-medical/programmatic leave in excess of 42 days combined per calendar year.
 - b. The initial determination of resident income for patient payment shall be made by the Eligibility Site. The Eligibility Site shall notify the Long-Term Care institution of current resident income.
 - c. On receipt of AP-5615 form, the Eligibility Site will, within five working days:
 - i) For an admission, a readmission or a transfer from/to private pay, Medicare, or another payer source:
 - 1) Verify and correct, if necessary, data entered by the Long-Term Care institution.
 - 2) List and/or verify the resident's monthly income adjustments and/or Long-Term Care Insurance benefit payments; and compute patient payment. Provide the completed AP-5615 to the Long-Term Care institution.
 - 3) Correct the automated system to indicate the Long-Term Care institution name and provider number and to reflect the current distribution of income. Submit the AP-5615 form to the Department.
 - d. For change in patient payment with respect to changes in resident income:
 - i) Verify changes in resident income, and correct if necessary. All such corrections must be initialed,
 - ii) Compute patient payment and provide the completed AP-5615 to the Long-Term Care institution.
 - e. For change in patient payment with respect to the post-eligibility treatment of income, the Eligibility Site shall:
 - i) Review the AP-5615 form for Medicare part B premium deduction allowances for the first two months of admission.
 - ii) If client is already on the Medicare Buy-In program for Medicare part B, do not adjust patient payment on AP-5615 form for the Medicare premium deduction. If client is not on the Buy-In program, adjust AP-5615 form for the Medicare premium deduction for the first two months of Long-Term Care institution eligibility.

- iii) If the client has a Medicare D premium, the Eligibility Site shall use the amount as an income adjustment/deduction in the patient payment calculation and complete the AP-5615 form.
- f. For resident leave of absence:
 - i) Non-Medical/Programmatic Leave. When combined non-medical/programmatic days in excess of 42 days are reported, verify adherence to the restrictions and conditions of section 8.482.44.
 - ii) Medical Leave/Hospitalization. Verify that the patient payment is apportioned correctly between the nursing facility and the hospital so that no Medicaid payment is requested for the period. See also section 8.482.43.
 - iii) The nursing facility may wait until the end of the month to complete the AP-5615 form for an ongoing hospitalization.
- g. For change in payer status:
 - i) If Medicare or insurance is a primary payer during the month, verify the nursing facility's calculation of the patient payment.
 - ii) Complete and provide the AP-5615 to the nursing facility.
- h. For discharge or death of resident:
 - i) Verify the date of death or discharge, and verify the correct patient payment including the resident's monthly income for the discharged month, and the amount calculated by per diem. All corrections must be initialed.
 - ii) Note if the resident entered another Long-Term Care institution and, if so, enter the name of the new Long-Term Care institution in the system.
 - iii) In the event the resident may return to the same facility, the AP-5615 form may be completed at the end of the month for discharges due to hospitalization.
- i. For discontinuation of Long-Term Care eligibility:
 - i) Initiate and send an AP-5615 form to the Long-Term Care institution within 5 working days of the date of determination that the client's eligibility will be discontinued. Indicate the date the discontinuation will be effective.
- j. Failure to provide a correct and timely AP-5615 to the Long-Term Care institution may result in the refusal of the Department to reimburse such Long-Term Care institution care. The AP-5615 form is required in order for a Prior Authorization Request (PAR) to be issued for Long-Term Care institution claim reimbursement.
- k. General Instructions:
 - i) The AP-5615 form must be verified and a signed AP-5615 form returned to the Long-Term Care institution.
 - ii) The AP-5615 form must be signed and dated by the director of the Eligibility Site or by his/her designee.

- iii) AP-5615 forms may be initiated by either the Long-Term Care institution or Eligibility Site. If the Eligibility Site is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the Long-Term Care institution, the Eligibility Site may initiate the revision to the AP-5615 form. In such case, one copy of the AP-5615 form showing the changes will be sent to the Long-Term Care institution.
- I. The Department may deduct excess payments from the Eligibility Site administrative reimbursement as stated in the Colorado Department of Human Services Finance Staff Manual, Volume 5 if the Eligibility Site fails to:
 - i) Perform the duties as detailed in this section; or
 - ii) Adhere to the limitations on a reduced patient payment; as detailed in section 8.100.7.V.4; or
 - iii) Notify the Long-Term Care institution within 5 working days of any changes in resident income, provided the Long-Term Care institution is not authorized to receive the resident's income; and excessive Medicaid funds are paid to the Long-Term Care institution as a result of this negligence.
- 2. Collection of Patient Payment
 - a. It shall be the responsibility of the Long-Term Care institution to collect from the client, or from the client's family, conservator or administrator, the patient payment, which is to be applied to the cost of client care. The Department is not responsible for any deficiency in patient payment accounts, due to failure of the Long-Term Care institution to collect such income.
 - b. If, however, the Long-Term Care institution is unable to collect such funds, through refusal of the resident or the resident's family, conservator, administrator or responsible party to release such income, the Long-Term Care institution shall immediately notify the Eligibility Site.
 - c. When notified by the Long-Term Care institution of the refusal of the client or the client's family, conservator administrator or responsible party to pay the patient payment due, the Eligibility Site shall immediately contact the refusing party. If, after such contact, the party still refuses to release such income, the action shall be deemed a failure to cooperate, and the Eligibility Site shall proceed to discontinue Medicaid benefits for the resident.
- 3. Calculation of Patient Payment
 - a. Specific instructions for computing the patient payment amount are contained in this volume under The "Status of Long-Term Care institution Care" Form, AP-5615
 - b. Once an applicant for Nursing Facility Medical Assistance has been determined eligible for Medical Assistance, the Eligibility Site shall determine the patient payment due to the Nursing Facility which is to be applied to the Medicaid reimbursement for the cost of care. That patient payment is calculated by:
 - i) Determining all applicable income of the recipient
 - ii) Deducting all applicable allowable monthly income adjustments, which include:
 - 1) Personal Needs Allowance

- 2) If applicable, Monthly Income Allowance for the community spouse.
- 3) If applicable, Family Dependent Allowance
- 4) If applicable, Home Maintenance Allowance
- 5) If applicable, Trustee/Maintenance Fees: actual fees, with a maximum of \$20 per month
- 6) If applicable, Mandatory Income Tax Withheld
- 7) Mandatory garnishments repaying Federal assistance overpayment
- 8) Medical or remedial care expenses that are not subject to payment by a third party:
 - a) Medicare Part B Premium expenses, if applicable, are deductible only for the first and second month in the Nursing Facility.
 - b) Medicare Part D Premium expenses, if applicable, are ongoing deductions.
 - c) Other medical and remedial expenses covered under the Nursing Facility PETI (NF PETI) program are not deductible. NF PETI-approved expenses are allowed only for residents with a patient payment, but do not change the patient payment amount. For NF PETI, see the Section 8.482.33 in this volume "Post Eligibility Treatment of Income".

c. Long-Term Care Insurance

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

- i) If Long-Term Care insurance is received for the month, and:
 - 1) If, after all deductions, the client has income available for a patient payment, add this to the amount of the Long-Term Care insurance to determine the total patient payment.
 - a) If the total amount is greater than the allowable cost of care, the Long-Term Care insurance is applied before the client's income, or;
 - b) If after all deductions, the client does not have income available for the patient payment, only the Long-Term Care insurance payment is used.

d. Personal Needs Allowances

- i) Non-Veteran related personal needs allowance

- 1) Prior to January 1, 2015 the personal needs allowance base amount is \$50 per month.
 - 2) Effective January 1, 2015 the personal needs allowance base amount is \$75 per month and will be adjusted annually at the same rate as the statewide average of the nursing facility per diem rate net of patient payment pursuant to C.R.S. § 25.5-6-202(9)(b)(I). Each yearly adjustment will set a new base amount.
 - a) The first annual rate adjustment to the new \$75 base amount will occur on January 1, 2015.
- ii) Veterans-related personal needs allowance
- Effective 07/01/91, the personal needs allowance shall be \$90 per month for a veteran in a Long-Term Care institution who has no spouse or dependent child and who receives a non-service connected disability pension from the U.S. Veterans Administration. The personal needs allowance shall also be \$90 per month for the widow(er) of a veteran with no dependent children.
- 1) Public Law requires that a veteran, without a spouse or dependent child, who enters a Long-Term Care institution have their veteran's pension reduced to \$90 which is to be reserved for their personal needs. This reduction in pension is not applicable to veteran's who reside in a State Veteran's Nursing facility. If a veteran, who does not reside in a State Veteran's Nursing facility, receives a pension reduction of \$90 he/she is allowed to apply this \$90 to his/her personal needs allowance. It is not considered income toward the patient payment. The same regulation applies to a widow of a veteran without any dependent children.
 - 2) To verify if those veterans residing in State Veteran's Nursing facilities are receiving a non-service connected pension you may request their award letter from the Department of Veterans Affairs or call the Department of Veterans Affairs and verify through contact. If they are receiving any amount in a non-service connected pension they are entitled to a \$90 personal needs allowance so long as they do not have a spouse or dependent child. The same regulation applies to a widow of a veteran without any dependent children.
- iii) For aged, disabled, or blind Long-Term Care institution recipients engaged in income-producing activities, an additional amount of \$65 per month plus one-half of the remaining gross income may be retained by the individual.

- iv) Effective September 15, 1994, aged, disabled, or blind Long-Term Care institution residents, HCBS or PACE recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included as a deduction from the patient payment. The patient payment deduction must be for a specific accounting period when the taxes are owed and expected to be withheld from income or paid by the individual in the accounting period. The Eligibility Site must verify that the taxes were withheld. If the taxes are not paid, the Eligibility Site must establish a recovery. The deduction is also applicable for any Federal pensions with mandated tax withholdings from unearned income despite the individual earner being institutionalized. All other pensions will discontinue the tax withholding once notified that the recipient is receiving institutionalized care through Medicaid, thus signifying that the withholding was not mandatory. This deduction does not apply to individuals who have elected to have taxes withheld from their earnings as a means to receiving a greater tax refund.
- e. The reserve specified in section 8.100.7.V.3.d.iii. of this volume shall apply to Long-Term Care institution residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:
 - i) work in a sheltered workshop or work activity center;
 - ii) “protected employment” which means the employer gives special privileges to the individual;
 - iii) an activity that produced income in connection with a course of vocational rehabilitation;
 - iv) employment training sessions;
 - v) activities within the facility such as crafts products and facility employment.
- f. In determining the personal needs reserve amount for Long-Term Care institution residents engaged in income-producing activities:
 - i) The personal needs allowance is reserved from earned income only when the person has insufficient unearned income to meet this need;
 - ii) In determining countable earned income of a Long-Term Care institution resident, the following rules shall apply:
 - 1) \$65 shall be subtracted from the gross earned income.
 - 2) The result shall be divided in half.
 - 3) The remaining income is the countable earned income and shall be considered in determining the patient payment.
 - iii) When the personal needs allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.

- g. Other Deductions Reserved from Recipient's Income:
- i) In the case of a married, long-term care recipient who is institutionalized in a Long-Term Care institution and who has a spouse (and, in some cases, other dependent family members) living in the community, there are "spousal protection" rules which permit the contribution of the institutionalized spouse's income toward their living expenses. See section 8.100.7.K.
 - ii) For a Long-Term Care institution recipient with no family at home, an amount in addition to the personal needs allowance may be reserved for maintenance of the recipient's home for a temporary period, not to exceed 6 months, if a physician has certified that the person is likely to return to his/her home within that period.

This additional reserve from recipient income is referred to as Home Maintenance Allowance and the amount of the deduction must be based on actual and verified shelter expenses such as mortgage payments, taxes, utilities to prevent freeze, etc.

The Home Maintenance Allowance:

- 1) Prior to July 1, 2018 shall not exceed the total of the current shelter and utilities components of the applicable standard of assistance (OAP for aged recipients; AND/SSI-CS or AB/SSI-CS for disabled or blind recipients).

- 2) Beginning July 1, 2018

- a) The Home Maintenance Allowance shall not exceed the Home Maintenance Allowance Maximum described in this section.

Claimable utility costs will be limited to the lesser of the following amounts:

The standard utility allowance used by Colorado under 7 U.S.C. 2014(e) (2018), which is hereby incorporated by reference.

The incorporation of 7 U.S.C. 2014(e) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

Or;

The individual's actual, verified, utility expenses.

- b) The Maximum Home Maintenance Allowance is The Individual Needs Standard minus 105% Federal Poverty Limit (FPL) for a household of 1, rounded to the nearest whole dollar, and is determined as follows:

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- (1) The Department will calculate the Individual Needs Standard by dividing the Federal Minimum Monthly Maintenance Needs Allowance maximum by the Federal Minimum Monthly Maintenance Needs Allowance (MMMNA), described at 8.100.7.Q, which is in place on January 1st of each calendar year. The result of this division will be multiplied by 150% of FPL for a household of 1.
 - (2) The Home Maintenance Maximum is determined by subtracting 150% FPL for a household of 1 from the Individual Needs Standard and adding 30% of 150% FPL for a household of 1. The result will be rounded to the nearest whole dollar.
 - h. The necessity for the deduction from a recipient's income specified in section 8.100.7.V.3 shall be fully explained in the case record. Such additional reserve amount must be entered on the eligibility reporting form.
 - i. As of July 1, 1988, an SSI cash recipient may continue to receive SSI benefits when he/she is expected to be institutionalized for three months or less. This provision is intended to allow temporarily institutionalized recipients to pay the necessary expenses to maintain the principal place of residence.
 - i) Payments made under this continued benefit provision are not considered over-payments of SSI benefits if the recipient's stay is more than 90 days.
 - ii) The amount of Supplemental Security Income (SSI) benefit paid to an institutionalized individual is deducted from gross income when computing the patient payment.
 - j. When a nursing facility resident's SSI is reduced due to institutionalization, the difference between the reduced SSI payment and the personal needs allowance amount shall be provided through the Adult Financial program so that the resident receives the full personal needs allowance.
 - 4. Reduction of the Patient Payment
 - a. Patient payment may be reduced only under the following conditions:
 - i) A resident's income is equal to or less than the personal needs allowance and there is no long term care insurance payment, in which case the patient payment is zero; or
 - ii) A resident's income is equal to or less than the sum of all allowable and appropriate deductions, and there is no long term care insurance payment; or
 - iii) A resident is admitted to the Long Term Care institution from his/her home and the resident's funds are committed elsewhere for that month; or
 - iv) The resident is admitted from his/her home, where his/her funds were previously committed, to the hospital, and subsequently to the Long Term Care institution, in the same calendar month; or

- v) The resident is discharged to his/her home, and the Eligibility Site determines that the income is necessary for living expenses; or
 - vi) The resident is admitted from another Long Term Care institution or from private pay within the facility and has committed the entire patient payment for the month for payment of care already provided in the month of admission.
 - vii) Medicare assesses a co-insurance payment for a QMB recipient; the recipient's patient payment cannot be used for payment of Medicare co-insurance.
 - b. Patient payment may not be waived in the following instances:
 - i) Transfers between nursing facilities, except that the patient payment for the receiving facility may be waived if the patient payment has already been committed to the former nursing facility; or
 - ii) Discharges from nursing facility to a hospital or other medical institution when Medicaid is paying for services in the medical institution; or
 - iii) Changes from private pay within the facility and the patient payment is not already committed for care provided under private pay status; or
 - iv) The death of the resident.
 - c. The Eligibility Site shall verify and approve partial month patient payments due to transfers, discharges or death when calculated by the nursing facility based upon the nursing facility's per diem rate.
 - d. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.
5. Responsibilities of the Eligibility Site Regarding the Personal Needs Fund
- a. It shall be the responsibility of the Eligibility Site to explain to the resident the various options for handling the personal needs monies, as well as the resident's rights to such funds. The resident has the option to allow the Long Term Care institution to hold such funds in trust.
 - b. It shall be the responsibility of the Eligibility Site to assure that the Long Term Care institution properly transfers or disposes of the resident's personal needs funds within 30 days of discharge from the Long Term Care institution, or transfer to another Long Term Care institution.
 - c. The Eligibility Site shall notify the State Department if they become aware that a Long Term Care institution has retained personal needs funds more than 30 days after the death of a resident.
6. For rules regarding post eligibility treatment of income, see the section in this volume titled "Post Eligibility Treatment of Income"

8.125 PROVIDER SCREENING

8.125.1 DEFINITIONS.

Managed Care Entity is defined at 42 CFR § 455.101.

Ownership interest is defined at 42 CFR § 455.101.

Person with an ownership or control interest is defined at 42 CFR § 455.101.

Enrollment is defined as the process by which an individual or entity not currently enrolled as a Colorado Medicaid provider submits a provider application, undergoes any applicable screening, pays an application fee, as appropriate for the provider type, and is approved by the Department for participation in the Medicaid program. Entities that have never previously enrolled as Medicaid providers or whose enrollment was previously terminated and are not currently enrolled are required to enroll. The date of enrollment shall be considered the date that is communicated to the provider in communication from the Department or its fiscal agent verifying the provider's enrollment in Medicaid.

Revalidation is defined as the process by which an individual or entity actively enrolled as a Colorado Medicaid provider resubmits a provider application, undergoes a state-defined screening process, pays an application fee, as appropriate for the provider type, and is approved by the Department to continue participation in the Medicaid program.

Disclosing Entity and Other Disclosing Entity are defined at 42 CFR § 455.101.

8.125.2 PROVIDERS DESIGNATED AS LIMITED CATEGORICAL RISK AND NEW PROVIDER TYPES

8.125.2.A. Except as provided for in Section 8.125.2.B, provider types not designated as moderate or high categorical risk at Sections 8.125.3 or 8.125.4 shall be considered limited risk.

8.125.2.B. The risk category for each provider type designated by CMS shall be the risk category for purposes of this rule regardless of whether a provider type may be listed in Sections 8.125.3 or 8.125.4.

8.125.3 PROVIDERS DESIGNATED AS MODERATE CATEGORICAL RISK

8.125.3.A. Emergency Transportation including ambulance service suppliers

8.125.3.B. Non-Emergency Medical Transportation

8.125.3.C. Community Mental Health Center

8.125.3.D. Hospice

8.125.3.E. Independent Laboratory

8.125.3.F. Comprehensive Outpatient Rehabilitation Facility

8.125.3.G. Physical Therapists, both individuals and group practices

8.125.3.H. X-Ray Facilities

8.125.3.I. Revalidating Home Health agencies

- 8.125.3.J. Revalidating Durable Medical equipment suppliers, including revalidating pharmacies that supply Durable Medical Equipment
- 8.125.3.K. Revalidating Personal Care Agencies under the state plan
- 8.125.3.L. Providers of the following services for HCBS waiver members:
1. Alternative Care Facility
 2. Adult Day Services
 3. Assistive Technology, if the provider is revalidating
 4. Behavioral Programing
 5. Behavioral Therapies
 6. Behavioral Health Supports
 7. Behavioral Services
 8. Care Giver Education
 9. Children's Case Management
 10. Children's Habilitation Residential Program (CHRP)
 11. Community Connector
 12. Community Mental Health Services
 13. Community Transition Services
 14. Complementary and Integrative Health
 15. Day Habilitation
 16. Day Treatment
 17. Expressive Therapy
 18. Home Delivered Meals
 19. Home Modifications/Adaptations/Accessibility
 20. Independent Living Skills Training
 21. In-Home Support Services, if the provider is revalidating
 22. Intensive Case Management
 23. Massage Therapy
 24. Mentorship

25. Non-Medical Transportation
 26. Palliative/Supportive Care Skilled
 27. Peer Mentorship
 28. Personal Care/Homemaker Services, if the provider is revalidating
 29. Personal Emergency Response System/Medication Reminder/Electronic Monitoring
 30. Prevocational Services
 31. Professional Services
 32. Residential Habilitation Services
 33. Respite
 34. Specialized Day Rehabilitation Services
 35. Specialized Medical Equipment and Supplies, if the provider is revalidating
 36. Substance Abuse Counseling
 37. Supported Employment
 38. Supported Living Program
 39. Therapy and Counseling
 40. Transitional Living Program
 41. Youth Day Services
- 8.125.3.M. Medicare Only Providers
1. Independent Diagnostic Testing Facility
 2. Revalidating Medicare Diabetes Prevention Program Supplier
 3. Newly enrolling Opioid Treatment Program that has been fully and continuously certified by SAMHSA since October 24, 2018.
 4. Revalidating Opioid Treatment Program
- 8.125.4 PROVIDERS DESIGNATED AS HIGH CATEGORICAL RISK**
- 8.125.4.A. Enrolling DME Suppliers
- 8.125.4.B. Enrolling Home Health Agencies
- 8.125.4.C. Enrolling Personal Care Agencies providing services under the state plan
- 8.125.4.D. Enrolling providers of the following services for HCBS waiver members:

1. Assistive Technology
 2. Personal Care/Homemaker Services
 3. Specialized Medical Equipment and Supplies
 4. In-Home Support Services
- 8.125.4.E. Medicare Only Providers
1. Enrolling Medicare Diabetes Prevention Program Supplier
 2. Enrolling Opioid Treatment Program that has not been fully and continuously certified by SAMHSA since October 24, 2018.
- 8.125.4.F. Enrolling and revalidating providers for which the Department has suspended payments during an investigation of a credible allegation of fraud, for the duration of the suspension of payments.
- 8.125.4.G. Enrolling and revalidating providers which have a delinquent debt owed to the State arising out of Medicare, Colorado Medical Assistance or other programs administered by the Department, not including providers which are current under a settlement or repayment agreement with the State.
- 8.125.4.H. Providers that were excluded by the HHS Office of Inspector General or had their provider agreement terminated for cause by the Department, its contractors or agents or another State's Medicaid program at any time within the previous 10 years.
- 8.125.4.I. Providers applying for enrollment within six (6) months from the time that the Department or CMS lifts a temporary enrollment moratorium on the provider's enrollment type.
- 8.125.5 PROVIDERS WITH MULTIPLE RISK LEVELS**
- 8.125.5.A Providers shall be screened at the highest applicable risk level for which a provider meets the criteria. Providers shall only pay one application fee per location.
- 8.125.6 PROVIDERS WITH MULTIPLE LOCATIONS**
- 8.125.6.A. Providers must enroll separately each location from which they provide services. Only claims for services provided at locations that are enrolled are eligible for reimbursement.
- 8.125.6.B. Each provider site will be screened separately and must pay a separate application fee. Providers shall only pay one application fee per location.
- 8.125.7 ENROLLMENT AND SCREENING OF PROVIDERS**
- 8.125.7.A. All enrolling and revalidating providers must be screened in accordance with requirements appropriate to their categorical risk level.
- 8.125.7.B. Notwithstanding any other provision of the Colorado Code of Regulations, providers who provide services to Medicaid members as part of a managed care entity's provider network who would have to enroll in order to participate in fee-for-service Medicaid must enroll with the Department and be screened as Medicaid providers.

8.125.7.C. Nothing in Section 8.125.7.B shall require a provider who provides services to Medicaid members as part of a managed care entity's provider network to participate in fee-for-service Medicaid.

8.125.7.D. All physicians or other professionals who order, prescribe, or refer services or items for Medicaid members, whether as part of fee-for-service Medicaid or as part of a managed care entity's provider network under either the state plan, the Children's Health Insurance Program, or a waiver, must be enrolled in order for claims submitted for those ordered, referred, or prescribed services or items to be reimbursed or accepted for the calculation of managed care rates by the Department.

8.125.7.E. The Department may exempt certain providers from all or part of the screening requirements when certain providers have been screened, approved and enrolled or revalidated:

1. By Medicare within the last 5 years, or
2. By another state's Medicaid program within the last 5 years, provided the Department has determined that the state in which the provider was enrolled or revalidated has screening requirements at least as comprehensive and stringent as those for Colorado Medicaid.

8.125.7.F. The Department may deny a Provider's enrollment or terminate a Provider agreement for failure to comply with screening requirements.

8.125.7.G. The Department may terminate a Provider agreement or deny the Provider's enrollment if CMS or the Department determines that the provider has falsified any information provided on the application or cannot verify the identity of any provider applicant.

8.125.8 NATIONAL PROVIDER IDENTIFIER FOR ORDERING, PRESCRIBING, REFERRING

8.125.8.A. As a condition of reimbursement, any claim submitted for a service or item that was ordered, referred, or prescribed for a Medicaid member must contain the National Provider Identifier (NPI) of the ordering, prescribing or referring physician or other professional.

8.125.9 VERIFICATION OF PROVIDER LICENSES

8.125.9.A. If a provider is required to possess a license or certification in order to provide services or supplies in the State of Colorado, then that provider must be so licensed as a condition of enrollment as a Medicaid provider.

8.125.9.B. Required licenses must be kept current and active without any current limitations throughout the term of the agreement.

8.125.10 REVALIDATION

8.125.10.A. Actively enrolled providers must complete all requirements for revalidation at least every 5 years as established by the Department, or upon request from the Department for an off cycle review.

8.125.10.B. The date of revalidation shall be considered the date that the provider's application was initially approved plus 5 years, or by an off-cycle request from the Department.

8.125.10.C. If a provider fails to comply with any requirement for revalidation by the deadlines established by Sections 8.125.10.A. or 8.125.10.B., the provider agreement may be terminated. In the event that the provider agreement is terminated pursuant to this section, any claims for dates of service submitted after deadlines established by Sections 8.125.10.A. or 8.125.10.B., are not reimbursable beginning on the day after the date indicated by Section 8.125.10.B.

8.125.11 - 8.125.13 Repealed [Emergency rules eff. 10/14/2022]

8.125.14 TEMPORARY MORATORIA

8.125.14.A. In consultation with CMS and HHS, the Department may impose temporary moratoria on the enrollment of new providers or provider types, or impose numerical caps or other limits on providers that the Department and the Secretary of HHS identify as being a significant potential risk for fraud, waste, or abuse, unless the Department determines that such an action would adversely impact Medicaid members' access to medical assistance.

8.125.14.B. Before imposing any moratoria, caps, or other limits on provider enrollment, the Department shall notify the Secretary of HHS in writing and include all details of the moratoria.

8.125.14.C. The Department shall obtain the Secretary of HHS's concurrence with imposition of the moratoria, caps, or other limits on provider enrollment, before such limits shall take effect.

8.125.15 DISCLOSURES BY MEDICAID PROVIDERS, MANAGED CARE ENTITIES, MEDICARE PROVIDERS AND FISCAL AGENTS

8.125.15.A. All providers, disclosing entities, fiscal agents, and managed care entities must provide the following federally required disclosures to the Department:

1. The name and address of any entity (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity having direct or indirect ownership of 5 percent or more. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.
2. For individuals: Date of birth and Social Security number
3. For business entities: Other tax identification number for any entity with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.
4. Whether the entity (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the entity (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
5. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
6. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

7. The identity of any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.
 8. Full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
- 8.125.15.B. Disclosures from any provider or disclosing entity are due at any of the following times:
1. Upon the provider or disclosing entity submitting the provider application.
 2. Upon the provider or disclosing entity executing the provider agreement.
 3. Upon request of the Department during revalidation.
 4. Within 35 days after any change in ownership of the disclosing entity.
- 8.125.15.C. Disclosures from fiscal agents are due at any of the following times:
1. Upon the fiscal agent submitting its proposal in accordance with the State's procurement process.
 2. Upon the fiscal agent executing a contract with the State.
 3. Upon renewal or extension of the contract.
 4. Within 35 days after any change in ownership of the fiscal agent.
- 8.125.15.D. Disclosures from managed care entities are due at any of the following times:
1. Upon the managed care entity submitting its proposal in accordance with the State's procurement process.
 2. Upon the managed care entity executing a contract with the State.
 3. Upon renewal or extension of the contract.
 4. Within 35 days after any change in ownership of the managed care entity.
- 8.125.15.E. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose ownership or control information as required by 42 CFR § 455.104. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose information related to business transactions as required by 42 CFR § 455.105 beginning on the day following the date the information was due and ending on the day before the date on which the information was supplied. Any payment made to a provider or entity that is not reimbursable in accordance with this section shall be considered an overpayment.

- 8.125.15.F. The Department may terminate the agreement of any provider or entity or deny enrollment of any provider that fails to disclose information when requested or required by 42 CFR § 455.100-106.

8.126 COLORADO NPI RULE

8.126.1 Definitions

- A. Billing Provider Field means the data field on a Claim that reflects the Health Care Provider to which the payer issues payment.
- B. Campus means the physical area immediately adjacent to the Hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers of Medicare and Medicaid Services to be part of the provider's campus.
- C. Claim means a request for payment for the delivery of medical care, services, or goods authorized under the Medical Assistance Program, submitted to the Department through its fiscal agent by a Health Care Provider. Claim includes the transmission of encounter information for the purpose of reporting the delivery of medical care, services, or goods.
- D. Health Care Provider means any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Medical Assistance Program members.
1. A Health Care Provider includes an Organization Health Care Provider, Subpart of an Organization Health Care Provider, Off Campus Location, and a Site of an Organization Health Care Provider.
 2. Unless specified otherwise in Subsection 8.126.1, a Health Care Provider may include a Health Care Provider located outside the state of Colorado (out-of-state provider) that is licensed and/or certified pursuant to their state laws.
- E. Hospital means an Organization Health Care Provider that is enrolled in the Medical Assistance Program under the Provider Type of "Hospital - General" as defined in this Subsection 8.126.1.
- F. Medical Assistance Program means the programs authorized under Articles 4, 5, 6, 8, and 10 of Title 25.5.
- G. National Provider Identifier (NPI) means the standard, unique health identifier for Health Care Providers or Organization Health Care Providers that is used by the National Plan and Provider Enumeration System (NPPES) in accordance with 45 C.F.R. pt. 162.
- H. Off-Campus Location means a facility that:
1. Has operations that are directly or indirectly owned or controlled by, in whole or in part, or affiliated with, a Hospital, regardless of whether the operations are under the same governing body as the Hospital;
 2. Is not on the Hospital's Campus;
 3. Provides services that are organizationally and functionally integrated with the Hospital;
 4. Is an outpatient facility providing preventive, diagnostic, treatment, or emergency services; and

5. Is identified on the Hospital's State License Addendum issued by the Colorado Department of Public Health and Environment or, for Hospitals licensed outside of Colorado, documentation demonstrating direct or indirect ownership or control of the Off-Campus Location.
- I. Organization Health Care Provider means a Health Care Provider that is not an individual.
- J. Provider Type means a classification of Health Care Provider or Organization Health Care Provider to which the payer issues payment for services provided to individuals enrolled in the Medical Assistance Program, according to the Provider Type license, accreditation, certification, and/or service provided. The Provider Types recognized by the Department are as follows:
 1. Administrative Services Organization (ASO) is an entity that has entered into a valid, active contract to provide ASO services with the Colorado Department of Health Care Policy and Financing.
 2. Ambulatory Surgical Center (ASC) means a health care entity that is:
 - a. Licensed by the Colorado Department of Public Health and Environment as an Ambulatory Surgical Center; and
 - b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as an Ambulatory Surgical Center.
 3. Audiologist means an individual licensed as an audiologist by the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.
 4. Behavioral Therapy Clinic means any group practice that has at least one affiliated Behavioral Therapy Individual. The affiliated Behavioral Therapy Individual must be enrolled in the Colorado Medical Assistance Program.
 5. Behavioral Therapy Individual means an individual that:
 - a. Is nationally certified as a Board-Certified Behavioral Analyst (BCBA); or
 - b. Meets one of the following:
 - (1) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology and is actively licensed by the State Board of Examiners; and has completed 400 hours of training; and/or has direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or
 - (2) Has a doctoral degree in one of the behavioral or health sciences; and has completed 800 hours of specific training; and/or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or
 - (3) Is nationally certified as a BCBA; or

- (4) Has a master's degree or higher in behavioral or health sciences; and is a licensed teacher with an endorsement of school psychologist; or is a licensed teacher with an endorsement of special education or early childhood special education; or is credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist); and has completed 1,000 hours of direct supervised training or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.
- 6. Birthing Center means a health care entity licensed as a Birth Center by the Colorado Department of Public Health and Environment. Out-of-state providers are not eligible for enrollment.
- 7. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers.
- 8. Certified Registered Nurse Anesthetist (CRNA) means an individual who is:
 - a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and
 - b. Included within the advanced practice registry as a CRNA.
- 9. Clinic – Dental means any group practice that has at least one affiliated, licensed dentist or dental hygienist.
 - a. The affiliated dentist or dental hygienist must be enrolled in the Colorado Medical Assistance Program; and
 - b. A dental practice or clinic must be owned by a licensed dentist except if the dental practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.); and
 - c. A dental hygiene practice or clinic must be owned by a licensed dentist or licensed dental hygienist except if the dental hygiene practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.)
- 10. Clinic – Practitioner means any group practice that has at least one affiliated, licensed physician, osteopath, or podiatrist. The affiliated practitioner must be enrolled in the Colorado Medical Assistance Program.
- 11. Community Clinic means a health care entity that is:
 - a. Licensed as a Community Clinic or Freestanding Emergency Department (FSED) by the Colorado Department of Public Health and Environment;
 - b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program; and

- c. Owned by a Medicare participating hospital.
- 12. Community Mental Health Center (CMHC) means a health care entity that:
 - a. Is licensed as a Community Mental Health Center by the Colorado Department of Public Health and Environment;
 - b. Has program approval to operate as a CMHC from the Colorado Department of Human Services; and
 - c. If the CMHC delivers substance use disorder services, shall have Substance Use Disorder program approval from Colorado Department of Human Services.
- 13. Dental Hygienist means an individual who is licensed as a Dental Hygienist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.
- 14. Dentist means an individual who is licensed as a Dentist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.
- 15. Dialysis Treatment Clinic [Formerly Known as Dialysis Center] means a health care entity that is:
 - a. Licensed as a Dialysis Treatment Clinic by the Colorado Department of Public Health and Environment; and
 - b. Certified by Centers for Medicare and Medicaid Services to participate in the Medicare program as an End-Stage Renal Dialysis Facility (ESRD).
- 16. Federally Qualified Health Center (FQHC) means a health care entity that has been awarded a Section 330 Grant from the Health Resources and Services Administration. A health care entity that has been designated as a “look-alike” is also eligible to be enrolled as an FQHC.
- 17. Foreign Teaching Physician means an individual who is licensed as a distinguished foreign teaching physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.
- 18. Home and Community Based Services (HCBS) means Health First Colorado (Colorado’s Medicaid Program)’s community-based care alternatives to institutional, Long-Term care. Providers enrolling as an HCBS provider shall meet all applicable state and federal requirements to provide HCBS by waiver and specialty type.
- 19. Home Health Agency means a health care entity that:
 - a. Has a Class A Home Care Agency license from the Colorado Department of Public Health and Environment; and
 - b. Is certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as Home Health Agency.
- 20. Hospice means a health care entity that is:
 - a. Licensed as a Hospice by the Colorado Department of Public Health and Environment; and

- b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospice.
- 21. Hospital – General means a health care entity that is:
 - a. Licensed as a General Hospital by the Colorado Department of Public Health and Environment; and
 - b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospital.
- 22. Hospital – Psychiatric [Formerly Known as Hospital - Mental] means a health care entity that is:
 - a. Licensed as a Psychiatric Hospital by the Colorado Department of Public Health and Environment; and
 - b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Psychiatric Hospital.
- 23. Independent Laboratory means a laboratory that:
 - a. Has a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification; and
 - b. Is certified through the Centers for Medicare and Medicaid Services as a laboratory.
- 24. Indian Health Service – Federally Qualified Health Center (FQHC) means a health care entity that:
 - a. Is treated by the Centers for Medicare and Medicaid Services as a comprehensive Federally funded health center; and
 - b. Includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.
- 25. Indian Health Service – Pharmacy means a health care entity that has evidence of participation in the Indian Health Service.
- 26. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Formerly Known as Nursing Facility – ICF/IID] means a health care entity that is:
 - a. Licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities through the Colorado Department of Public Health and Environment; and
 - b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as an ICF/IID.
- 27. Licensed Behavioral Health Clinician means an individual that is licensed by the Colorado Department of Regulatory Agencies as either:

- a. A Licensed Clinical Social Worker;
 - b. A Licensed Professional Counselor;
 - c. A Licensed Marriage and Family Therapist; or
 - d. A Licensed Addiction Counselor.
28. Licensed Psychologist means an individual who is licensed as a psychologist by the State Board of Psychologist Examiners within the Colorado Department of Regulatory Agencies.
29. Managed Care Entity [Formerly Known as Health Maintenance Organization (HMO)] means an entity that has a valid and comprehensive or all-inclusive risk contract with the Colorado Department of Health Care Policy and Financing.
30. Medicare Only Providers means a provider enrolled in the Medical Assistance Program for purposes of Medicare cost-sharing only, pursuant to 42 CFR §455.410(d).
31. Non-Physician Practitioner Group means any group practice consisting of any of the following:
- a. Licensed Nurse Practitioners;
 - b. Licensed Audiologists;
 - c. Licensed Occupational Therapists;
 - d. Licensed Behavioral Health Clinicians;
 - e. Licensed Psychologists;
 - f. Licensed Speech Therapists; and/or
 - g. Licensed Physical Therapists.
 - h. Beginning on the effective date of this amended rule, and for the remainder of the COVID-19 Public Health Emergency (PHE), providers that have enrolled as a Mass Immunizer Roster Biller (provider specialty type 73) with Medicare may temporarily enroll in the medical assistance program as a Non-Physician Practitioner Group for the purpose of billing for the administration of COVID-19 vaccinations for medical assistance clients.
32. Non-Physician Practitioner Individual means a registered nurse, which means an individual licensed as a Registered Nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies.
33. Nurse Midwife means an individual who is:
- a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and
 - b. Included within the advanced practice registry as a Nurse Midwife.
34. Nurse Practitioner means an individual who is:

- a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and
 - b. Included within the advanced practice registry as a Nurse Practitioner.
- 35. Nursing Facility means a health care entity that is:
 - a. Licensed as a Nursing Care Facility through the Colorado Department of Public Health and Environment; and
 - b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as a Skilled Nursing Care Facility.
- 36. Occupational Therapist means an individual who is licensed as an Occupational Therapist by the Director of the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.
- 37. Optical Outlet means a health care supplier that is qualified to make and supply eyeglasses and contact lenses for the correction of vision. If, in the performance of its duties, the Optical Outlet requires laboratory services, the laboratory is required to have a current and valid CLIA certification.
- 38. Optometrist means an individual who is licensed as an Optometrist by the State Board of Optometry within the Colorado Department of Regulatory Agencies.
- 39. Osteopath means an individual who holds a degree of “doctor of osteopathy,” and who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.
- 40. Personal Care Agency means a health care entity that has a Class A or Class B Home Care Agency license from the Colorado Department of Public Health and Environment.
- 41. Pharmacist means an individual who is licensed as a Pharmacist by the State Board of Pharmacy within the Colorado Department of Regulatory Agencies.
- 42. Pharmacy means a pharmacy, pharmacy outlet, or prescription drug outlet registered by the Board of Pharmacy within the Colorado Department of Regulatory Agencies.
- 43. Physical Therapist means an individual who is licensed as a Physical Therapist by the Physical Therapy Board within the Colorado Department of Regulatory Agencies.
- 44. Physician means an individual who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.
- 45. Physician Assistant means an individual who is licensed as a physician assistant by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.
- 46. Podiatrist means an individual licensed as a podiatrist by the Colorado Podiatry Board within the Colorado Department of Regulatory Agencies.
- 47. Psychiatric Residential Treatment Facility (PRTF) means a health care entity that:
 - a. Is licensed by the Colorado Department of Human Services as a Residential Child Care Facility and a PRTF; and

- b. Is certified as a qualified residential provider by the Department of Public Health and Environment; and
 - c. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children; and
 - d. Has provided an attestation to the Department that the PRTF is in compliance with the conditions of participation as required by Colorado Department of Human Services and the Centers for Medicare and Medicaid Services.
- 48. Qualified Medicare Beneficiary (QMB) Benefits Only means the provider type designation used for Chiropractors who participate under the QMB Program. Chiropractor means an individual licensed as a chiropractor by the Board of Chiropractic Examiners within the Colorado Department of Regulatory Agencies. QMB Benefits Only providers must also be certified as QMB Benefits Only providers through the Centers for Medicare and Medicaid Services.
- 49. Regional Accountable Entity (RAE) means an entity that has entered into a valid, existing contract with the Colorado Department of Health Care Policy and Financing to be a Regional Accountable Entity.
- 50. Rehabilitation Agency means a group practice that requires at least one affiliated and licensed professional enrolled in the Colorado Medical Assistance Program.
- 51. Residential Child Care Facility (RCCF) means a health care entity that is:
 - a. Designated by the Colorado Department of Human Services to provide Medicaid-reimbursable mental health services as an RCCF; and
 - b. Licensed by Colorado Department of Human Services as an RCCF.
- 52. Rural Health Clinic (RHC) means a clinic that is certified by the Centers for Medicare and Medicaid Services as a Rural Health Clinic.
- 53. School Health Services means a school district or Board of Cooperative Educational Services that has a valid, active contract with the Colorado Department of Health Care Policy and Financing to participate in the Colorado School Health Services Program.
 - a. The Site at which an Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program enrolled under the Provider Type of School Health Services is a school district.
- 54. Speech Therapist is an individual certified as a Speech Language Pathologist by the Director of the Divisions of Professions and Occupations within the Colorado Department of Regulatory Agencies.
- 55. Substance Use Disorder (SUD) – Clinic means a health care entity that:
 - a. Is licensed as a SUD Provider by the Colorado Department of Human Services;
 - b. Has program approval to operate as a SUD – Clinic from Colorado Department of Human Services; and

- c. Has at least one affiliated advanced practice nurse, physician/psychiatrist, physician assistant, or behavioral health clinician who is certified in addiction medicine.
- 56. Supply means a Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider that meets one or both of the following definitions:
 - a. Complex Rehabilitation Technology (CRT) Supplier means a health care supplier that meets all the requirements of Section 8.590.5.D, and that:
 - (1) Has a Sales Tax Certificate or Tax-Exempt Certificate;
 - (2) Has CRT Professional Certification; and
 - (3) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS and CRT.
 - b. Durable Medical Equipment (DME) means a health care supplier that meets the requirements of Sections 8.590.5.A and B, and that:
 - (1) Has a Sales Tax Certificate or Tax-Exempt Certificate; and
 - (2) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS.
- 57. Transportation means a provider that meets one or both of the following definitions:
 - a. Emergency Medical Transportation (EMT) [Formerly Known as Emergency Medical Transportation and Air Ambulance] means providers that:
 - (1) Meet all provider screening requirements in Section 8.125.
 - (2) Comply with commercial liability insurance requirements.
 - (3) Maintain the appropriate licensure for:
 - (a) Ground ambulance license as required by Colorado Department of Public Health and Environment; and
 - (b) Air ambulance license as required by Colorado Department of Public Health and Environment.
 - (4) License, operate, and equip ground and air ambulances in accordance with federal and state regulations.
 - b. Non-Emergent Medical Transportation (NEMT) means a provider that:
 - (1) Has a Public Utilities Commission (PUC) common carrier certificate as a taxicab; or
 - (2) Has a PUC Medicaid Client Transport (MCT) Permit as required by the PUC; or
 - (3) Has a ground ambulance license as required by Department of Public Health and Environment; or

- (4) Has an Air Ambulance license as required by Colorado Department of Public Health and Environment; or
 - (5) Is exempt from licensure requirements in accordance with the PUC.
- 58. X-Ray Facility means an imaging center that:
 - a. Has an X-Ray Facility and Machine Registration Report certified by the Colorado Department of Public Health and Environment; and
 - b. Is certified by the Centers for Medicare and Medicaid Services to participate in Medicare as an X-Ray facility.
- K. Service Facility Location Field means the physical location specifically where services were rendered as identified on the Claim.
- L. Site means the physical location by street address, including suite number, where goods and/or services are provided. The term Site when involving a Health Care Provider that voluntarily contracts with a RAE as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home, also includes the following requirements:
 - 1. PCMP services must be identifiable from other goods and/or services, including services provided by specialists provided by the Health Care Provider in the same physical location through a separate and unique NPI.
 - 2. PCMP services provided at a Campus or Off-Campus Location must be identifiable from other goods and/or services, including services provided by specialists, provided by the Health Care Provider on the same Campus or Off-Campus Location through a separate and unique NPI.
- M. Subpart means a component or separate physical location of an Organization Health Care Provider that may be separately licensed or certified. This definition is intended to be consistent with the use of the term "Subpart" as defined in 45 C.F.R. pt. 162.
- N. The definitions in Subsection 8.126.1 apply only to Section 8.126.

8.126.2 Enrollment of Health Care Providers

- A. Health Care Providers must enroll in the Medical Assistance Program through the Department's Fiscal Agent, if they:
 - 1. deliver medical care, services, or goods authorized under the Medical Assistance Program; and
 - 2. are required to submit a Claim.

8.126.3 Health Care Provider Requirements to Obtain and Use an NPI

- A. A Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must:
 - 1. Enroll with a unique NPI that identifies the Health Care Provider that delivers medical care, services, or goods authorized under the Medical Assistance Program; and

2. Utilize the Health Care Provider's unique NPI for all Claims.
 - a. A Health Care Provider that is not enrolled as of January 1, 2020, must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.
 - b. All Off Campus Locations must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.
 - c. All Health Care Providers must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2021.
 - d. On every Claim, including Coordination of Benefits Agreement (COBA) automatic crossover Claims, the Organization Health Care Provider shall use the Service Facility Location Field to represent the most specific Site with an NPI where the services are rendered unless the Billing Provider Field represents the most specific Site with an NPI where the services are rendered.

8.126.4 Organization Health Care Provider Requirements to Obtain and Use an NPI

- A. Each Organization Health Care Provider and each Subpart of an Organization Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must enroll using a unique NPI.
 1. Each Organization Health Care Provider must enroll using its unique NPI for each Site at which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.
 - a. A Hospital must enroll in the Medical Assistance Program with a unique NPI for:
 - (1) Its Campus; and
 - (2) Each Off-Campus Location.
 2. Each Organization Health Care Provider must enroll in the Medical Assistance Program using a unique NPI for each Provider Type at each Site from which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.
 - a. A Hospital must enroll with a unique NPI for each Provider Type at each Site at its Campus and at each Off-Campus Location at which it delivers medical care, services, or goods authorized under the Medical Assistance Program.
 3. An Organization Health Care Provider that is a School Health Services provider type must enroll once per School District and not each individual Site.

8.126.5 Health Care Provider Requirements Not Eligible to Receive an NPI

- A. A Health Care Provider that is not eligible pursuant to 45 C.F.R. § 162.410 to receive an NPI shall:

1. Enroll without submitting an NPI. The Health Care Provider must obtain a unique identification number assigned by the Department through its Fiscal Agent, that identifies both the unique Provider Type at each Site at which the Health Care Provider delivers medical care, services or goods authorized under the Medical Assistance Program; and
2. Use the unique identification number assigned by the Department through its Fiscal Agent on every Claim.
 - a. A Health Care Provider that is not eligible to obtain an NPI that is not enrolled as of January 1, 2020, must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2020.
 - b. All Health Care Providers that are not eligible to obtain an NPI must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2021.

8.126.6 New Providers as of January 1, 2020

- A. A Health Care Provider that is not enrolled as of January 1, 2020, shall not apply to be enrolled to deliver medical care, services, or goods authorized under the Medical Assistance Program unless the Health Care Provider complies with Section 8.126.

8.126.7 Existing Providers as of January 1, 2021

- A. A Health Care Provider that is enrolled as of January 1, 2021, shall not apply to have their enrollment revalidated to deliver medical care, services, or goods authorized under the Medical Assistance Program, as required under 42 C.F.R. § 455.414, unless the Health Care Provider complies with Section 8.126.

8.130 PROVIDER PARTICIPATION

Providers will not discriminate on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

8.130.1 DEFINITIONS

- A. "Advanced Directive" means a written instruction, such as a Living Will or Durable Power of Attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the state, that relates to the provision of medical care when the individual is incapacitated.
- B. "Agent" means any person who has been delegated the authority to obligate or act on behalf of a Provider.
- C. "Change of Information" means any change in information contained in the Provider's current enrollment record with the Department, including, but not limited to, any change to a person or entity who holds a direct or indirect ownership interest in the Provider exceeding five percent and any change to the Provider's licensure, certification registration status, accreditation, bankruptcy status, address (including any change to location(s) where good and services are rendered), contact person, telephone number, email address, or criminal conviction disclosures within the scope of 42 CFR § 455.106.
- D. "Change of Ownership" means that a Provider has been issued a new tax identification number.

- E. "Colorado Department of Health Care Policy and Financing" or "Department" means the Colorado State governmental agency responsible for the administration of the Medical Assistance Program, , Child Health Plan Plus, the old age pension health and medical care program, and the supplemental old age pension health and medical care program pursuant to Title XIX of the Social Security Act and Title 25.5 of the Colorado Revised Statutes.
- F. "Inactivation" means a Provider's billing privileges have been stopped but can be restored upon resolution of the basis of inactivation.
- G. "Provider" means 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, where applicable, a current valid license or certificate to provide such services or to dispense such goods.
- H. "Requesting Agency" means the US Department of Health and Human Services or its designees, the Department or its designees, the Colorado Department of Human Services or its designees, or the Medicaid Fraud Control Unit or its designees, acting through their representatives who have written or other authorization to act on behalf of these agencies.

8.130.2 MAINTENANCE OF RECORDS

- A. Each Provider shall:
 - 1. Maintain legible, complete, and accurate records necessary to establish that conditions of payment for Medical Assistance Program covered goods and services have been met, and to fully disclose the basis for the type, frequency, extent, duration, and delivery of goods and/or services provided to Medical Assistance Program members, including but not limited to:
 - a. Billings,
 - b. Prior authorization requests,
 - c. All medical records, service reports, and orders prescribing treatment plans,
 - d. Records of goods prescribed, ordered for, or furnished to, members, and unaltered copies of original invoices for such items,
 - e. Records of all payments received from the Medical Assistance Program, and
 - f. Records required elsewhere in Section 8.000 et seq.
 - 2. The records shall be created at the time the goods or services are provided.
- B. Records of Providers shall include employment records, including but not limited to shift schedules, payroll records, and time-cards of employees.
- C. Providers who issue prescriptions shall keep in the patient's record, the date of each prescription and the name, strength, and quantity of the item prescribed.
- D. Records must be maintained for seven (7) years unless an additional retention period is required elsewhere in Section 8.000 et seq., or in an individual Provider participation agreement.

- E. Each Provider shall retain any other records created in the regular operation of business that relate to the type and extent of goods and/or services provided (for example, superbills). All records must be legible, verifiable, and must comply with generally accepted accounting principles, auditing standards, and all applicable state and federal laws, rules, and regulations.
- F. Each entry in a medical record must be signed and dated by the individual providing the medical service or good. Stamped signatures are not acceptable.
- G. Providers utilizing electronic record-keeping may apply computerized signatures and dates to a medical record if their record-keeping systems guarantee the following security measures:
 - 1. Restrict application of an electronic signature to the specific individual identified by the signature. System security must prevent one person from signing another person's name.
 - 2. Prevent alterations to authenticated (signed and dated) records. If the Provider chooses to supplement a previous entry, the system must only allow a new entry that explains the supplement. The Provider must not be allowed to change the initial entry.
 - 3. Printed or displayed electronic records must note that signatures and dates have been applied electronically.
- H. At the discretion of the Requesting Agency, record verification may include, but will not be limited to, interviews with Providers, employees of Providers, billing services that bill on behalf of Providers, and any member of a corporate structure that includes the Provider as a member.

8.130.3 ADVANCE DIRECTIVES

- A. Providers shall provide adult Medical Assistance Program members with written information about the individual's rights under state law to accept or refuse medical treatment, the right to formulate advance directives, and the Providers' policies regarding the implementation of such rights as follows:
 - 1. Hospitals, at the time of the individual's admission as an inpatient.
 - 2. Nursing facilities, at the time of the individual's admission as a resident.
 - 3. Providers of home health care or personal care services, in advance of the individual coming under the care of the Provider.
 - 4. Hospice programs, at the time of initial receipt of hospice care by the individual from the program.
 - 5. Health maintenance organizations, at the time of enrollment of the individual with the organization.
- B. The Provider shall maintain written policies and procedures with respect to all adult individuals receiving medical or personal care by or through the Provider, which shall include:
 - 1. Documentation in the individual's medical records indicating whether the individual has executed an advance directive.
 - 2. Documentation that the individual will not be discriminated against, nor will the provision of care be conditioned on whether he/she has executed an advance directive.

3. Documentation ensuring compliance with requirements of state law respecting advanced directives.
 4. Documentation in the individual's medical record substantiating the Provider's reason(s) for non-compliance with an advance directive based on conscience or professional ethics.
- C. Providers shall provide education for staff and the patient/member community on issues concerning advance directives.

8.130.35 SCREENING FOR EXCLUDED EMPLOYEES AND CONTRACTORS

- A. As a condition of enrollment and participation in the Medical Assistance Program, each Provider shall comply with the following requirements for screening for employees and contractors who have been excluded from participation in Medicaid and Medicare by the US Department of Health & Human Services Office of Inspector General:
1. Each Provider shall utilize the US Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (www.oig.hhs.gov) to determine if a prospective employee or newly signed contractor has been excluded from participation in a Medical Assistance Program.
 - a. Such screening should be performed within five (5) business days of the date on which the new employee was hired or new contract was signed.
 2. Each Provider shall screen its employees and contractors against the List of Excluded Individuals/Entities at least monthly to capture any exclusions or reinstatements that have occurred since the last search of the database.
 3. If a Provider determines that an employee or contractor of the Provider has been excluded, then the Provider shall report this to the Department within five (5) business days of the date of discovery.
 4. Each screening must be documented in a manner that can be provided to the Department upon request.
- B. Except as otherwise provided in federal law, if the Medical Assistance Program pays for any goods or services furnished, ordered, or prescribed by an excluded individual or entity that is employed by or has contracted with a Provider, such payment shall constitute an overpayment and shall be subject to overpayment recovery, pursuant to Section 8.076. Such Provider may also be subject to sanctions by the Department, including the termination of the Provider agreement, as described at 8.076.5., if the Provider knew or should have known of the exclusion. The Provider may also be subject to civil and monetary penalties imposed by the US Department of Health and Human Services.
1. To the extent that such amount can be traced, the amount of the overpayment shall include any funds expended by the Medical Assistance Program to pay the excluded individual's or contractor's salary, expenses, or fringe benefits.
- C. Subject to federal law and the Department's discretion, failure of a Provider to comply with the screening requirements listed at Section 8.130.35.A. may constitute good cause sufficient to justify termination of the Provider agreement, as described at 8.076.5.

8.130.40 PROVIDER EMPLOYEE OR CONTRACTOR LICENSE VERIFICATION

- A. As a condition of participation in the Medical Assistance program, any Provider who provides or who has employees or contractors who provide services or supplies must ensure that, at the time services or supplies are provided, the Provider, the employee, or the contractor possesses the license, certification, or credential that is required in the State of Colorado to provide such services or supplies.

8.130.45 REPORTING CHANGES

- A. Within thirty-five (35) calendar days, Provider shall update the provider portal of the Department's Medicaid Management Information System (MMIS) with any Change of Information or Change in Ownership.
- B. Failure by the Provider to notify the Department of any Change of Information or Change in Ownership in accordance with section 8.130.45.A.:
 - 1. May result in the denial, suspension, inactivation, or termination of the Provider agreement or contract.
 - 2. Does not exempt a Medical Assistance Program Provider from compliance with 10 CCR 2505-3 and 10 CCR 2505-10.

8.130.50 REQUIREMENT TO VERIFY ENROLLMENT OF MEMBER AT TIME OF SERVICE

- A. A Provider shall verify and document that the member is enrolled in the applicable Medical Assistance Program at the time the service is rendered.
- B. A Provider shall verify that payments received are for medically necessary goods and services that were actually rendered, and that claims and encounters submitted for payment are true and correct.

8.130.60 PROVIDERS ARE RESPONSIBLE FOR ALL CLAIMS SUBMITTED

- A. A Provider shall accept full legal responsibility for all claims submitted under the Provider's Medical Assistance Program ID number to the Medical Assistance Program, whether submitted by the Provider or submitted on the Provider's behalf.
 - 1. A Provider shall comply with all federal and state civil and criminal statutes, regulations, and rules relating to the delivery of goods and services to eligible individuals, and to the submission of claims for such goods and services. A Provider's non-compliance may result in no payment for goods and services rendered.
- B. A Provider shall furnish to the Department its National Provider Identifier (NPI) (if eligible for an NPI) and include the NPI on all claims submitted pursuant to Sections 8.125.8 and 8.126.3.
- C. A Provider shall request payment only for those goods and services which are medically necessary, as such term is defined in Section 8.076.1.8. and in any other subsection of these rules defining medical necessity, and which are rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision.
 - 1. A Provider shall submit claims only for those goods and services provided by health care personnel who meet the professional qualifications established by the State.

2. Any misrepresentation or falsification of a claim submitted by a Provider, or on a Provider's behalf, may subject the Provider to fines and/or imprisonment under state or federal law.
- D. If at any time the Department determines that a Provider has failed to maintain compliance with any state or federal laws, rules, or regulations, the Provider may be suspended from participation in the Medical Assistance Program, and may be subject to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

8.130.70 COMPLIANCE WITH GUIDANCE

- A. Providers must comply with all state and federal statutes, rules, regulations, and guidance.
- B. Guidance includes, but is not limited to:
 1. Department Billing Manual
 2. Department Provider Bulletins
 3. Department Memo Series
 4. Uniform Service Coding Standards
 5. Current Procedural Terminology (CPT) code set
 6. Current Healthcare Common Procedure Coding System (HCPCS)
 7. Current International Classification of Diseases (ICD))
- C. Failure to comply may subject the Provider to authorized administrative actions, civil investigation, and criminal investigation.

8.130.80 INACTIVATING PROVIDER AGREEMENTS

- A. A Provider may have its Provider Participation Agreement inactivated and will no longer be able to bill for goods and services if any of the following occur:
 1. The Provider's license, certification, or accreditation has expired or is subject to conditions or restrictions.
 2. The Provider has failed to complete Provider revalidation.
 3. The Provider is no longer eligible to participate as a Medical Assistance Program Provider or breaches the Provider agreement.
 4. There is a Change of Ownership.
 5. The Provider's business closes, or the business is nonoperational.
 6. The Provider is deceased or retired.
 7. The Provider is inactive and has not submitted any claims activity for 24 months.
- B. The Provider will be sent written notice thirty (30) days prior to the inactivation, unless otherwise required by federal or state statute, regulation, or rule.

1. The notice will detail the reason for the inactivation.
2. The notice will give the Provider the opportunity to dispute the inactivation.
- C. If the Provider elects to dispute the inactivation, the Department must receive the Provider's written request to dispute the inactivation within thirty (30) calendar days of the date of the inactivation notice.
- D. The Department will review the request and issue a determination on the inactivation which will include the Provider's right to file an appeal in accordance with Section 8.050.
- E. The effective date of the inactivation may be backdated to the date of the occurrence described in Section 8.130.80.A.

8.170 STATE IDENTIFICATION NUMBER

- .10 As medical assistance is administered on an individual recipient basis, rather than on a household basis, the individual recipient is uniquely identified. A state assigned number is used for this purpose. This state identification number consists of an alpha (letter) prefix, followed by a six-digit number. When an individual is approved for medical assistance, the state identification number is assigned. This number is transmitted to the county department via the automated system.
- .20 The State Identification Number is the only numeric designation medical assistance providers will have, other than the name, to identify individuals. This number is required to be entered on all billing transactions.

In order to carry out this responsibility for facilitating provision of medical benefits to recipients, to properly respond to inquiries from providers, to secure benefits of medical resources other than Medicaid (see 8.061 et seq.), and for other administrative purposes, county departments are to maintain cross reference files of household and medical identification numbers.

8.180 MEDICAL IDENTIFICATION CARDS AND DURATION OF ELIGIBILITY

8.181 IDENTIFICATION

- .10 The state department will issue identification cards directly to clients who are eligible for benefits under a medical assistance program.
- .20 The providers of benefits in the Department's medical assistance programs are instructed to use the identifying information to access an automated eligibility database to obtain the client's current or previous eligibility for medical assistance for a given date of service.

8.182 MEDICAL IDENTIFICATION CARD

Each eligible client shall have a medical identification card issued from the state department's office to obtain medical services.

8.183 INSTRUCTIONS FOR HANDLING UNDELIVERED MEDICAL IDENTIFICATION CARDS

The Post Office returns all undelivered Medical Identification Cards to the county departments when recipients are deceased, no longer at that address, etc. The following steps will be taken to assure delivery of cards to the recipient.

- A. If the address shown in the envelope window is incorrect or no longer valid, the county departments are not to make the address change for remailing on the returned envelope. Counties are to open the envelope, paste a white sticker over the incorrect address, type in the correct address, use a separate envelope with the corrected address, insert the Medical Identification Card Mailer, and remail the card and its carrier to the client's new (correct) address. (This includes out-of-state moves if the client remains eligible.)
- B. Counties shall immediately correct the address on the automated system.
- C. If the recipient is deceased, the county shall destroy the identification card and make appropriate change in the eligibility system.

8.190 ACUTE MEDICAL BENEFITS DETERMINATION

8.190.1 A client or provider may request a coverage determination for new acute medical benefits or services by submitting a written request to the Department.

8.190.1.A. Written requests shall include documentation on all the following criteria regarding the benefit or service:

- 1. Prescribed by a doctor of medicine or osteopathy, or an optometrist, dentist or podiatrist acting within the scope of their respective licenses;
- 2. A reasonable, appropriate and effective method for meeting the medical need;
- 3. The expected use is in accordance with current medical standards or practices;
- 4. Proven cost effective method of treatment;
- 5. Does not result in an unsafe environment or situation;
- 6. Not experimental, investigational and is accepted by the medical community as standard practice;
- 7. Primary purpose is not to enhance personal comfort or convenience; and
- 8. Considered to be medically necessary for the diagnosis.

8.190.2 The requestor shall be notified in writing of the Department's decision regarding coverage.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, 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 All Versions list on the rule's current version page. To view versions effective on or after 03/04/2007, 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]