DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.100

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 PROGRAM REQUIREMENTS

8.100.1 LEGAL BASIS

.11 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.

.12 Colorado Revised Statutes, Title 26, 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.

.13 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.

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

8.100.2 GENERAL PROVISIONS

.21 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.

.22a. The county department shall advise individuals concerning the benefits of the medical assistance program and determine and redetermine eligibility for medical assistance in accordance with rules and regulations of the State Department. A person who is applying for Medicaid or a client who is discontinued from Medicaid in one category shall be evaluated under other categories of eligibility. There is no time limit for Medicaid coverage as long as the client remains categorically eligible.

b. Designated staff of the Department of Health Care Policy and Financing shall be authorized to determine eligibility for medical assistance as part of the eligibility review conducted for the Childrens Basic Health Plan. This eligibility determination is restricted to the Family and Children's categories including those identified in Section 8.101.1. Eligibility will be determined in accordance with rules and regulations applicable to the Families and Children's categories outlined in Sections 8.100.2 through 8.100.5 and 8.100.8 through 8.106. Once eligibility is determined and the timeframe for an appeal has lapsed, the case file will be transferred to the county department in which the applicant(s) resides. The county department shall be responsible for the on-going maintenance and

redetermination of the case.

.23 The county department shall provide written information from the state 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.

B. Applicants who are institutionalized.

C. Applicants/clients who will turn age 55 before their next eligibility redetermination.

D. Clients approved for admittance to an institution.

.235 An applicant and community spouse of an applicant for HCBS, PACE or institutional services shall disclose a description of any interest the applicant or spouse has in an annuity or similar financial instrument at the time of application, regardless of whether the annuity is irrevocable or treated as an asset.

.236 The county department or medical assistance site shall provide written notice to any applicant for HCBS, PACE or institutional services that the Department shall be a preferred remainder beneficiary in any interest in any annuity or similar financial instrument of a Medicaid recipient or community spouse of a Medicaid recipient. This remainder beneficiary interest is for the total amount of medical assistance provided to the individual and applies to any annuity purchased on or after February 8, 2006.

.237 The county department or medical assistance site shall notify in writing the issuer of any annuity or similar financial instrument described in 8.100.236 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 county department when there is a change in the amount of income or principal that is being withdrawn from the annuity.

.24 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.

.25 Details concerning the nature and scope of benefits of the Colorado Medical Assistance Program are contained in other chapters of this manual.

.26 A person who is applying for or receiving Medicaid 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 Medicaid shall be referred, using the form as specified by the State Department, for child support enforcement services.

.27 The county department shall process an application for Medicaid benefits within the following deadlines:

A. 90 days for persons who apply for Medicaid on the basis of disability.

B. 45 days for all other Medicaid applicants.

C. The above deadlines cover the period from the date of application to the date the county department mails a notice of its decision to the applicant.

D. In unusual circumstances documented in the case record, the county department may delay its decision on the application beyond the applicable deadline. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action, or an administrative or other emergency beyond the agency's control.

E. The county department shall not use the above timeframes as a waiting period before determining eligibility, or as a reason for denying eligibility.

F. For clients who apply for Medicaid on the basis of disability, the county department 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 county department shall send this notice 91 days following the application for Medicaid on the basis of disability.

G. For information regarding continuation of benefits during the pendency of an appeal to the SSA based upon termination of disability benefits see Section 8.057.5.C

.28 Effective July 1, 1997, as a condition of eligibility for Medicaid, any legal immigrant who is applying for or receiving Medicaid shall agree in writing that, during the time period the client is receiving Medicaid, he or she will not sign an affidavit of support for the purpose of sponsoring an alien who is seeking permission from the Immigration and Naturalization Service to enter or remain in the United States. A legal immigrant's eligibility for Medicaid shall not be affected by the fact that he or she has signed an affidavit of support for an alien before July 1, 1997.

.29 All regulations for the administration of the Medicaid programs for Families and Children are included in this Staff Manual Volume 8, from 8.100 through 8.106. Staff Manual Volume 3 rules do not apply to these programs.

8.100.3 PROCESSING STANDARDS

.31 Persons applying to the county 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 designated by the Colorado Department of Health Care Policy and Financing.

Persons requesting Medicaid Only for Family and Children's categories, including 1931 Medicaid, need only to complete the "Application for Colorado Health Care."

Pregnant women and children may apply for medical assistance at sites other than the County Department of Social Services. These sites shall be approved by the State Department to receive and initially process these applications. The application shall not be the same as those used to apply for financial assistance programs. The County Department of Social Services shall determine eligibility.

Application interviews or requested trips to the county office for medical assistance shall not be required. All correspondence may be done by mail or telephone.

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

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

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

.34 The application processing requirements and verification requirements which apply for purposes of medical assistance are determined by the Colorado Department of Health Care Policy and Financing and set forth in rules approved by the Medical Services Board. A consent form (IM-12) shall not be required to request information from Social Security regarding medical assistance applicants or clients.

.35 When an individual applies for Medicaid on the basis of disability or blindness, the county department shall take the application and determine whether the individual is eligible for Medicaid long term care or any of the categories of assistance described at 8.110.2 under SSI RELATED CASES and at 8.121 under QUALIFIED DISABLED AND WORKING INDIVIDUALS. If the applicant does not qualify for Medicaid on one of those bases, he/she shall be referred to the local Social Security office to apply for SSI by use of the DEN-DO-A/P-88.

Applicants who apply for long term care Medicaid on the basis of disability or blindness shall complete a disability determination form in addition to the required medical assistance application. The disability determination form shall be collected by a designated county representative and shall be forwarded the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated county representative.

.36 County departments and outreach sites in which an individual is able to apply for Medicaid benefits shall also provide the applicant the opportunity to register to vote.

A. The county department/outreach site shall provide to the applicant the prescribed voter registration application.

B. The county department/outreach site shall not:

1. Seek to influence the applicant's political preference or party registration;

2. Display any political preference or party allegiance;

3. 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

4. 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 county department/outreach 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 county department. These records shall not be part of the public assistance case record and are not subject to subpoena.

E. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the county department/outreach 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.

.37 Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote. The resident county shall follow the above procedure. The paying county 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.

.38 The county departments shall refer Medicaid applicants who are pregnant and/or under 21 years old to EPSDT by copying the page of the Medicaid only application that includes the EPSDT benefit questions. The county department will then forward this page to the EPSDT office within five working days from the date of receipt of the application.

8.100.4 FURNISHING ASSISTANCE

.41 Medical assistance shall be approved effective as of the date of application for medical assistance or as of the date the person becomes eligible for medical assistance, whichever is later. Individuals held in correctional facilities or who are held in community corrections programs that are determined eligible for medical assistance shall be approved effective as of the individual's date of release. Additionally, an applicant for medical assistance shall be provided such assistance any time during the three (3) 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.

.42 An explanation of the conditions for retroactive medical assistance shall be given to all applicants. Those applicants who within the three (3) 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 of the Colorado Medicaid Program or the Colorado Modified Medical Program as applicable, 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. Minimum verification required for the Medicaid program, as defined at 8.105.5,A, shall be secured to determine backdating eligibility. Proof of the declared medical service shall not be required.

.43 To be eligible for retroactive medical assistance, the categorically needy disabled or blind person shall either

A. have received SSI money payment or Social Security disability insurance (DIB) for that time, or

B. be determined to have met the SSI definition of disability or blindness at that time through the procedure for processing applicant/client determinations as described in the chapter on AID TO NEEDY DISABLED OR BLIND PERSONS in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1).

.44 Any person at any time during a calendar month who is determined to be eligible for medical assistance shall be eligible for benefits during all the subsequent portion of that month.

8.100.5 GROUPS ASSISTED UNDER THE PROGRAM

.51 The Colorado Medicaid Program provides benefits to persons who meet the federal definition of categorically needy.

.52 The following are considered as categorically needy:

A. Families and children listed at 8.101.11.

B. Persons who are eligible for cash assistance under the Colorado Works Program (Temporary Assistance to Needy Families) pursuant to C.R.S. 26-2-706.

C. Persons who are legal immigrants and fall into one of the categories in 8.100.53,A,2 or 3, 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.

D. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B.

E. Persons who are eligible for financial assistance under OAP and SSI, but are not receiving the money payment;

F. 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 Medicaid except for the cost of living adjustments (COLA's) received.

G. Persons who are blind, disabled, or aged individuals residing in the medical institution or intermediate care facility 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. Persons who are blind, disabled or aged 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.

I. Disabled adult children who are at least 18 years of age and who lost their SSI on or after May 1, 1987, due to the receipt of social security benefits drawn from his/her parents' Social Security Number as disabled adult child (DAC).

J. Children age 18 and under who would otherwise require institutionalization in an Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF), or an acute care hospital in lieu of a SNF as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).

K. 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 Colorado Modified Medical Program. These persons qualify for a SISC Code C.

L. Persons who apply for and meet the criteria for one of the categorical Medicaid assistance programs, but do not meet the criteria of citizenship shall receive Medicaid that can only be used for emergencies.

8.100.53 To be eligible to receive medical assistance, an eligible person shall:

A. Fall into one of the following categories:

1. 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

2. Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

3. Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medicaid 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:

    a. lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA") : No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    b. paroled into the United States for at least one year under Section 212(d)(5) of the INA: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    c. granted conditional entry under Section 203(a)(7) of the INA, as in effect prior to April 1, 1980: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    d. determined by the county department, 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. sec. 1641, has been battered or subjected to extreme cruelty which necessitates the provision of medical assistance (Medicaid) : No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    e. lawfully admitted for permanent residence under the INA with 40 qualifying quarters as defined under Title II of the Social Security Act: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library. The 40 quarters is counted based on a combination of the quarters worked by the individual, the individual's spouse as long as they remain married or spouse is deceased, and/or the individual's parent while the individual is under age 18; or

4. Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

    a. lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children); or

    b. 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

    c. granted asylum under Section 208 of the INA: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    d. refugee under Section 207 of the INA: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    e. 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: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    f. Cuban or Haitian entrant, as defined in Section 501(e)(2) of the Refugee Education Assistance Act of 1980 for seven years after the date of entry into the United States: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    g. 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. 450b(e) : No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

    h. 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) : No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library; or

i. lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict for seven years after the date of entry into the United States; or

j. a victim of a severe form of trafficking in persons, as defined in Section 103 of the Trafficking Victims Act of 2000, 22 U.S.C. 7102 for seven years after the date of entry into the United States: No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

A2. For determinations of initial eligibility and redeterminations of eligibility for medical assistance made on or after July 1, 2006, provide satisfactory documentary evidence of citizenship or nationality and identity unless such satisfactory documentary evidence has already been provided, as described in 8.100.53.A2.4.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.

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

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

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

c. 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.

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

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

f. Children born to a woman who has applied for, has been determined eligible, and is receiving Medicaid on the date of the child's birth, as described in 8.101.11.E. This includes instances where the labor and delivery services were provided before the date of application and were covered by Medicaid as an emergency service based on retroactive eligibility.

g. Individuals receiving Medicaid during a period of presumptive eligibility.

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

a. Primary Evidence of Citizenship and Identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and

citizenship:

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

a) includes the applicant or recipient, and

b) was issued without limitation. A passport issued with a limitation may be used as proof of identity, as outlined in 8.100.53.A2.3.

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

3) 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.

b. Secondary Evidence of Citizenship. If primary evidence from the list in 8.100.53.A2.2.a. is unavailable, 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 8.100.53.A2.3. to establish identity. Secondary evidence of citizenship includes:

1) A U.S. public birth certificate.

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

1) One of the 50 States,

2) The District of Columbia,

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

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

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

6) American Samoa,

7) Swain's Island, or

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

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

c) 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 8.100.53.A2.2.d.

2) 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.

3) 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.

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

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

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

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

6) 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.

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

8) A final adoption decree that:

   a) shows the child’s name and U.S. place of birth, or

   b) 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.

9) 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.

10) U.S. Military Record that shows a U.S. place of birth, including a DD-214.

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

12) 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 that at any time on or after February 27, 2001, the following conditions have been met:

a) 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);

b) The child is under the age of 18;

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

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

e) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred.

8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

c. Third Level Evidence of U.S. Citizenship. Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence is available. Third level evidence shall be used only when primary evidence cannot be obtained within 10 business days, secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the U.S. A second document from 8.100.53.A2.3. to establish identity shall also be presented.

1) Extract of a hospital record on hospital letterhead.

a) The record shall have been established at the time of the

person's birth;

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

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

d) 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.

e) Souvenir "birth certificates" issued by a hospital are not acceptable.

2) Life, health, or other insurance record.

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

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

c) 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.

3) Religious record.

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

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

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

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

4) Early school record that meets the following criteria:

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

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

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

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

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

d. Fourth Level Evidence of Citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence

shall only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained within 10 business days, and the applicant alleges U.S. citizenship. The affidavit process described in 8.100.53.A2.2.d.5. may be used by U.S. citizens or nationals born inside or outside the U.S. In addition, a second document establishing identity shall be presented as described in 8.100.53.A2.3.

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

2) One of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for Medicaid. 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.

    a) Seneca Indian tribal census record;

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

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

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

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

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

3) 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.

4) Medical (clinic, doctor, or hospital) record.

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

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

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

    d) 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) 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 the documentation requirement needs to be

met through affidavits, the following rules apply:

a) 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);

b) 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;

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

d) 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;

e) 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

f) The affidavits shall be signed under penalty of perjury and need not be notarized.

e. 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 8.100.53.A2.3. to establish identity shall also be presented.

1) Puerto Rico:

a) 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

b) 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.

2) U.S. Virgin Islands:

a) 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

b) 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

c) 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.

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

a) 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

b) 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

c) 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).

d) 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.

3. Evidence of Identity. 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 8.100.53.A2.2.b. through e.

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 8.100.53.A2.2.b. or 8.100.53.A2.2.c. The following requirements must be met:

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

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

3) All documents used must contain consistent identifying information.

4) 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:

1) Clinic, doctor, or hospital records; or

2) School records.

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

b) 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.

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

a) 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

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

c) The affidavit is not required to be notarized.

k. Expired identity documents.

1) 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.

4. Documentation Requirements.

a. Effective January 1, 2008, all citizenship and identity documents must either be originals or copies certified by the issuing agency, except as provided in 8.100.53.A2.4.f. Uncertified copies, including notarized copies, are not acceptable.

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 there is a reasonable basis for questioning the authenticity of the document.

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

1) Individuals are strongly encouraged to use alternatives to mailing original documents to counties, such as those described in 8.100.53.A2.4.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.

1) 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.

2) Upon request by the client or county, the copy of the original document with the “Citizenship and Identity Documentation Received” form, stamp, or other verification as described in 8.100.53.A2.4.e.1 shall be mailed or delivered directly to the county within five business days.

f. Counties shall accept photocopies of citizenship and identity documents from any location described in 8.100.53.A2.4.e provided the photocopies include the form, stamp, or verification described in 8.100.53.A2.4.e.1.

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

1) Upon receiving the original documents, county 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 8.100.53.A2.4.e.1. This form, stamp, or other verification shall be attached to or directly applied to the copy.

2) 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.

3) 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:

1) Later evidence raises a question about the individual’s citizenship or identity; or

2) 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 Medicaid and the county has not retained the citizenship and identity documentation the individual previously provided.

5. Record Retention Requirements

a. The county shall retain a paper or electronically scanned copy of an

individual's citizenship and identity documentation, including any verification described in 8.100.53.A2.4.e.1, for at least five years from the ending date of the individual's last period of Medicaid 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:

        1) 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;

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

        3) 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 county shall provide a reasonable level of assistance to applicants and clients in obtaining the requiring citizenship and identity documentation.

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

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

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

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

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

8. Individuals Requiring Additional Assistance

    a. The county shall provide additional assistance beyond the level described in 8.100.53.A2.7 to applicants and clients in obtaining the required citizenship and identity documentation if the client or applicant:

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

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

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

        1) Contacting any known family members who may have the required

documentation;

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

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

c. The county shall document its efforts at providing additional assistance to the client or applicant. Such documentation shall be subject to the record retention requirements described in 8.100.53.A2.5.a.

9. Reasonable Opportunity Period

a. If a Medicaid applicant or recipient does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. If the applicant or recipient does not provide the required documentation within the reasonable opportunity period, then:

1) the applicant's Medicaid application shall be denied, or

2) the recipient's Medicaid benefits shall be terminated.

b. The reasonable opportunity period for Family Programs covered under 8.100.53.A2 is 14 calendar days. For the purpose of this section, Family Programs are defined as the following:

Commonly Used Program Name	Rule Citation
1931 Medicaid	8.105.11
Transitional Medicaid	8.106.71-75
Four Month Extended Medicaid	8.106.76
Institutionalized under age 21	8.101.2.A
Parents Plus Program	8.101.11.O
Qualified Child	8.101.11.B
Expanded Child	8.101.11.F
Ribicoff Child	8.101.11.G
Qualified Pregnant	8.101.11.J.a
Expanded Pregnant	8.101.11.J.b

c. The reasonable opportunity period for Adult Programs covered under 8.100.53.A2 is 70 calendar days. For the purpose of this rule, Adult Programs are defined as the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.110.61-.613

Old Age Pension B (OAP-B)	8.110.61-613
Qualified Disabled Widow/Widower	8.110.29-.291
Pickle	8.110.21-.27
Long-Term Care	8.110.30
Breast and Cervical Cancer Program (BCCP)	8.715

B. Be a resident of Colorado;

C. Not be an inmate of a public institution, except as a patient in a public medical institution or as a resident of an intermediate care facility or as a resident of a publicly operated community residence which serves no more than 16 residents;

D. 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 Colorado Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medicaid reimbursement. See the section on NEEDY PERSONS UNDER 21 for special provisions extending Medicaid coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

E. Furnish a Social Security Account Number (SSN) or evidence that an application for a SSN has been submitted;

F. Meet all financial eligibility requirements of the Medical Assistance program for which application is being made, including but not limited to the provisions for deeming the income and resources, if applicable, of alien sponsors;

G. Meet the definition of disability or blindness, when applicable. Those definitions appear in this staff manual at 8.110.32 under PERSONS IN MEDICAL FACILITIES OR OTHER RESIDENTIAL PLACEMENT.

H. Meet all other requirements of the Medical Assistance program for which application is being made.

EXCEPTION: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medicaid assistance programs, but do not meet the criteria of citizenship shall receive Medicaid that can only be used for emergency medical care.

Non-qualified aliens need not furnish evidence that an application for a SSN has been made. The rules on confidentiality prevent the agency from reporting to the Immigration and Naturalization Service persons who have applied for or are receiving assistance. These persons need not select a primary care physician, since they are eligible only for emergency medical services.

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

An emergency medical condition is a 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:

(a) placing the patient's health in serious jeopardy,

(b) serious impairment of bodily function, or

(c) serious dysfunction of any bodily organ or part.

A physician shall make a written statement certifying the presence of a medical emergency condition when services are provided and shall indicate that services were for a medical emergency on the claim form.

Coverage 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, such as postpartum care. Coverage will include prenatal care, if and only if, the client receives prenatal care through "The Prenatal Care for Undocumented Women Pilot Program" delivered in a geographic area covered by the Managed Care Organization contracting with the State for the delivery of such services and according to specifications contained within C.R.S. 26-4-203.

.54 Individuals shall live in the county in which they make application. Individuals held in correctional facilities or who are held in community corrections programs shall apply for medical assistance in the county specified as his/her county of residence upon release. 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 medical assistance, 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 county completes the determination and transfers the case as applicable.

.55 A resident of Colorado is defined as a person that is living in, other than temporarily, within the state of Colorado at the time of application. For institutionalized individuals who are incapable of indicating intent as to their state of residence, the state where the institution is located shall be the person's state of residence 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 become incapable of indicating intent before age 21, the state of residence is that of the individual's parents 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;

d. in the case of conflicting opinions between states, the state of residence is the state where the individual is physically located.

.56 For purposes of this section on establishing an individual's state of residence, an individual is considered incapable of indicated 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 manual;

b. the person is judged legally incompetent; or

c. medical documentation, or other documentation acceptable to the county, supports a finding that the person is incapable of indicating an intent.

.57 If a state arranged for an individual to be placed in an institution located in another state, the state making the placement shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent.

8.100.6 FEDERAL FINANCIAL PARTICIPATION

.61 The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medicaid Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons. The FFP/SMIB status shall be specified for all aged, disabled or blind recipients by submitting the applicable Supplemental Income Status Code (SISC) on the eligibility reporting form.

.62 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.

.63 The specifications for each coverage group are contained in subsequent sections of this chapter on medical assistance eligibility. The SISC codes which apply to the coverage groups are shown in the left-hand margin.

.64 Recipients of financial assistance under State AND, State AB, or OAP "C" are not eligible for medical assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.7 REDETERMINATION OF ELIGIBILITY

.71 A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medicaid client continues to be eligible to receive medical assistance. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months for Title XIX Category 04 (Medicaid only) cases.

.72 The county department shall provide to the Medicaid client the opportunity to register to vote, in accordance with the provisions of Section 8.100.36 of this staff manual.

.73 The county department shall promptly redetermine eligibility when:

A. it receives and verifies information which indicates a change in a client's circumstances which may affect continued eligibility for medical assistance; or

B. it receives direction to do so from the State Department.

.74 A redetermination form, approved by the Colorado Department of Health Care Policy and Financing, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself can not be required to be returned. The only verification that can be required at redetermination is the same minimal verification listed in Section 8.105.5 of this Staff Manual. The following procedures relate to mail-out redetermination:

A. A Redetermination Form shall be mailed to the client together with any other forms to be completed;

B. A self-addressed, stamped, return envelope shall be mailed to the client with the required forms;

C. Required verification shall be returned by the client to the county department no later than ten working days after their receipt of the redetermination verification information requires form;

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

E. 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.

F. The county department shall notify in writing the issuer of any annuity or financial instrument described in 8.100.74.E. 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 county department when there is a change in the amount of income or principal that is being withdrawn from the annuity.

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

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

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

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

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

A. due to incomplete information, the request form shall be mailed back to the client with a letter specifying the items that require completion. A self-addressed, stamped, return envelope shall be enclosed;

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

8.100.8 CONFIDENTIALITY

.81 All information obtained by the county department concerning an applicant for or a recipient of Medicaid is confidential information.

.82 A signature on the Application for Colorado Health Care allows a county 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 a county employee will, in itself, disclose that an application for Medicaid has been made by an individual. In this type of contact, as well as other community contacts, the county should strive to maintain confidentiality.

The signature on the Application for Colorado Health Care 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 Medicaid program.

.83 County department staff may release a client's Medicaid state identification number and approval eligibility spans to a Medicaid provider for billing purposes. County department staff may inform a Medicaid provider that an application has been denied but may not inform them of the reason why.

.84 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 county agency.

.85 The county must obtain permission from a family or individual, 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. 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 county must notify the family or individual immediately after supplying the information.

.86 The counties 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 county representative to testify concerning an applicant or recipient, the county must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

.87 The following types of information are confidential and shall be safeguarded:

a. Names and addresses of applicants for and recipients of Medicaid;

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), SSA or Internal Revenue Service;

g. Any information received in connection with third party resources;

h. Any information received for verifying income and resources if applicable, or other eligibility and the amount of medical assistance payments.

.88 The confidential information listed above may be released to persons outside the county department 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.

.89 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 county department 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.

8.100.9 PROTECTION AGAINST DISCRIMINATION

.91 County departments are to administer Medical assistance programs 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.

.92 The county department 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 to 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 Medical assistance programs;

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 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 Medical programs of assistance.

.93 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 county department to Medical assistance recipients.

.94 An individual who believes he/she is being discriminated against may file a complaint with the county department, the State Department, or directly with the Federal government. When a complaint is filed with the county department, 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 and Section 504 of the Rehabilitation Act of 1973.

8.101.1 MEDICAID ELIGIBILITY FOR FAMILIES AND CHILDREN [Eff. 03/30/2008]

.11 Medical assistance shall be provided to families and children who meet the federal definition of categorically needy. All references to 1931 Medicaid apply to AFDC rules effective on July 16, 1996. The following are considered under this group.

A. Persons who would have been eligible for AFDC (1931 Medicaid).

B. Children who would be eligible for 1931 Medicaid except for the consideration of income from a stepparent outside the assistance unit, or a grandparent outside the assistance unit.

C. Persons who would be eligible for 1931 Medicaid except for the inclusion in the assistance unit of a child/children whose income makes the unit ineligible. This also applies to parents with only one child.

D. Persons who would be eligible for 1931 Medicaid except for the income of a child(ren) outside the assistance unit whose income makes the unit ineligible.

E. A child born to a woman eligible for and receiving Medicaid at the time of the child's birth, is

continuously eligible for one year as long as the child remains a member of the household. This applies to children born to undocumented aliens and certain legal aliens as outlined in Section 8.100.53. To receive Medicaid under this category, the family need not file an application nor provide a social security number or proof of application for a social security number for the newborn. Anyone can report the birth of the baby by telephone. Information provided shall include the baby's name, date of birth, and mother's name or Medicaid number. A newborn can be reported to the county department at any time. Once reported a newborn meeting the above criteria shall be put on Medicaid from date of birth.

F. Children up to age six whose income does not exceed their proportionate share of 133% of the federal poverty level; or whose total family income does not exceed 133% of the federal poverty level.

G. Children born after September 30, 1983, not 19 years of age whose income does not exceed their proportionate share of 100% of the federal poverty level; or whose total family income does not exceed 100% of the federal poverty level.

H. If an individual is found ineligible because his/her income exceeds their proportionate share of the federal poverty level, a recalculation shall be performed to look at the Medicaid required household as a whole. The household's total income, after the allowable Medicaid deductions, shall be compared to the maximum federal poverty level. If the individual is then eligible under this process, he/she shall be coded under the same category for which they originally were determined ineligible.

I. Medical assistance shall be provided to persons in a facility eligible for Medical reimbursement who, if they left the facility, would be eligible for 1931 Medicaid.

J. Medical assistance shall be provided to a woman:

a. whose pregnancy is medically verified in writing by a medical professional (a certified medial assistant or higher level position supervised by a registered nurse or doctor), if pregnancy is not observable; and

b. whose income does not exceed her proportionate share of 133% of the federal poverty level or whose total family income does not exceed 133% of federal poverty level; and

c. for a period beginning with the date of application for medical assistance or as of the date the person becomes eligible for medical assistance, whichever is the later calendar date, through 60 additional days from the date the pregnancy ends.

K. Until the implementation of SB 03-176, a pregnant legal alien is eligible for state-funded prenatal medical care if she meets the eligibility requirements for expectant mothers listed in J.

L. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medicaid presumptive eligibility sites. A child under the age of nineteen may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites.

To be eligible for presumptive eligibility, an applicant shall have a verified pregnancy, declare that her household's income shall not exceed 133% of federal poverty level and declare that she is a United States citizen or a documented immigrant.

To be eligible for presumptive eligibility, a child under the age of 19 shall have a declared household income that does not exceed 100% of federal poverty level for a child age 6-18 or 133% of federal poverty level for a child under the age of 6 and declare that the child is a United States citizen or a documented immigrant of at least five years.

Presumptive eligibility sites shall be certified by the Department of Health Care Policy and Financing to make presumptive eligibility determinations. Sites shall be re-certified by the Department of Health Care Policy and Financing every 2 years to remain approved presumptive eligibility sites.

The presumptive eligibility sites shall attempt to obtain all necessary documentation to complete the application within fourteen calendar days of application.

The presumptive eligibility site shall forward the application to the county within five business days of being completed. If the application is not completed within fourteen calendar days, on the fifteenth calendar day following application, the presumptive eligibility sites shall forward the application to the appropriate county.

The presumptive eligibility period shall be no less than 45 days. The presumptive eligibility period ends on the last day of the month following the completion of the 45 day Presumptive Eligibility period. The county department shall make a Medicaid eligibility determination within 45 days from receipt of the application. The effective date of Medicaid eligibility shall be the date of application.

A Presumptive eligible client may not appeal the end of a presumptive eligibility period.

M. Presumptively eligible women and Medicaid 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 Section 8.058 of staff manual Volume 8 entitled "State Hearings" . *[Eff 08/30/2006]*

N. Household size for all Medicaid categories shall include the unborn child(ren) as a child(ren) living in the home in determining eligibility. *[Eff 08/30/2006]*

O. Effective July 01, 2006 and thereafter, adult parents who have a child on Medicaid or the Children's Basic Health Plan and are above the income limits for 1931 Medicaid and at or below 60% of the federal poverty level income guideline. Eligible individuals may not qualify for Medicaid in this category if the legislative appropriation is expended. *[Eff 08/30/2006]*

8.101.2 NEEDY PERSONS UNDER 21

Medical assistance shall be provided to certain needy persons under 21 years of age, including the following:

A. Those receiving care in an intermediate care facility eligible for Medicaid reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medicaid reimbursement.

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. See Colorado Department of Human Services "Social Services Staff Manual" Section 7 for specific eligibility requirements (12 CCR 2599). A child shall be the responsibility of the county, even if the child may be in a medical institution at that time.

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 family income is less than the AFDC needs standard for his/her family size excluding step-parent income.

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 Medicaid 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 will be extended until the individual's 21st birthday.

8.101.3 NON-FINANCIAL REQUIREMENTS [Eff. 08/30/2007]

.31 Residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. An absence shall be considered to be temporary when the person, at the time he/she leaves, intends to return.

.32 A non-resident shall mean a person who considers his/her place of residence to be other than Colorado. Persons who come to the state to receive medical assistance or for any other reason do not acquire residence so long as they consider their permanent place of residence to be elsewhere.

.33 When a family or individual moves from one county to another within Colorado, the client shall report their change of address to the county that carries their current active Medicaid case(s). The originating county shall electronically transfer the case to the new county of residence in Colorado Benefits Management System (CBMS). The originating county must contact the receiving county of the client's transfer of Medicaid.

.34 The receiving county shall accept a phone call from the originating county or the client that he/she has moved to the receiving county. If the family or individual wishes to apply for other types of assistance or wishes to apply for Medicaid for additional family members, they shall submit a new application.

.35 If the household is transferring the current Medicaid eligibility, the receiving county can not mandate a new application, verification, or an office visit to authorize the transfer. The receiving county, if the data contained in CBMS is questionable, can request copies of specific case documents to be forwarded from the originating county or medical assistance site.

.36 If a household applies in the county they live in and then moves out of that county during the application determination process, the originating county shall complete the processing of that application. The originating county will then follow the same transfer process.

.37

A. Cases closed for the discontinuation reason of "unable to locate" in the originating county

shall be treated the same in the receiving county. The discontinued client will need to reapply at the receiving county for medical assistance.

B. 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 county, the receiving county shall reopen the case with case comments in CBMS.

8.101.4 ELEMENTS CONSIDERED IN DETERMINING NEED

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A. In determining eligibility for medical assistance for household members, financial responsibility is limited to spouse being responsible for spouse, and parent being responsible for a dependent child. Financial responsibility of parents for a dependent child is not changed by the fact that the child may be pregnant or that she is a mother and caretaker of her own child.

B. A declared common law spouse retains the same financial responsibility as a legally married spouse. Once declared as common law, financial responsibility remains unless separation or divorce occurs.

.41 A parent means only a natural (including expectant) or adoptive parent.

.42 Dependent children are those who are;

A. under age 18 years of age; or

B. between the ages of 18 and 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19. Such children are eligible through the month of completion.

A dependent child is still considered to be a student in regular attendance during official school or training program vacation periods; absences due to illness, convalescence or family emergency; or the month which the child completes a school or training program.

Regular attendance means enrolled in a program of study or training leading to certificate, or diploma and physically attending:

1. full-time, or

2. at least half-time and regularly employed in or actively seeking part-time employment, or

3. at least half time and precluded from full-time attendance or part-time employment because of a verified physical handicap.

Full-time attendance in a program of study or training means secondary school attendance (including cooperative training programs), vocational or technical school of twenty-five (25) clock hours per week or as defined by the school. Participation in an approved program of training through employment and related education and technical instruction apprenticeship program may also meet the requirement as full-time attendance. Half-time attendance exists when the individuals attends school between twenty-four (24) to twelve (12) clock hours per week.

.43 Any family member who is receiving financial assistance from SSI or OAP-A is not considered a member of the Medicaid required household and the individual's income and resources are

disregarded in making the determination of need for medical assistance.

The following family members living in the same residence shall be included in the Medicaid required household:

A. dependent children who are not receiving SSI benefits,

B. parents of the dependent children not receiving benefits from SSI or Old Age Pension because he/she is age 65 or older.

.44 If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other.

.45 Income of parents of minor parents under the age of 18 living in the same household shall be attributed to the minor parent unless the minor parent is married or separated from marriage. Financial responsibility is between spouses, with each spouse being responsible for the spouse.

8.102.1 GENERAL RESOURCES AND INCOME EXEMPTIONS

.41 For the purpose of determining eligibility for medical assistance the following shall be exempt from consideration as either resources, if applicable, or income:

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. 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).

D. Home produce utilized for personal consumption.

E. 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.

F. Experimental Housing Allowance Program (EHAP) payments made by HUD under Section 23 of the U.S. Housing Act.

G. Payments made from Indian judgement 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).

H. 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).

I. Assistance from other agencies and organizations.

J. 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.

K. Payments received for providing foster care.

L. 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.

M. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program.

N. 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.

O. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).

P. 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.

Q. 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.

R. 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.

S. 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.

T. 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).

U. Effective January 1, 1989, 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).

V. A child receiving subsidized adoption funds shall be excluded from the Medicaid 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.

W. Effective January 1, 1991, the Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.

X. Any money received from the Radiation Exposure Compensation Trust Fund, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.

Y. Reimbursement or restoration of out-of-pocket expenses.

Z. Effective 8/1/1994, payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.

AA. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds.

BB. Effective March 1, 2000, all wages paid by the United States Census Bureau for temporary employment related to U.S. Census 2000 activities.

8.103.1 CONSIDERATION OF INCOME FOR FAMILIES AND CHILDRE MEDICAID PROGRAM

Income for Categorical Medicaid eligibility is that income which is received by an individual or family in the month in which they are applying for or receiving medical assistance.

.11 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.

.12 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 cash, shelter or other items in lieu of wages.

.13 Received, as is used in the preceding paragraphs, means "actually" received or legally becomes available, whichever occurs first; that is, the point at which the income first is available to the individual to use. For example, interest income on a savings account is counted when it is credited to the account.

.14 Compensation received from the Crime Victims Compensation Act shall be considered as income to the extent that it exceeds the expenses for which it was designated, i.e., medical and/or burial expenses.

.15 The first $50 per household per month of any current monthly support obligation shall be disregarded. Monthly support includes child support, and/or maintenance, and/or alimony.

.16 All Home Care Allowance (HCA) income paid to a Medicaid applicant/client by the HCA recipient to provide home care services is countable earned income.

.17 Participation in the Workforce Investment Act (WIA) affects eligibility for medical assistance as follows.

A. Wages derived from participation in a program carried our 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.

.18 Income of a medical assistance applicant/client who is attending school (student in a secondary education or undergraduate degree program) shall be treated as follows:

A. Income received from a college work-study program grant shall be exempt when it is part of a "need-based package" administered by the U.S. Commission of Education.

B. Scholarships given to individuals for education and training are exempt.

C. Income received by the medical assistance client which exceeds the work study grant specified in the need-based package shall be considered earned income.

D. All earned income that is received by a dependent child who is a full-time student or a part-time student who is not a full-time employee shall be disregarded for the eligibility test as long as they remain a student.

E. All earned income of dependent children who are not students (except income from WIA for up to six months in each calendar year) shall be considered in determining eligibility for medical assistance. All disregards from the earned income shall apply as listed in Section 8.104.10 of this manual.

8.103.19 An individual involved in a profit making activity 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 expenses include, but are not limited to:

1. the rent of business premises,

2. wholesale cost of merchandise,

3. utilities,

4. taxes,

5. labor, and

6. upkeep of necessary equipment.

B. The following are not allowed as business expenses:

1. Depreciation of equipment;

2. The cost of and payment on the principal of loans for capital asset or durable goods;

3. 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 required to only allow the percentage of the expense that is business related.

8.103.20 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 income is no longer deducted.

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.

8.104 EARNED INCOME DISREGARDS

.10 The earned income disregards described in this section shall be applied to the gross wages of each individual who is employed in the following order:

A. deduct the employment expense disregard of $90; and

B. deduct dependent care disregard.

For purposes of this section, a dependent is defined as a dependent child or adult included in the Medicaid required household. The employed person is allowed a dependent care deduction of the actual verified amount of the dependent care expenses of up to $175 per month per each dependent two (2) years and older; up to $200 per month per dependent less than two (2) years old.

In order to receive a dependent care deduction, declaration from the client is acceptable. The declaration, verbal, or written on the application, shall include the total dependent care costs paid per child for the month(s) Medicaid eligibility is being determined. The client may also present receipts or other documentation of paid costs for dependent care for these months.

8.105.1 1931 MEDICAID--GROUPS ASSISTED UNDER CERTAIN AFDC PROGRAM RULES, AS OUTLINED IN THIS SECTION, THAT WERE EFFECTIVE ON JULY 16, 1996.

.11 Medical assistance shall be provided to needy families who would have been eligible for Aid to Families with Dependent Children(AFDC) under regulations in effect on July 16, 1996. No other TANF/Colorado Works criterion applies to this group. Counties shall not require that a Medicaid

applicant/ recipient comply with any TANF/Colorado Works requirements. All references to the 1931 Medicaid Program apply to AFDC rules effective on July 16, 1996.

.12 Needy families are those whose income is less than the State standard of assistance.

.13 Dependent Children are those who are:

A. deprived of parental support or care due to the family income falling at or below the federal poverty level, and

B. living in the home of a parent or specified relative, or in foster care under certain conditions.

.14 Parent means only a natural (including expectant) or adoptive parent.

.15 In this section on 1931 Medicaid, the term's "applicant" and "client" include all the family members for whom 1931 Medicaid assistance would have been considered.

.16 Only certain family members are eligible persons and shall be in the same Medicaid required household:

A. dependent children under the age of 18;

B. dependent children between the ages of 18 and 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19. Such children are eligible through the month of completion;

C. The caretaker relative (a parent(s) or specified relative of a dependent child).

.17 Application for 1931 Medicaid Only assistance shall be made by a specified relative with whom the dependent child is living. A specified caretaker relative is any relation by blood, marriage or adoption who is within the fifth degree of kinship to the dependent child, such as:

A. a parent;

B. a brother, sister, uncle, aunt, first cousin, first cousin once removed, nephew, niece, or persons of preceding generations denoted by prefixes of grand, great, great-great, or great-great-great;

C. a spouse of any person included in the above groups even after the marriage is terminated by death or divorce; or

D. stepparent, stepbrother, stepsister, step-aunt, etc.

There is no age requirement for the caretaker nor is the status of emancipation a requirement in regard to the caretaker relative. The caretaker relative is a specified relative who exercises responsibility for the care and control of the dependent child.

8.105.2 SITUATIONAL REQUIREMENTS

.21 To receive medical assistance as an 1931 Medicaid Only, a person shall meet the requirements at 8.100.53, and not be receiving financial assistance from AFDC foster care, OAP-A or SSI.

.22 Persons who may be eligible for benefits under either 1931 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, and

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;

D. may change their selection if their circumstances change or if they decide later that it would be more to their advantage to receive benefits from the other program;

E. if they choose to receive benefits from SSI, their resources and income are disregarded for the purpose of determining the eligibility of any other family members for 1931. The SSI recipient's resources and income (including any resources jointly owned or received) are disregarded in determining the 1931 resource limit and/or standard of assistance.

F. An individual receiving Aid to the Needy Disabled (AND) may also receive 1931 Medicaid Only. An AND recipient shall be eligible for 1931 Medicaid Only, if the recipient meets all the requirements of 1931 Medicaid including the Medicaid required household. For these individuals counties shall include the applicants AND payment as unearned income to the Medicaid required household along with all other income.

If the AND individual's AND payment and other income makes the 1931 Medicaid required household ineligible, counties shall disregard the AND individual and give the remaining members 1931 Medicaid as long as their income is within the allowable limits.

.23 Before 1931 Medicaid assistance is provided,

A. each person for whom Medicaid assistance is being requested shall furnish a Social Security Number, or, if one has not been issued or is unknown, shall apply for the number. The application for an SSN shall be verified and documented in the case record by the county. Upon receipt of the assigned Social Security Number, the client shall provide the number to the county department;

This requirement does not apply to those individuals who are not requesting Medicaid assistance yet appear on the application, nor does it apply to undocumented individuals or eligible newborns born to a Medicaid mother.

B. An eligible person shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources is any health coverage or insurance other than Medicaid.

.24 A 1931 applicant's or client's refusal to furnish or apply for a Social Security Number or provide information regarding third party resources affects the family's eligibility for assistance as follows:

A. that person's needs cannot be taken into account in determining eligibility for Medicaid, or

B. 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.

.25 The applicant's signature on the application form is required to receive medical assistance.

.26 Medical assistance is not available to the unborn child, but only to the pregnant mother.

Medical assistance is not available to meet the needs of the father of an unborn child when there are no other children in the 1931 Medicaid assistance unit.

8.105.3 APPLICATION FOR 1931 MEDICAID ONLY

.31 Applicants may file an application at any time a county department is open for business. They will not be restricted to a certain time of day. Applicants may also file an application at any state approved outreach site.

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

.33 The county has the responsibility to assure that the specified relative receives information regarding program benefits and requirements applicable to the family members, but the county can make no restrictions regarding which family members on whose behalf the specified relative may request assistance.

If found to be ineligible for a particular program, the Single Purpose application is reviewed and processed for other programs the household has requested on the Single Purpose Application, Part One. This may include food stamps, adult services, refugee services and categories of medical only under the Social Services program. Referrals to other community agencies and organizations shall be made for the applicant.

If the applicant applied for Medicaid on the Application for Colorado Health Care and was found ineligible, this application shall be reviewed for all other Family and Children's Medicaid eligibility programs. If any child(ren) are found ineligible for all other Medicaid categories, and denied with cause (over age, income, or as defined by the Colorado Office of Program Development) the application shall be forwarded to the Child Health Plan Plus Program with the reason of denial.

.34 Persons required to be in the same assistance unit shall file for 1931 Medicaid as one assistance unit. Persons not required to be in one assistance unit, but residing in the same household shall have the option of applying for 1931 Medicaid assistance as separate units. Each assistance unit shall be budgeted using the appropriate need standard for the unit.

.35 Any person(s) in the Medicaid required household that are found ineligible for any financial program shall be continued on Medicaid unless the reason of ineligibility is specific to the requirements specified in this Volume 8.

8.105.4 LIVING IN THE HOME OF THE CARETAKER RELATIVE

.41 A dependent child is considered to be living in the home of the caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child and even though

A. the child is under the jurisdiction of the court (for example, receiving probation services);

B. legal custody is held by an agency that does not have physical possession of the child;

C. the child is in regular attendance at a school away from home;

D. either the child or the relative is away from the home to receive medical treatment;

E. either the child or the relative is temporarily absent from the home;

F. 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 AFDC home as of the time the foster care plan is changed.

8.105.5 ESTABLISHING THE FACTS OF ELIGIBILITY

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

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

1. A Social Security Number shall be provided for each individual on the application for whom Medicaid assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made.

2. Verification of earned income shall be provided if the applicant earned money in the month for which eligibility is being determined or during the previous month.

   a. Prior to implementation of the Colorado Benefits Management System (CBMS), earned income shall be verified by a full calendar month of wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month has not ended or the earned income information is not yet available. 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. If the applicant is self employed, detailed ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable.

   b. Upon implementation of CBMS, 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. 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.

3. Pregnancy verification, if applicable, and if the pregnancy is not observable.

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

5. Verification of all unearned income may be declared by the client verbally or on the application.

B. Additional Verification - No other verification shall be required of the client unless information is found to be questionable on the basis of fact. Questionable is defined as tangible information that contradicts other statements, documents, or file records.

C. The determination that information is questionable shall be documented in the applicant's case file.

D. Each applicant shall be given the state-approved eligibility checklist which will provide 1931 Medicaid-specific eligibility factors which shall be verified and suggested methods for verifying each essential eligibility factor.

E. Information that exists in another case record shall be used to verify those factors that are not subject to change, if the information is reasonably accessible.

F. Upon request, applicants will be given an extension of time in which to submit requested verification within the 45-day period. Notification of the right to this extension is provided in the state-approved eligibility checklist.

Applicants may request an extension of time beyond 45 days to obtain necessary verification. The extension beyond the 45 days may be granted at the county's discretion.

.52 The criteria of age, school attendance, and relationship can be declared by the client unless questionable (as defined in 8.105.5B). If questionable, these criteria can 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.

.53 Establishing that a dependent child meets the eligibility criterion of

A. age, if questionable - requires (1) viewing the birth certificate or comparably reliable document, and (2) recording the source of verification in the case file;

B. school attendance, if questionable - requires (1) obtaining confirmation from the school by phone or in writing, and (2) recording the means of verification on the review record;

C. living in the home of the caretaker relative, if questionable - requires (1) viewing the appropriate documents which identify the relationship, (2) recording these sources of verification on the review record, and (3) recording on the review record the information used to determine that the child is living with the caretaker relative. As an example, the review record may show that the child was seen during the home visit...or, if the child is of school age, the school attendance verification may be used to confirm the home address.

.54 To receive medical assistance as an expectant mother, the fact of pregnancy, if not observable, shall be verified by a written medical statement confirming the pregnancy and the estimated date of delivery.

.55 The caretaker relative shall be given an opportunity to provide additional information or documentation.

.56 A contact with a collateral source to secure documentation may be made only if the caretaker relative has provided written authorization.

8.106 DEPRIVATION FOR MEDICAID ONLY ASSISTANCE

.70 The only deprivation factor for Medicaid is that one or two parent households are at or below the

income limits for the category for which they are applying.

8.106.7 TRANSITIONAL MEDICAID

.71 Eligibility for transitional medical assistance shall be extended for up to twelve months (beginning with the first month of ineligibility) for families who would otherwise become ineligible for medical assistance under 1931 Medicaid. The extension shall be applied for an individual who is eligible and receiving assistance under 1931 Medicaid in at least 3 of the 6 months immediately preceding the month in which the family would have become ineligible for 1931 Medicaid assistance, and

A. who becomes ineligible for 1931 Medicaid solely because of new or increased income from employment, or hours of employment, provided the employed member of the family continues to be employed, or

B. who becomes ineligible for 1931 Medicaid after allowable deductions of $90, Daycare ($200 < 2, $175 > 2years old) due solely to the loss of the $30 plus 1/3 or $30 disregards because of the expiration of the time limit.

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

.72 To be eligible for the first six months of Transitional Medicaid, the assistance unit shall be eligible in all respects before the increased earnings or hours, or loss of the $30 + 1/3 or $30 disregards. The employed family member shall be included in the 1931 Medicaid assistant unit. The employed family member or a family member who was excluded because he/she did not meet an eligibility requirement need not be in the assistance unit.

.73 Eligibility for Transitional Medicaid occurs:

A. When the individual is a dependent child under 18 or under 19 if expected to graduate by 19th birthday; or

B. When the household continues to include at least one child who was a member of the household in the month the assistance unit became ineligible for 1931 Medicaid benefits. The child need not be dependent under Title IV-A. For purposes of Transitional Medicaid, a dependent child is one who is under age 18 (or under 19 if expected to graduate from high school by 19th birthday).

If it is determined that the household no longer has a child living in the home, Transitional Medicaid is discontinued at the end of the month in which the household does not include child under 18 or under 19 if expected to graduate by 19th birthday.

.74 To remain eligible for Transitional Medicaid:

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

B. Assistance Units are required to report earnings and necessary child care costs by the 21st of the fourth month of the twelve-month Transitional Medicaid period via the appropriate reporting form. Failure to report without good cause shall result in ineligibility for Transitional Medicaid for months seven (7) through twelve (12) of the twelve-month Transitional Medicaid period.

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

.75 To continue to receive Medicaid during the second six months of Transitional Medicaid:

A. The family shall meet all initial eligibility requirements of the first six months of Transitional Medicaid;

B. The family shall request the benefits;

C. Family's average gross earnings minus the caretaker's necessary child care cost cannot exceed 185% of the federal poverty level for the household size; and

D. If health insurance is available from the employer to the employee, at no cost to the former 1931 Medicaid recipient, the recipient shall enroll in the insurance program.

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

F. When Transitional Medicaid ends, the county shall review the file for all other categories of Medicaid for which the family members may be eligible. A new application shall not be required for this process.

.76 Eligibility for medical assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for 1931 Medicaid due solely or partially to the receipt of support income. Support income may be child support, maintenance, or alimony. The extension shall be applied for a family which receives assistance under 1931 Medicaid 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 Medicaid extension, the family shall be eligible for 1931 Medicaid in all respects before the support income is applied. The support recipient shall be included in the 1931 Medicaid calculation for the extension to apply.

8.110 MEDICAL ASSISTANCE FOR THE AGED, DISABLED OR BLIND

8.110.1 SSI ELIGIBLES

.11 Benefits of the Colorado Medicaid Program must be provided to the following: *[Eff. 08/30/2008]*

a. persons receiving financial assistance under the federal Supplemental Security Income program (SSI); *[Eff. 08/30/2008]*

b. persons who are eligible for financial assistance under SSI, but are not receiving SSI; *[Eff. 08/30/2008]*

c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and *[Eff. 08/30/2008]*

d. persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources. *[Eff. 08/30/2008]*

.115 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. *[Eff. 08/30/2008]*

a. Special Provisions for Infants *[Eff. 08/30/2008]*

1. 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: *[Eff. 08/30/2008]*

a) the infant was born in a hospital; *[Eff. 08/30/2008]*

b) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and *[Eff. 08/30/2008]*

c) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI. *[Eff. 08/30/2008]*

.12 The State Department of Social Services has entered into an agreement with the Social Security Administration (SSA) in which SSA shall determine Medicaid eligibility for all SSI applicants. *[Eff. 08/30/2008]*

Medicaid benefits shall be provided to all individuals receiving SSI benefits as are determined by SSA to be eligible for Medicaid. *[Eff. 08/30/2008]*

The county department shall receive a weekly unmatched listing of all individuals newly approved and also, a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the county to complete an eligibility form authorizing medical assistance. *[Eff. 08/30/2008]*

.121 All individuals receiving Medicaid who are under 21 years of age and have an absent parent must be referred, using the form as specified by the State Department, to the Child Support Enforcement unit. Failure of the family to cooperate in establishing child support shall not affect the eligibility for Medicaid of the Medicaid recipient.

.13 The weekly unmatched listing shall include the answer to the following two (2) questions:

a. Do you have any other medical resources?

b. Do you have any prior medical bills?

If the SSI recipient answers "No" to both of the questions, the county shall approve the SSI recipient for Medicaid only effective the date of the SSI approval as indicated on the SDX.

The county shall notify the individual of the approval for Medicaid. This notice shall advise the SSI recipient that he/she may also be eligible for financial assistance and if the individual is interested, he/she should contact the county department. An application is required if these individuals request financial assistance (AND/AB/SSI-CS).

If the unmatched list indicates that the recipient answered "Yes" to either or both of the questions, the county department shall contact the individual prior to processing the eligibility reporting form to obtain the medical resources and determine eligibility for retroactive Medicaid for up to three (3) months prior to SSI approval as described in this volume in the section on FURNISHING ASSISTANCE.

.14 Medicaid eligibility shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

The completed eligibility reporting form authorizing medical assistance shall be submitted to the State Department within ten (10) days of the receipt of the unmatched SSI listing by the county department. Notification, also, shall be sent to the SSI recipient within this time frame, advising him/her of the approval of Medicaid and that financial assistance may be available.

The SISC Code for this type of assistance is B .

If the county is unable to contact the individual or obtain the information needed within the ten (10) day time limit, the eligibility reporting form shall be completed as though the questions were answered "No." The county, upon obtaining the necessary information, shall correct and re-submit the eligibility reporting form entering the appropriate information.

.15 When Medicaid eligibility has been denied or terminated, based on a denial or termination of SSI which is later overturned, Medicaid eligibility must then be approved for the months the initial SSI payment was intended to cover.

.16 Medicaid benefits must be provided to persons who remain eligible under SSI but are not receiving the SSI payment, since for purposes of Medicaid eligibility such individuals continue to be considered as SSI recipients. 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. These will show up on the SDX (SSI/State Data Exchange System) as payment status codes C01 with "zero" payment and S06, S07, and S08. SDX status code M01 with "zero" payment or status code S09 must be checked with the local SSA/SSI office to determine whether the individual is SSI eligible.

.17 If the county obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.

8.110.2 SSI RELATED CASES

.21 Medical assistance must be provided to a person who was receiving financial assistance under SSI or a mandatory state supplementary payment and who lost such assistance because of the Social Security (excludes RRB) cost of living adjustment (COLA) paid in July 1977 or after. Medical assistance must also be provided to a person who loses eligibility for SSI or a mandatory state supplement any time after July 1977 due to the receipt of Social Security benefits. The situations that require continued medical assistance are outlined as follows:

A. The person lost OAP and/or SSI because of a cost of living adjustment to his/her own Social Security benefits.

B. The person lost OAP and/or SSI because of increased income deemed from a parent or spouse due to a cost of living adjustment received by the parent or spouse.

C. The person lost OAP and/or SSI due to the receipt of Social Security benefits (OASDI) during the current or previous years, and would be eligible for OAP and/or SSI except for the cost of living adjustments (COLA's) received since the last month for which the individual was both eligible for and received SSI and/or OAP and was eligible for OASDI concurrently.

.22 The cost-of-living increase disregard specified in the preceding action must continue to be applied in each subsequent eligibility determination and the disregard amount then must include the increase that resulted in loss of eligibility for financial assistance plus subsequent OASDI cost-of-living increases paid to that time. 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 (see B above). This provision is retroactive to November 1, 1985, in accordance with U.S. District Court injunction of Lynch vs. Rank.

.23 Some of the disabled or blind persons who lose eligibility for SSI due to an OASDI cost-of-living increase may still be eligible for financial assistance under State AND or AB, or OAP "B". The county must determine eligibility for assistance under these programs. For such cases, the SISC code which must be entered on the reporting form is B .

.24 To redetermine eligibility of medical assistance recipients to whom the 1977 and later cost-of-living increase disregards apply, the county must:

A. establish whether the person received payments under SSI or OAP and, for the same month, was entitled to Social Security (OASDI) payment;

B. determine the Social Security income before the loss of financial assistance;

C. determine the current income;

D. subtract the previous Social Security income from the current income to find the cumulative OASDI COLAs since financial assistance was lost;

E. subtract the cumulative COLAs from the current income.

If the figure in step E is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria, such as age, resources, disability, citizenship and residency, medical eligibility must continue.

.25 An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be contacted by the county department 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.

.26 Medical assistance must be provided to a person who was receiving financial assistance under AND or 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.

.27 To redetermine the eligibility of medical assistance recipients to whom the 1972 disregard applies, the county must:

A. review the case against the current applicable program definitions and requirements;

B. apply the resource and income criteria specified in the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS;

C. subtract the 1972 disregard amount from the income;

D. consider the remainder against the current appropriate SSI benefit level.

.28 Medical assistance must be provided to an SSI recipient who is receiving benefits as a child disabled prior to the age of 22 and who loses SSI due to the receipt of OASDI drawn from his/her parents' 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.

.29 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. 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.

.291 Effective January 1, 1991, medical assistance shall be provided to disabled widow(er)s age 50 through 64 who lost SSI and/or state supplementation due to the receipt of Social Security benefits as a disabled widow(er). The individual shall remain eligible for Medicaid 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 by January 1, 1991;

D. no longer receive SSI payments because of Social Security payments;

E. not have hospital insurance under Medicare; and,

F. meet all other Medicaid requirements.

8.110.3 PERSONS IN MEDICAL FACILITIES OR OTHER RESIDENTIAL PLACEMENT

.30 Medical assistance shall be provided to an institutionalized adult who meets the following criteria:

A. Has attained the age of 65 years or is disabled according to the definition of disability and blindness applicable to Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), as stated in Title 20 of the Code of Federal Regulations. This includes individuals who meet the disability requirement by virtue of age; and

B. Has been institutionalized for at least 30 consecutive days. The 30 day consecutive stay may be a combination of days in a hospital, nursing facility, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE). Following 30 consecutive days of institutionalization, Medicaid benefits start as of the first day when institutionalization began if all other eligibility requirements

were met as of that date; and

C. Is in a facility eligible for Medicaid reimbursement if the individual is in a hospital or nursing facility; and

D. Whose gross income does not exceed 300% of the current individual SSI benefit level. 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 home, or an HCBS or PACE program or

2. A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medicaid reimbursement; or

E. Is in a nursing facility or in an HCBS or PACE program and whose gross income exceeds the 300% level and who establishes an income trust in accordance with the rules on income trusts in this volume; and

F. Whose resources conform with the regulations regarding resource limits and exemptions set forth in the section on Financial Eligibility for Individuals Eligible for the Colorado Medicaid Programs in this volume; and

G. Who has not transferred assets for less than fair market value on or after the look-back date defined in Section 8.110.53.B.4. which would incur a penalty period of ineligibility in accordance with the regulations on transfers without fair consideration in the section on Financial Eligibility for Individuals Eligible for the Colorado Medicaid Program in this volume.

H. In addition, if the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of 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 Medicaid eligibility.

.32 Medicaid programs for the aged, blind and disabled require clients under age 65 to meet the definition of disability or blindness used by the U.S. Social Security Administration for the Supplemental Security Income (SSI) Program. Those definitions are as follows:

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

2. blindness means (1) vision in the better eye of 20/200 or less with the use of a correcting lens, or (2) tunnel vision to the extent that the field of vision is no greater than 20 degrees.

33. 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 staff manual, and in accordance with the following federal regulations:

A. 42 C.F.R. §435.530 through §435.540; §435.541(a), (b)(1), (e), and (f); and §435.916 (revised as of 10/1/00);

B. the requirements for evidence and periodic reexaminations applicable to disability determinations under the SSI program, as specified in 20 C.F.R. §416.901 through

§416.995, and §416.998 (revised as of 4/1/00); and

C. the requirements concerning the composition and qualifications of disability review teams, as specified in 20 C.F.R. §416.1015 through §416.1016 (revised as of 4/1/00).

D. No amendments or later editions of those federal regulations are incorporated. Upon request, copies of the federal regulations are available for public inspection or will be provided at cost by the Department of Health Care Policy and Financing, Office of Medical Assistance, 1575 Sherman Street, Denver, CO, 80203; may be examined at any State Publications Depository Library; or may be accessed on the Internet at www.access.gpo.gov/nara/cfr .

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 8.059.115.

NOTE: Sections 8.110.31 and 8.110.34 were deleted effective October 1, 2000.

.35 For the purpose of applying the special income standard for aged, disabled or blind persons in medical facilities, gross income means income before application of any deductions, exemptions or disregards appropriate to the SSI program.

.36 When assistance is provided to an individual who is admitted to a nursing home on or after January 1, 1981, the county of domicile immediately prior to admission to the nursing home must be determined. This information is entered into the automated system.

.37 County of domicile refers to the county or State where the person made his permanent home immediately prior to institutionalized long term care. The permanent home or domicile may sometimes be different than the county of current residence.

County of domicile is determined the first time a person is admitted to a nursing home and does not change unless the person is absent from the nursing home for more than one month. When new placement or readmittance to a nursing home occurs, the county department that is processing the nursing home admittance (application) will make the determination of the county of domicile using the criteria of determining the county or state of permanent home just prior to institutionalized long term care.

In cases where a person leaves a nursing home to go to the home of a relative or friend, where he may or may not wish to establish a permanent home, the county of domicile does not change until the client shows the intent to make that home a permanent residence.

For those persons whose permanent home or domicile is in another state, no Colorado county will be regarded as county of domicile, and the State Department of Social Services in that case shall be responsible for full payment.

If the county of domicile is not indicated on the system when an individual is admitted to the nursing home, the county that is currently providing assistance will be assumed to be on the county of domicile.

The county processing the nursing home admission shall enter an explanation of the determination of county of domicile in the case record. If the county of domicile is not the county processing the admission, the county department in the county of domicile must be notified using a DSS-1 or equivalent form.

.371 If the county of domicile cannot be agreed to by the county departments involved in making a determination, the situation will be referred to the Director. Office of Field Administration

or such other unit in the State Department designated by the Executive Director. The Director. Office of Field Administration or such other unit will determine the county of domicile, and such decision shall be binding on the county departments involved.

.38 When a recipient moves from his/her home to a nursing home in another county or when a recipient moves from one nursing home to another in a different county:

A. the paying county will send a Form NH-TR-1 to the county of new residence informing that county of:

1. all identifying information about the client:

2. name of the new nursing home;

3. date of the move;

4. the date of proposed closure of the case;

5. contact person for eligibility information.

B. the paying county will send a copy of this form to the nursing home administrator of the new nursing home. AP-5615 form should be attached showing the date of closure.

C. the county of new residence will obtain the AP-R1 (Redetermination) form.

D. the county of new residence will send a Form NH-TR-2 requesting eligibility information and/or informing the paying county of proposed date of approval. The county of new residence will use information from the AP-R1 and information from the paying county to determine continuing eligibility.

E. the county of new residence notifies the client of approval.

F. the county of new residence will initiate an AP-5615 to show the date of approval.

G. the paying county shall send a PA-75 to the nursing home client.

Should Medicaid reimbursement be interrupted, the county of residence will have the responsibility to process the application and back date the Medicaid eligibility date to cover the period of eligibility.

Communications between each county department and the nursing facility administrator in the counties regarding the transfer process is essential.

.381 Medical assistance must be provided to an institutionalized child less than 18 years of age:

A. whose family income and assets exceed the SSI limits, but whose gross family income does not exceed 300% of the current SSI benefit level; and

1. who meets all other SSI program definitions and requirements; and

2. who has been determined to be institutionalized for at least 30 consecutive days The 30 day consecutive stay must be in a medical facility and may be a combination of days in a hospital, nursing facility, or receiving services from a HCBS program as an HCBS recipient. For example, an individual hospitalized on March 10 cannot meet this requirement until

April 8. Following 30 consecutive days of institutionalization. Medicaid benefits start as of the first day when institutionalization began (March 10 in the example), assuming that all other eligibility requirements were met as of that date; or

B. In the alternative to A. who is determined by the federal Social Security Administration to be SSI eligible because he/she meets all SSI eligibility criteria, including financial, due to the disregard to family income or assets because the child is institutionalized and not living in the parents' home. Medical assistance will be provided beginning the first day of the month following the month during which the child ceases to live with his or her parent(s).

.382 An appeal process is available to children identified by C.R.S. 27-103-101 to 107, 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.

.39 Medical assistance must be provided to an institutionalized child less than 18 years of age when either of the following conditions are met:

A. The child's family's income and assets exceed the SSI limits, but their gross family income does not exceed 300% of the current SSI benefit level; and

1. the child meets all other SSI program definitions and requirements; and

2. the child has been determined to be institutionalized for at least 30 consecutive days. The 30 day consecutive stay must be in a medical facility and may be a combination of days in a hospital, nursing facility, or receiving services from a HCBS program as an HCBS recipient. For example, an individual hospitalized on March 10 cannot meet this requirement until April 9. Following 30 consecutive days of institutionalization, Medicaid benefits start as of the first day when institutionalization began (March 10 in the example), assuming that all other eligibility requirements were met as of that date; or

B. the child is determined by the federal Social Security Administration to be SSI eligible because he/she meets all SSI eligibility criteria, including financial, due to the disregard of family income or assets because the child is institutionalized and not living in the parents' home. Medical assistance will be provided beginning the first day of the month following the month during which the child ceases to live with his or her parent(s).

.391 An appeal process is available to children identified by C.R.S. 27-10.3-104, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Colorado Department of Human Services (9CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to medical assistance eligibility.

8.110.4 NURSING FACILITY RECIPIENT INCOME

.41 Except as specified below, once a nursing facility/hospitalized applicant has been determined eligible for medical assistance, all income of the recipient which is in excess of the amount reserved for personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, and less home maintenance allowance, and less allowable expenses for medical and remedial care (see PETI deductions as defined in Medical Assistance Staff Manual sections 8.110.49 and 8.482.33), must be applied to the cost of care. For persons with income below $50,

no PETI deduction will be allowed. Specific instructions for computing the patient payment amount are contained in the Medical Assistance Staff Manual section on nursing facility care.

.42 The amount to be reserved for personal needs is $50/month with the following exceptions:

A. Effective 7/1/91, the personal needs allowance shall be $90/month for a veteran in a nursing facility 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/month for the widow(er) of a veteran with no dependent children.

B. For aged, disabled, or blind nursing facility 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

C. Effective September 15, 1994, aged, disabled, or blind nursing facility residents or HCBS recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included in their personal needs allowance. The personal needs allowance 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 county must verify that the taxes were withheld. If the taxes are not paid, the county must establish a recovery.

.43 The reserve specified in Section 8.110.42, B, of this Staff Manual shall apply to nursing facility residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:

A. work in a sheltered workshop or work activity center;

B. "protected employment" which means the employer gives special privileges to the individual;

C. an activity that produced income in connection with a course of vocational rehabilitation;

D. employment training sessions;

E. activities within the facility such as crafts products and facility employment.

.44 In determining the personal needs reserve amount for nursing facility residents engaged in income-producing activities:

A. The $50 allowance for personal needs is reserved from earned income only when the person has insufficient unearned income to meet this need;

B. In determining countable earned income of a nursing facility 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.

C. When the $50 allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.

.45 Other Deductions Reserved from Recipient's Income:

A. In the case of a married, long-term care recipient who is institutionalized in a nursing facility or hospital 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 those sections in Staff Manual Volume 8 under "TREATMENT OF INCOME AND RESOURCES FOR INSTITUTIONALIZED SPOUSES".

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

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

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

C. Effective April 8, 1988, an additional amount may be deducted from the patient payment for expenses incurred by a nursing facility recipient for medical or remedial care that is not paid for by Colorado Medicaid or any third party insurance. See those sections in Staff Manual Volume 8 under "POST ELIGIBILITY TREATMENT OF INCOME".

.46 The necessity for the deduction from a recipient's income specified in Section 8.110.45 shall be fully explained in the case record. Such additional reserve amount must be entered on the eligibility reporting form.

.47 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.

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.

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

8.110.49 POST ELIGIBILITY TREATMENT OF INCOME

Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or third party insurance, including health insurance premiums, deductibles or co-insurance, dental care, hearing aids, supplies and care, and corrective lenses, eye care, and supplies, and other incurred expenses for medical or remedial care that are not subject to payment by a third party.

All PETI expenses in excess of $400 per calendar year must be prior authorized by the Colorado Department of Health Care Policy and Financing (HCPF) or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supply, to validate that the requested expense is not a benefit of the Colorado Medicaid program, and to determine if the

expenses requested are duplication of expenses previously prior authorized.

The allowable expenses are subject to the following criteria:

A. Health insurance premiums, deductibles, or co-insurance (as defined by State law).

1. Monthly premium payment paid by the resident for health insurance. If payments exceed the patient payment amount for one month, calculate a monthly average by dividing the total premium by the number of months of coverage. The resulting amount is to be applied as a monthly PETI expense for the months of coverage.

2. Medicare premiums are not an allowable deduction except in "medical only" eligibility cases and only for the first two (2) months not covered by Medicaid.

3. Health insurance premiums will be allowed for the resident only.

4. Health insurance premiums will only be allowed if the health insurance information is entered into the COIN system and MMIS for purposes of third party recovery.

5. Health insurance premiums, deductibles, and co-insurance must be reviewed by the Colorado Department of Health Care Policy and Financing or its designee for final approval. If duplicate coverage has been purchased, only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-insurances which the Department or its designee determine to be too expensive in relation to coverage purchased shall not be allowed.

B. Special Medical Services (dental care, hearing aids, and corrective lenses).

1. General Instructions (applies to all special medical services).

a. All PETI expenses exceeding $400 per calendar year for equipment, supplies, or services must be authorized by the Colorado Department of Health Care Policy and Financing or its designee to be considered an allowable cost.

b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the recipient may have.

c. All allowable costs must be documented in the resident's record with date of purchase and receipt of payment, whether or not it meets the requirements for prior authorization. Lack of documentation shall cause the patient payment deduction to be disallowed, causing the provider to be overpaid by the Medicaid program.

d. All allowable costs must be for items that are medically necessary as described in 8.011, and medical necessity must be documented by the attending physician. The physician statement must be current, within one year of the authorization.

e. The resident or legally appointed guardian must agree to the purchase of service/equipment and charge, with signed documentation in the resident's record.

f. Nursing homes are not permitted to assess any surcharge or handling fee to the patient's income.

g. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.

h. The allowable costs for services and supplies may not exceed the basic Medicaid rate.

i. In the case of damage or loss of supplies, replacement items may be requested with relevant documentation. If the damage or loss is due to negligence on the part of the nursing home, the nursing home is responsible for the cost of replacement.

j. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.

k. If the client does not make a patient payment, then no PETI will be allowed.

l. PETI payments may not exceed the patient payment. Payments made over a period of time shall only be allowed if the provider agrees to accept installment payments.

m. The deduction for medical and remedial care expenses that were incurred as a result of an imposition of a transfer of assets penalty period is limited to zero.

2. Dental Care Instructions

a. Prescription of dentures (partial or full plate, fixed or removable), or dental care, must be made by a licensed dentist (Doctor of Dental Surgery, Doctor of Medical Dentistry).

b. The prescription (as defined in 2.a.) must be part of a comprehensive evaluation to determine the medical necessity and suitability for wearing dentures or for other dental care.

c. Oral and maxillofacial surgery that is required to render soft-tissue and bony structures suitable for wearing dentures must be prior authorized by the Department as defined in 8.200.10 and 8.200.30.

3. Hearing Aid Instructions

a. All referrals for hearing aids must be certified by the attending physician, and must include an evaluation for suitability and specifications of the appropriate appliance, as per Section 8.287.02.

b. Purchase of new hearing aids to replace pre-existing hearing aids must include documentation of reason the pre-existing hearing aid must be replaced. The documentation shall also describe the trade-in value given for the pre-existing aid if appropriate.

4. Corrective Lenses Instructions

a. The evaluation of the need for corrective eye- glasses (lenses) must be a part of a comprehensive general visual examination conducted by a licensed ophthalmologist or

b. The medical necessity for prescribed corrective lenses should not be based on the determination of the refractive state of the visual system alone, but should be identified by the current procedural terminology in the Physician Current Procedures Terminology (CPT) code as established by the American Medical Association. This document is available through the American Medical Association, 515 North State Street, Chicago, Illinois 60610 or http://www.ama-assn.org/catalog.

C. Prior Authorization Request Process:

For allowable expenses that exceed $400 per client in a calendar year, costs must be prior authorized by the Colorado Department of Health Care Policy and Financing or its designee. The process is as follows:

1. Prior authorization requests must be submitted to the Colorado Department of Health Care Policy and Financing or its designee by the nursing facility on the form prescribed by the State. In addition to the information requested on the form, the following attachments must be included:

   a. A description of the service or supply, and the estimated cost.

   b. A physician's statement indicating the medical necessity of the service or supply.

2. Prior authorizations will be certified based on the following criteria:

   a. The request is not a benefit of the Medicaid program.

   b. The cost of the request does not exceed the basic Medicaid rate for such services or supply.

   c. The special medical service or supply is medically necessary, as defined in 8.011.

3. The Colorado Department of Health Care Policy and Financing or its designee shall review and approve/deny the PETI Prior Authorization Request within ten (10) working days of receipt.

4. Upon receipt of the approved Prior Authorization Request from the DHCPF or its designee, the nursing facility may adjust the patient payment by the amount authorized on the following month's Medicaid billing or on the nursing facility's next billing cycle.

5. All documentation of the incurred expenses must be available in the client's financial and medical record for audit purposes. Lack of documentation shall cause the patient payment deduction to be disallowed causing the provider to be overpaid by the Medicaid program.

8.110.50 FINANCIAL ELIGIBILITY REQUIREMENTS FOR ELDERLY, BLIND AND DISABLED INDIVIDUALS

The following regulations for financial eligibility apply to individuals who are age 65 or over or who have been determined to be disabled or blind in accordance with Social Security regulations. Staff Manual Volume 3 (9 CCR 2503-1) is not applicable to these individuals.

Treatment of income: Income is defined as anything received in cash or in kind that can be used to meet the individual's needs for food or shelter. In-kind income is not cash but is actually food or shelter or something that can be used to obtain food or shelter.

A. Availability of income

1. Income is available when it is actually received or when the individual has a legal interest in a sum.

2. 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.

B. Earned income is payment in cash or in kind for services performed as an employee or from self-employment. Earned income includes the following:

1. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment.

2. Net earnings from self-employment

3. Payments for services performed in a sheltered workshop

4. Royalties and honoraria

C. Earned income disregards

1. The gross amount of earned income is countable toward eligibility with the following exclusions

a. $65.00 shall be subtracted from gross earned income.

b. The remaining amount shall be divided in half and the resulting amount is countable income

c. Any other applicable exemptions in 20 C.F.R. 416.1112. No amendments or later editions are incorporated. The Director of the Office of Medical Assistance of the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of 20 C.F.R. 416.1112; or the materials may be examined at any publications repository library

D. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes the following:

1. Pensions and other period payments, such as

a. Private pensions or disability benefits

b. Social Security benefits

c. Social Security Disability Income (SSDI)

d. Supplemental Security Income (SSI) payments

e. Workers' Compensation payments

d. Railroad retirement annuities

e. Unemployment insurance payments

f. Veterans benefits other than Aid and Attendance (A&A) and Unreimbursed Medical Expenses (UME).

2. Alimony and support payments

3. Interest, dividends and certain royalties on countable resources

4. Support and maintenance in kind

5. The following are unearned income in the month received and a countable resource the following month:

   a. Death benefits, reduced by the cost of last illness and burial

   b. Prizes and rewards

   c. Gifts and inheritances

6. Interest payments on promissory notes established on or after March 1, 2007.

E. Determining ownership of income *[Eff 08/30/2006]*

1. If payment is made solely to one individual, the income shall be considered available income to that individual. *[Eff 08/30/2006]*

2. If payment is made to more than one individual, the income shall be considered available to each individual in proportion to their interests. *[Eff 08/30/2006]*

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. *[Eff 08/30/2006]*

4. Income from the Community Spouse's Resource Allowance, as defined in the spousal protection rules in this volume, is income to the community spouse. *[Eff 08/30/2006]*

F. Income-producing property *[Eff 08/30/2006]*

1. Net rental income from an exempt home or a life estate interest in an exempt home is countable after the following allowable deductions: *[Eff 08/30/2006]*

   a. Property taxes and insurance *[Eff 08/30/2006]*

   b. Necessary reasonable routine maintenance expenses *[Eff 08/30/2006]*

   c. Reasonable management fee for a professional property manager. *[Eff 08/30/2006]*

2. Nonbusiness property that is necessary to produce good or services essential to self support is excluded up to $6000 for applicants who are not applying for long-term care in a nursing facility. *[Eff 08/30/2006]*

3. Property used in a trade or business which is essential to self-support is excluded up to a limit

of $6000 if it produces 6% return of the excluded value. This exclusion does not apply to applicants for long term care in a nursing facility. *[Eff 08/30/2006]*

G. Treatment of payments from the Department of Veterans Affairs (VA) for aid and attendance (A&A) and unreimbursed medical expenses (UME) *[Eff 08/30/2006]*

1. Payments for aid and attendance (A&A) and unreimbursed medical expenses (UME) shall not be considered as income or be paid as patient payment for the following: *[Eff 08/30/2006]*

   a. Veteran in a medical facility that is not a state veteran's medical facility *[Eff 08/30/2006]*

   b. Veteran or spouse of a veteran in a state veteran's medical facility who has a spouse or child at home *[Eff 08/30/2006]*

2. Payments for aid and attendance (A&A) and unreimbursed medical expenses (UME) to a veteran or spouse of a veteran in a state veteran's medical facility shall be treated as follows: *[Eff 08/30/2006]*

   a. Payments shall not be considered as income. *[Eff 08/30/2006]*

   b. Payments shall be used as patient payment to the medical facility *[Eff 08/30/2006]*

H. Reverse mortgages *[Eff 08/30/2006]*

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. *[Eff 08/30/2006]*

2. Funds remaining the following month after the payment is made will be countable as a resource. *[Eff 08/30/2006]*

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 at 8.110.53 and may result in a penalty period of ineligibility. *[Eff 08/30/2006]*

I. Treatment of income and resources for married couples *[Eff 08/30/2006]*

1. The income and resources of both spouses are counted in determining eligibility for either or both spouses with the following exceptions: *[Eff 08/30/2006]*

   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. *[Eff 08/30/2006]*

   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. *[Eff 08/30/2006]*

   c. If one spouse is applying for long term care in a nursing facility or Home and Community Based Services (HCBS), refer to the rules on Treatment of Income and Resources for Institutionalized Spouses at 8.112. *[Eff 08/30/2006]*

J. Income limits for eligibility for long-term care in a hospital, nursing facility, Home and Community

Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE) *[Eff 08/30/2006]*

1. For an individual who is institutionalized in a hospital or nursing facility or receiving HCBS or PACE for a period of not less than 30 days, the income limit is three times the benefit level for Supplemental Security Income (SSI). *[Eff 08/30/2006]*

2. If the income exceeds three times the SSI benefit level but is below the regional average private pay rate for the nursing facility, the individual may become income eligible for long term care by establishing an income trust in accordance with the rules on income trusts at 8.110.52,B. Income trusts are not valid for establishing income eligibility for hospital care. *[Eff 08/30/2006]*

3. Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the nursing facility. *[Eff 08/30/2006]*

K. Other groups eligible for medical assistance *[Eff 08/30/2006]*

1. Recipients of Supplemental Security Income (SSI) and Old Age Pension (OAP) A or B with a SISC code A or B are eligible for medical assistance, not including longterm care. For long term care eligibility in a nursing facility or Home and Community Based Services (HCBS), a separate application must be submitted to the county department of social services. *[Eff 08/30/2006]*

8.110.51 FINANCIAL ELIGIBILITY REQUIREMENTS FOR INDIVIDUALS ELIGIBLE FOR THE COLORADO MEDICAID PROGRAM

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 $2000. For a married couple, the resource limit is $3000. If one spouse is institutionalized, refer to Treatment of Income and Resources for Institutionalized Spouses.

A. The following resources are exempt in determining eligibility:

1. The principal place of residence which is owned by the applicant or applicant's spouse, including the home in which the individual resides, the land on which the home is located and related out-buildings.

   a. 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.

   b. If an individual leaves his or her home to live in an institution, the home will 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. Dependent relative is defined as one who is claimed as a dependent for federal income tax purposes.

   c. 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.

   d. The home will still be considered the individual's principal place of residence and retain the exemption if all of the following conditions apply:

1) The individual is institutionalized.

2) The individual intends to return home whether or not in fact he or she does return home.

3) The intent to return home is documented in writing.

4) The intent to return home applies to the home the individual or spouse was living in prior to being institutionalized or a replacement house as long as a spouse or dependent relative continues to live there. Dependent relative is defined as one who is claimed as a dependent for federal income tax purposes.

e. For an institutionalized individual in a nursing facility, receiving HCBS or enrolled in the PACE program, 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. If the residence is transferred back into the name of the individual's name, the exemption will be regained.

f. 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.

g. For applications filed on or after January 1, 2006, an individual's home if:

1) The individual's equity interest in the home is $500,000 or less, or

2) The individual's equity interest in the home exceeds $500,000 and the individual's spouse, dependent child under the age of 21, or blind or disabled child resides in the home.

2. 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.

3. Household goods are not counted as a resource to an individual (and spouse, if any) if they are:

a. Items of personal property, found in or near the home, that are used on a regular basis; or

b. Items needed by the householder for maintenance, use and occupancy of the premises as a home.

c. 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.

4. Personal effects are not counted as a resource to an individual (and spouse, if any) if they are:

a. Items of personal property ordinarily worn or carried by the individual; or

b. Articles otherwise having an intimate relation to the individual.

c. 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.

d. 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.

5. The cash surrender value of all life insurance policies owned by an individual and spouse, if any, is a countable resource. However, if the total face value of all life insurance policies does not exceed $1500 on any person, the cash surrender value of those policies will be excluded.

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

   b. 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.

   c. 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.

6. 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.

   a. Burial spaces are defined as 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. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

      If any interest is earned on the value of an agreement for the purchase of a burial space, such interest is also exempt.

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

7. 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. "Irrevocable" means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than the individual's burial expenses.

8. 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 are also excluded if left to accumulate in the burial fund. However, the $1500 exemption is reduced by (a) the amount of any irrevocable burial funds such as are described in the preceding subparagraph, and (b) the face value of any life insurance policy whose cash surrender value is exempt. For a married couple, a separate $1500 exemption applies to each spouse.

B. Countable resources include the following:

1. Cash or funds held by a financial institution in a checking or savings account, certificate of deposit or money market account;

2. Current market value of stocks, bonds, and mutual funds;

3. 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:

    a. Submit statements from all of the account holders regarding:

        1) Who owns the funds.

        2) Why there is a joint account.

        3) Who has made deposits and withdrawals and how withdrawals have been spent.

    a. Submit account records showing deposits, withdrawals and interest in the months for which ownership of funds is at issue.

    b. 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.

4. Any real property that is subject to a recorded beneficiary deed and on which an estate recovery claim can be made.

5. For applications filed on or after January 1, 2006, an individual’s home if the individual’s equity interest in the home exceeds $500,000 and the individual’s spouse, dependent child under the age of 21, or blind or disabled child does not reside in the home.

6. Real property not exempt as the principal place of residence and not exempt as income producing property with a value of $6000 or less, as described at 8.110.50.

    a. 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:

        1) The applicant or client's signed statement to that effect.

        2) Verification of joint ownership.

3) A statement from the co-owner verifying the following:

a) The property is used as his principal place of residence.

b) The co-owner would have to move if the property were sold.

c) The co-owner would be unable to buy the applicant or client's interest in the property.

d) 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.

b. Excess real property will not be included in countable resources as long as reasonable efforts to sell it have been unsuccessful. Reasonable efforts to sell means:

1) The property is listed with a real estate agent at current market value.

2) If owner listed, the property must be for sale at current market value, advertised and shown to the public.

3) Any reasonable offer must be accepted and the owner has the burden of demonstrating that an offer was not reasonable.

4) If an offer is received that is at least two-thirds of the current market value, the individual must present evidence to establish that the offer was unreasonable.

5) Reasonable efforts to sell must continue and must be verified on a quarterly basis

7. 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.

8. 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.

9. The equity value of all automobiles that are in addition to one exempt vehicle. The equity value is the fair market value less any encumbrances. The fair market value is the average price an automobile of that particular year, make, model and condition will sell for on the open market to a private individual in the particular geographic area involved.

10. The cash surrender value of life insurance policies if the face value exceeds $1500.

11. Promissory notes established before April 1, 2006

a. The fair market value of a promissory note, mortgage, installment contract or similar instrument is an available countable resource

b. 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.

c. A note or similar instrument which transferred funds or assets for less than fair market value shall be considered as a transfer without fair consideration and a period of ineligibility shall be imposed.

12. Promissory notes established on or after April 1, 2006

a. 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 as found in the tables in Section 8.110.56 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.

b. The value of a promissory note, loan or mortgage which does not meet the criteria in Section 8.110.51.B.12.a. 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 without fair consideration provisions in Section 8.110.53.

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

a. 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

b. A promissory note, loan or mortgage which does not meet the following criteria shall be a transfer without fair consideration and subject to the provisions in Section 8.110.53.

1) Has a repayment term that is actuarially sound based on the individual's life expectancy as found in the tables in Section 8.110.56 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.

c. For purposes of calculating the transfer without fair consideration penalty period, the value of the promissory note, loan or mortgage is the outstanding balance as of the date of application.

C. 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.

a. Self-funded retirement accounts in the name of the applicant are countable as a resource to the applicant.

b. 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 c. below.

c. 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 nursing facility, 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.

2. 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.

D. Treatment of proceeds from disposition of resources

1. The net proceeds from the sale of exempt or non-exempt resources are considered available resources.

2. The net proceeds is 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 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.

E. Availability of resources and income

1. Resources and income shall be considered available both when actually available and when the applicant or client has a legal interest in a sum (including cash or equity value of a resource) and has the legal ability to make such sum available for support and maintenance.

2. If the applicant or client demonstrates with written documentation 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 county department of social services.

3. 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 a potential

resources or income.

4. 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.

5. If the resources or income has been transferred to a trust, the trust shall be submitted for review to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on eligibility in accordance with Section 8.110.52 (10 CCR 2505-10).

8.110.52 Consideration of trusts in determining Medicaid eligibility

A. Trusts established before August 11, 1993:

1. Medicaid Qualifying Trust (MQT)

a. In the case of a Medicaid 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.

b. 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 Medicaid 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."

2. 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 intermediate care facility for the developmentally disabled.

3. This provision does not apply to individuals who are receiving SSI.

B. Trusts established on or after July 1, 1994:

1. The following definitions apply to trusts established on or after July 1, 1994:

a. 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:

1) The individual or the individual's spouse,

2) 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

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

2. In determining an individual's eligibility for Medicaid, 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:

1) The individual or the individual's spouse

2) 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;

3) 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:

1) The purposes for which a trust is established;

2) Whether the trustees have or exercise any discretion under the trust;

3) Any restrictions on when or whether distributions may be made from the trust; or

4) Any restrictions on the use of distributions from the trust.

3. Revocable Trust

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.

4. Irrevocable Trust

a. 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:

1) 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.

2) Payments from that portion of the corpus, or income to or for the benefit of the individual, shall be considered income to the individual.

3) 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.

4) 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.

5. The preceding regulations for trusts established on or after July 1, 1994, do not apply to the following:

a. Income Trusts

1) 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 nursing facility 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 nursing facility 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 nursing facility 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 nursing facility 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 nursing facility are the allowable deductions which are permitted for Medicaid-eligible persons who do not have income trusts. Allowable deductions include only the following:

1) Personal need allowance

2) Spousal income payments

3) Approved PETI payments

d) Any funds remaining after the allowable deductions shall be paid solely to the cost of the nursing facility care in an amount not to exceed the Medicaid 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 Colorado Department of Health Care Policy and Financing (CDHCPF) 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 county department of social services and the CDHCPF 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 CDHCPF. The trust terminates upon the death of the individual or if the trust is not required for Medicaid eligibility in Colorado.

i) The trust must provide that upon the death of the individual or termination of the trust, whichever occurs sooner, the CDHCPF 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 CDHCPF must be notified 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 county department of social/human services or to the CDHCPF 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 CDHCPF 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 CDHCPF 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

1) 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) The only assets used to fund the trust 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. Zebley. (This provision is applicable to disability trusts established from July 1, 1994 to December 31, 2000.)

c) The trust is established solely for the benefit of the disabled individual by a parent, grandparent, legal guardian, or the court.

d) The sole lifetime beneficiaries of the trust are the individual for whose benefit the trust is established and the Colorado Department of Health Care Policy and Financing (CDHCPF).

e) The trust terminates upon the death of the individual or if the trust is no longer required for Medicaid eligibility in Colorado.

f) Any statutory lien pursuant to Section 26-4-403(4) 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 CDHCPF shall be named on the contract or settlement as the 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 CDHCPF shall receive all amounts remaining in the trust up to the amount of total medical assistance paid on behalf of the individual.

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 CDHCPF 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 CDHCPF 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) l), 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 CDHCPF must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.

p) 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 county department of social/human services or to the CDHCPF upon reasonable request or upon any change of trustee.

q) Prior to the establishment or funding of a disability trust, the trust shall be submitted for review to the CDHCPF, along with proof that the individual beneficiary is disabled according to Social Security criteria. No disability trust shall be valid unless the CDHCPF

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

1) A trust consisting of individual accounts established for disabled individuals for the purpose of establishing resource eligibility for Medicaid. 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 CDHCPF.

e) If the trust is funded with an annuity or other periodic payments, the CDHCPF 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 26-4-403(4) 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 CDHCPF 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 Medicaid 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.

2) 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 resumption 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.

C. When the individual beneficiary of an income, disability or pooled trust dies or the trust is terminated, the trustee shall promptly notify the county department of social services and the CDHCPF. To the extent required by these rules the trustee shall promptly forward the remainder of the trust property to the CDHCPF, up to the amount of medical assistance paid on behalf of the individual beneficiary.

D. Third Party Trusts

1. 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

2. The terms of the trust will determine whether the trust fund is countable as a resource or income for Medicaid eligibility.

   a. 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.

   b. If the trust requires income distributions, the amount of the income shall be countable as income in determining eligibility.

   c. If the trust requires principal distributions, that amount shall be considered as a countable resource.

   d. 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. Submission of Trust Documents and Records

1. The trustee of a trust which was established by or which benefits a Medicaid Applicant or client shall submit trust documents and records to the county department of social services and to the CDHCPF.

2. This requirement includes documents and records for income trusts, disability trusts and the joinder agreement for each pooled trust account.

3. The county department of social services shall submit any trust which is submitted with an application or at redetermination to the CDHCPF. The county department shall determine Medicaid eligibility based on the determination of the CDHCPF as to the effect of the trust on eligibility.

F. Federally Approved Trusts

1. If an SSI recipient has a trust which has been approved by the Social Security Administration, eligibility for Medicaid cannot be delayed or denied. Individuals on SSI are automatically eligible for Medicaid despite the existence of a federally approved trust.

2. If the county department of social/human services has a copy of a federally approved trust, the county must send a copy to the CDHCPF.

8.110.53 Transfers of assets without fair consideration

A. If an institutionalized individual or the spouse of such individual disposes of assets for less than fair market value on or after the look-back date, the individual shall be subject to a period of period of ineligibility for long term care services, including nursing facility care, Home and Community Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE).

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

1. Assets include all income and resources of the individual and such individual's spouse, including 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:

a. The individual or such individual's spouse,

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

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

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

3. 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.

4. For transfers made before February 8, 2006, the look-back date 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.

5. An institutionalized individual is one who is institutionalized in a medical facility, a nursing facility, 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 date, the transfer shall be evaluated as follows:

1. The fair market value of the transferred asset, less the actual amount received, if any, shall be divided by the average monthly private pay cost for nursing facility care in the state of Colorado at the time of application.

2. 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

b. The date on which the individual would 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 Medicaid; AND which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

3. 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 should be rounded up to the nearest whole number.

4. There is no maximum period of ineligibility.

5. 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.

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

   b. 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.

6. For transfers on or after February 8, 2006, the total amount of all of the transfers are added together and the penalty period is assessed as outlined in Section 8.110.53.C.2 above.

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

   b. 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.

7. The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and basic Medicaid services, but shall not be eligible for medical assistance for nursing facility services, Home and Community Based Services or the Program of All Inclusive Care for the Elderly due to the transfer without fair consideration.

8. 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.

D. Actions that prevent income or resources from being received, as set forth on the following list, which is not exclusive, shall create a rebuttable presumption that the transfer was without fair consideration:

1. Waiving pension income.

2. Waiving a right to receive an inheritance.

3. 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.

4. Failure of a surviving spouse to elect a share of a spouse's estate.

5. Failure to obtain a family allowance or exempt property from an estate of a deceased spouse or parent.

6. Not accepting or accessing a personal injury settlement.

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

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

9. 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.

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

E. 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 are 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:

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

      2) A term for repayment longer than the life expectancy of the holder of the note.

      3) Low payments.

      4) 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

   a. Subject to the look-back date described in Section 8.110.53.B.4., 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 8.110.51.B.12.a.1.-3. is the outstanding balance due as of the date of the individual’s application for medical assistance for services described in Section 8.110.53.B.5.

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

    a. Subject to the look-back date described in Section 8.110.53.B.4, 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 8.110.51.B.13.b.1-3 is the outstanding balance due as of the date of the individual's application for medical assistance for services described in Section 8.110.53.B.5.

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:

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

        2) 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.

        3) The agreement must be dated and the signature must be notarized.

        4) 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:

        1) 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

        2) 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

3) 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.

4. 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:

1) 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.

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

3) 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.

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

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

a. The spouse of such individual;

b. 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.

c) 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.

d. 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 nursing facility.

2. The assets were transferred:

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

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

c. 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.

d. 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.

3. Definition of the term "for the sole benefit of," as used in the preceding exceptions to the transfer penalty rules:

a. 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.

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

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

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

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

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

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

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

G. There is a rebuttable presumption the transfer without fair consideration was made for purposes of Medicaid eligibility.

1. The transfer is presumed to have been made for the purpose of obtaining eligibility or remaining eligible unless the individual provides convincing, objective evidence that the transfer was exclusively for some other purpose and the reason for the transfer did not include Medicaid eligibility. Transfers that are made to avoid the Medicaid lien or the Medicaid estate recovery program shall be included in the definition of Medicaid eligibility.

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

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

   a. 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 thirty-six 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.

   b. In any case where the transfer was made on behalf of the individual or the individual's spouse, by a guardian, conservator, or agent under a power of attorney to any spouse, child, grandchild, brother, sister, niece, nephew, parent, grandparent, by birth, adoption, or marriage of the guardian, conservator, or agent under a power of attorney.

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

   a. 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.

   b. Other assets were available at the time of the transfer to meet current and future needs of the individual, including the cost of nursing facility or other institutionalized care for a period of thirty-six months.

   c. 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 for less than fair market value. The presumption cannot be rebutted successfully by stating it was done for estate planning purposes or to avoid probate.

d. When the individual had some other purpose for transferring the assets, but any expectation of establishing eligibility could reasonably be inferred to be a factor in the decision to transfer the asset, the presumption cannot be successfully rebutted.

H. Apportionment of penalty period between spouses

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

2. 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.

I. 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 Medicaid eligibility.

J. Notice

1. 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.

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

K. Undue Hardship

1. 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. Undue hardship can be established only if all of the following conditions are met:

a. The individual is otherwise eligible;

b. The individual is unable to obtain medical care without the receipt of Medicaid benefits;

c. Application of the transfer penalty would deprive the individual of medical care such that the individual’s health or life would be endangered or would deprive the individual of food, clothing, shelter or other necessities of life; and

d. The individual must also produce evidence to prove that the assets have been irretrievably lost, and that all reasonable avenues of legal recourse to regain possession of them has been exhausted.

2. 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.

3. Notice of an undue hardship exception shall be given to the applicant or client, and a determination of whether an undue hardship waiver will be granted shall be given in a timely manner. An adverse determination may be appealed in accordance with the appeal process as set forth in RECIPIENT APPEALS PROTOCOLS/PROCESS in this volume.

4. 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.

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

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

2. 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.

3. All of the resources transferred for less than fair market value have been returned to the individual.

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

5. 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 nursing facility 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.

8.110.54 Treatment of Life Estates

A. Effective July 1, 1995, for an applicant/recipient of Medicaid, and/or his/her spouse, who established a life estate on his/her residence, a transfer of assets without fair consideration may occur. A transfer of assets without fair consideration occurs when a life estate was established on the residence by the applicant/recipient of Medicaid, and/or their spouse, on or after the look-back date. However, in no event shall these regulations apply to a life estate established before July 1, 1995.

The amount to be considered as a transfer of assets without fair consideration shall be computed by using equity value of the property and applying it to the life estate table contained in these rules as follows:

1. Determine the equity value of the property at the time the life estate was established. The equity value of the residential property shall be determined by obtaining the actual value and subtracting encumbrances. The actual value shall be obtained by using the actual value reported by a 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 percentage value for residential property as established by state law to obtain the actual value.

   Encumbrances include mortgages, liens, judgments, delinquent taxes, loan agreements, and other forms of indebtedness.

2. Multiply the equity value by the "Remainder" factor from the Life Estate Remainder Interest Table contained in these rules that corresponds to the person's age at the time the life estate was established. The result is the amount to be considered as a transfer of assets without fair consideration.

   When a life estate is established on the residence held by spouses in joint tenancy, the age of the youngest individual shall be used to calculate the amount of the transfer.

B. Effective April 1, 2006, the purchase of a life estate interest in an individual's home is a transfer without fair consideration unless the purchaser resides in the home for a period of at least one year after the date of purchase.

Once the transfer of asset amount is computed, the penalty period for transfer of assets without fair consideration is determined by using the steps as explained in subsection "G" of this section.

LIFE ESTATE REMAINDER INTEREST TABLE

AGE	REMAINDER	AGE	REMAINDER
0	.02812	30	.04457
1	.01012	31	.04746
2	.00983	32	.05058
3	.00992	33	.05392
4	.01019	34	.05750
5	.01062	35	.06132
6	.01116	36	.06540
7	.01178	37	.06974
8	.01252	38	.07433
9	.01337	39	.07917
10	.01435	40	.08429
11	.01547	41	.08970
12	.01671	42	.09543
13	.01802	43	.10145
14	.01934	44	.10779
15	.02063	45	.11442
16	.02185	46	.12137
17	.02300	47	.12863
18	.02410	48	.13626
19	.02520	49	.14422
20	.02635	50	.15257
21	.02755	51	.16126
22	.02880	52	.17031
23	.03014	53	.17972
24	.03159	54	.18946
25	.03322	55	.19954
26	.03505	56	.20994
27	.03710	57	.22069
28	.03938	58	.23178
29	.04187	59	.24325
60	.25509	85	.64641
61	.26733	86	.66236
62	.27998	87	.67738
63	.29304	88	.69141
64	.30648	89	.70474
65	.32030	90	.71779
66	.33449	91	.73045
67	.34902	92	.74229
68	.36390	93	.75308

69	.37914	94	.76272
70	.39478	95	.77113
71	.41086	96	.77819
72	.42739	97	.78450
73	.44429	98	.79000
74	.46138	99	.79514
75	.47851	100	.80025
76	.49559	101	.80468
77	.51258	102	.80946
78	.52951	103	.81563
79	.54643	104	.82144
80	.56341	105	.83038
81	.58033	106	.84512
82	.59705	107	.86591
83	.61358	108	.89932
84	.63002	109	.95455

8.110.55 Annuities

A. An annuity is a contract between an individual and a commercial company in which the individual invests funds and in return is guaranteed fixed substantially equal installments for life or a specified number of years.

1. Treatment of annuities purchased prior to July 1, 1995:

   a. An annuity purchased prior to July 1, 1995 is not an available resource if it is annuitized and regular returns are being received by the annuitant. The funds received are income in the month received.

   b. If the annuity purchased by the applicant/ client or his/her spouse has not been annuitized it shall be considered an available resource regardless of the irrevocable status.

2. Treatment of annuities purchased on or after July 1, 1995.

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

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

      2) The annuity is annuitized for the applicant/client or his/her spouse; and,

      3) The annuity is purchased on the life of the applicant/client or his/her spouse; and,

      4) The annuity provides payments for a period not exceeding the annuitant's projected life.

3. Treatment of annuities purchased on or after April 1, 1998.

a. The county department shall determine the MMMNA of the community spouse, if applicable. If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered a transfer without fair consideration in determining the institutionalized spouse's eligibility. This subsection applies only to the extent that the transferred amount causes the CSRA to exceed the maximum.

b. The county department shall determine if the applicant/client is receiving substantially equal installments from the annuity for the period of the annuity. If the annuity is not paid in substantially equal installments, the original purchase price of the annuity shall be considered as a transfer without fair consideration.

c. For annuities purchased before February 8, 2006, if an annuity was purchased more than 36 months prior to the date of application, the penalty period for a transfer without fair consideration has expired. Any income received from the annuity shall be considered as income in the month received.

4. Provisions for annuities purchased on or after February 8, 2006. These provisions are in addition to those listed in 8.110.55.A.3.

a. An applicant for HCBS, PACE or institutional services shall disclose a description of any interest the individual or his or her community spouse has in an annuity or similar financial instrument, regardless of whether the annuity or financial instrument is irrevocable or is treated as an asset.

b. By providing HCBS, PACE or institutional services, the Department shall be a remainder beneficiary of the annuity or similar financial instrument.

c. The county shall notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity for medical assistance provided to the individual. This notice shall include a statement requiring the issuer to notify the county when there is a change in the amount of income or principal that is being withdrawn from the annuity.

d. The purchase of an annuity shall be treated as a transfer without fair consideration unless:

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 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 for less than fair market value; or

3) The annuity is an Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or

4) The annuity is part of a deemed Individual Retirement Account under a qualified employer plan as described in Section 408(q) of the Internal Revenue Code of 1986; or

5) The annuity was purchased with proceeds from:

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

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

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

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

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

6) The annuity:

a) Is irrevocable and nonassignable; and

b) Is actuarially sound; and

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

8.110.56 Analysis of annuity to determine if purchase was a transfer without fair consideration

A. To determine if a transfer of assets without fair consideration has occurred in the purchase of an annuity, the eligibility technician must review the annuity and:

1. Determine the length of time of the return the annuity exceeds the reasonable life expectancy of the annuitant. The amount to be considered as a transfer of assets without fair consideration for this type of annuity shall be computed by using the Life Expectancy Tables contained in these regulations.

a. Determine the date on which the annuity was purchased.

b. Determine the amount of money used to purchase the annuity and the time period of return to the annuitant.

c. Determine the age of the annuitant at the time the annuity was purchased.

d. Determine the life expectancy of the annuitant at the time the annuity was purchased from the table contained in this section of these regulations. The appropriate table for male or female must be used.

e. If the return from the annuity exceeds the life expectancy of the annuitant, a transfer of assets without fair consideration exists for the portion of the annuity return that exceeds the life expectancy of the annuitant.

f. If the return of the annuity over its lifetime is less than the original purchase price, the difference shall be considered a transfer without fair consideration.

g. For annuities purchased before February 8, 2006, if the annuity was purchased more than 36 months prior to the date of application, the transfer period has expired

and any income shall be considered as income in the month received.

h. If the return is equal to or more than the original purchase price, the annuity is not a transfer without fair consideration and the money received by the annuitant from the annuity is considered as income in the month received.

2. If an irrevocable annuity is purchased by an applicant/client of Medicaid, or their his/her spouse, and the return or benefit from the annuity is transferred to a third party, a transfer of assets without fair consideration exists for the total amount of the annuity.

3. If a revocable annuity is purchased by an applicant/client of Medicaid, or his/her spouse, the total amount invested in the annuity is considered as a countable resource.

4. Once it has been determined that a transfer of assets without fair consideration exists, the penalty period shall be calculated by using the steps in accordance with the rules at 8.110.53.C.

LIFE EXPECTANCY TABLE – MALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006

Age	Life Expectancy	Age	Life Expectancy
0	71.80	30	44.06
1	71.53	31	43.15
2	70.58	32	42.24
3	69.62	33	41.33
4	68.65	34	40.23
5	67.67	35	39.52
6	66.69	36	38.62
7	65.71	37	37.73
8	64.73	38	36.83
9	63.74	39	35.94
10	62.75	40	35.05
11	61.76	41	34.15
12	60.78	42	33.26
13	59.79	43	32.37
14	58.82	44	31.49
15	57.85	45	30.61
16	56.91	46	29.74
17	55.97	47	28.88
18	55.05	48	28.02
19	54.13	49	27.17
20	53.21	50	26.32
21	52.29	51	25.48
22	51.38	52	24.65
23	50.46	53	23.82
24	45.55	54	23.01
25	48.63	55	22.21
26	47.73	56	21.43
27	46.80	57	20.66
28	45.88	58	19.90
29	44.97	59	19.15

LIFE EXPECTANCY TABLE – MALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8, 2006

Age	Life Expectancy	Age	Life Expectancy
0	74.14	30	45.90
1	73.70	31	44.96
2	72.74	32	44.03
3	71.77	33	43.09
4	70.79	34	42.16
5	69.81	35	41.23
6	68.82	36	40.30
7	67.83	37	39.38
8	66.84	38	38.46
9	65.85	39	37.55
10	64.86	40	36.64
11	63.87	41	35.73
12	62.88	42	34.83
13	61.89	43	33.94
14	60.91	44	33.05
15	59.93	45	32.16
16	58.97	46	31.29
17	58.02	47	30.42
18	57.07	48	29.56
19	56.14	49	28.70
20	55.20	50	27.85
21	54.27	51	27.00
22	53.35	52	26.16
23	52.42	53	25.32
24	51.50	54	24.50
25	50.57	55	23.68
26	49.64	56	22.86
27	48.71	57	22.06
28	47.77	58	21.27
29	46.84	59	20.49

LIFE EXPECTANCY TABLE – FEMALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006

Age	Life Expectancy	Age	Life Expectancy
0	78.79	30	50.15
1	78.42	31	49.19
2	77.48	32	48.23
3	76.51	33	47.27
4	75.54	34	46.31
5	74.56	35	45.35
6	73.57	36	44.40

7	72.59	37	43.45
8	71.60	38	42.50
9	70.61	39	41.55
10	69.62	40	40.61
11	68.63	41	39.66
12	67.64	42	38.72
13	66.65	43	37.78
14	65.67	44	36.85
15	64.68	45	35.92
16	63.71	46	35.00
17	62.74	47	34.08
18	61.77	48	33.17
19	60.80	49	32.27
20	59.83	50	31.37
21	58.86	51	30.48
22	57.89	52	29.60
23	56.92	53	28.72
24	55.95	54	27.86
25	54.98	55	27.00
26	54.02	56	26.15
27	53.05	57	25.31
28	52.08	58	24.48
29	51.12	59	23.67

LIFE EXPECTANCY TABLE – FEMALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8, 2006

Age	Life Expectancy	Age	Life Expectancy
0	79.45	30	50.53
1	78.94	31	49.56
2	77.97	32	48.60
3	77.00	33	47.63
4	76.01	34	46.67
5	75.03	35	45.71
6	74.04	36	44.76
7	73.05	37	43.80
8	72.06	38	42.86
9	71.07	39	41.91
10	70.08	40	40.97
11	69.09	41	40.03
12	68.09	42	39.09
13	67.10	43	38.16
14	66.11	44	37.23
15	65.13	45	36.31
16	64.15	46	35.39
17	63.17	47	34.47
18	62.20	48	33.56

19	61.22	49	32.65
20	60.25	50	31.75
21	59.28	51	30.85
22	58.30	52	29.95
23	57.33	53	29.07
24	56.36	54	28.18
25	55.39	55	27.31
26	54.41	56	26.44
27	53.44	57	25.58
28	52.47	58	24.73
29	51.50	59	23.89

.57 For the purpose of evaluating income, SSI criteria require that

A. the first $20 of total available unearned income (except for SSI income) must be disregarded;

B. an additional $65 plus 1/2 of the remainder of earned income must be disregarded;

C. income of spouses living together is considered mutually available and must be compared to the current SSI benefit level for a couple; net income of a non-recipient spouse must be reduced by an amount up to one-half the individual SSI benefit level for unmet needs of each non-recipient child in the family;

D. income of single persons must be compared to the current SSI benefit level for an individual (a one-third reduction applies to a person living in the household of another);

E. unemancipated children are not subject to a one-third reduction, an amount of parental income equal to the individual or couple SSI benefit level must be allowed for the needs of the parent or parents, up to one-half the individual SSI benefit level must be allowed for the unmet needs of each non-recipient child in the family, and the remainder must be considered as income available to the applicant or recipient child. For the purposes of this rule, "unemancipated child" means (1) a child under age 18 who is living in the same household with a parent or spouse of a parent, or (2) 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;

F. one-third of child support for the applicant/recipient child from an absent parent must be disregarded;

G. the first $400 of gross monthly earnings, not to exceed $1620 in a calendar year, shall be exempt from consideration as earned income of a disabled or blind child who is a student regularly attending school.

NOTE: Sections 8.110.58 - 8.110.59 deleted effective July 1, 2002.

8.110.6 OLD AGE PENSION CASES

.61 Colorado Medicaid must be provided to persons receiving OAP-A or OAP-B and SSI (SISC-B).

.611 Colorado Medicaid 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).

.612 Colorado Medicaid 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).

.613 Medicaid must be provided to persons in a facility eligible for Medicaid 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 Medicaid reimbursement. (SISC-A)

.62 Medicaid must be provided to a person who was receiving financial assistance under OAP "A" and who lost such assistance because of the Social Secruity (excludes RRB) cost of living adjustment (COLA) paid in July 1977 or after. Medical assistance must also be provided to a person who loses eligibility for OAP "A" any time after July 1977 due to the receipt of Social Security benefits. The situations that require continual medical assistance are outlined as follows:

A. The person lost OAP because of a cost of living adjustment to his/her own Social Security benefits.

B. The person lost OAP because of increased income deemed from a parent or spouse due to a cost of living adjustment to Social Security benefits received by the parent or spouse.

C. The person lost OAP due to the receipt of Social Security benefits (OASDI) during the current or previous years, and would be eligible for OAP except for cost of living adjustments (COLA's) received since the initial receipt of SSA.

.63 The cost-of-living increase disregard specified in the preceding section must continue to be applied in each subsequent eligibility determination and the disregard amount then must include the increase that resulted in loss of eligibility for financial assistance plus subsequent OASDI cost-of-living increases paid to that time. 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 9see B above). This provision is retroactive to November 1985 in accordance with U.S. District Court injunction of Lynch vs. Rank. (SISC-B)

.64 To redetermine eligibility of Medicaid recipients to whom the 1977 and later cost-of-living increase disregards apply, the county must:

A. establish whether the person received a payment under OAP and, for the same month, was entitled to a Social Security (OASDI) payment;

B. determine the Social Security income before the loss of financial assistance;

C. determine the current income;

D. subtract the previous Social Security income from the current income to find the cumulative COLAs since financial assistance was lost;

E. subtract the cumulative COLAs from the current income.

If the figure in step E is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria, such as age, resources, disability, citizenship and residency, medical eligibility must continue.

.65 Medicaid must be provided to a person who was receiving financial assistance under OAP 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. (SISC-B)

.66 The OAP-B individual included in AFDC assistance unit shall receive Medicaid as a member of the AFDC household. (SISC-B)

.67 The Colorado Modified Medical 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).

.68 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 - the SISC code is 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 the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS and for those who meet these 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 - the SISC code is C.

.69 Medicaid 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.

8.110.7 GRANDFATHERED-IN CASES

.71 Medicaid must be provided to aged, disabled or blind persons who are receiving mandatory state supplementary payments. Such persons are those with income below their December 1973 minimum income level (MIL).

.72 Medicaid must be provided to a person who was eligible for medical assistance in December 1973 as an inpatient of a medical facility,

A who continues to meet the December 1973 eligibility criteria for institutionalized persons. and who remains institutionalized.

.73 Medicaid must be provided to a person who was eligible for Medicaid 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.

8.110.8 PERSONS RECEIVING HOME AND COMMUNITY BASED SERVICES (HCBS)

.8 Individuals determined to be eligible for the Colorado Modified Medical Program shall not be eligible for Home & Community Based Services.

.81 Medicaid must be provided to persons who:

A. except for the level of their income would be eligible for SSI;

B. have gross income which does not exceed 300% of the current individual SSI benefit level;

C. will receive services as specified in the long term care rules section on HOME AND COMMUNITY BASED SERVICES in this staff manual.

.83 For purposes of evaluating resources, the county must apply the criteria specified in the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS.

.84 For purposes of applying the 300% income standard, gross income means income before application of any deductions, exemptions, or disregards appropriate to the SSI program. Individuals who are eligible to receive Home and Community Based Services under the 300% income standard are eligible effective from the first day of service provision.

.85 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 evaluated in accordance with rules contained in the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS.

.86 Upon the completion of a determination or redetermination of eligibility, the county department shall notify the Home and Community Based Services case management agency on a State prescribed form of the approval, denial, or termination of the case, or of income changes of clients affecting their eligibility or patient payment (PETI) obligation. For further information on assessing the PETI payments of clients with income above the Old Age Pension grant standard, refer to the section on PATIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME in this manual.

.87 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 Medicaid charges for ACF services. The total amount allowed for personal need and room and board cannot exceed the State's Old Age Pension Standard.

8.110.9 CONSIDERATION OF ALIEN SPONSORS: DEEMING OF INCOME AND RESOURCES

.91 All aliens who apply for Old Age Pension on or after April 16, 1988, for three (3) 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 Staff Manual Volume 3 for specific instructions on deeming income and resources.

8.111 MEDICARE CATASTROPHIC COVERAGE ACT (MCCA)

8.111.1 QUALIFIED MEDICARE BENEFICIARIES (QMB)

8.111.10 Effective July 1, 1989, a Qualified Medicare Beneficiary is an individual who:

A. receives Part A Medicare; and

B. For an individual, who has resources at or below twice the SSI individual resource limit, or for a couple who has resources at or below three times the SSI individual resource limit, as described in the previous section "SSI FINANCIAL ELIGIBILITY REQUIREMENTS"; 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.

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.

For QMB purposes, earned income of the applicant/recipient and/or the spouse, shall have the 65 plus 1/2 earned income disregard, in accordance with 8.110.57,B, applied before the earned income is considered toward the applicable income limit. If two or more individuals have earned income, the income of all the individuals shall be added together and the 65 plus 1/2 earned income disregard shall be applied to the total amount of earned income.

8.111.11 Medicare cost sharing expenses must be provided to qualified Medicare beneficiaries. This limited Medicaid package of Medicare cost sharing expenses only includes:

A. payment of Part A Medicare premiums where applicable; and,

B. payment of Part B Medicare premiums; and,

C. payment of coinsurance and deductibles for Medicare services whether or not a benefit of Medicaid up to the full Medicare rate or reasonable rates as established in the State Plan.

8.111.12 Individuals may be QMB recipients only or the individual may be classified as a dual eligible.

A. 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.

B. A dual eligible is a Medicare recipient who is otherwise eligible for Medicaid.

8.110.13 Individuals who apply for assistance as a QMB have the right to have their eligibility determined under all categories of assistance for which they may qualify.

8.111.14 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 the Income Maintenance Staff Manual.

8.111.15 Eligibility for QMB benefits shall be effective the month after 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.

QMB benefits are not retroactive and the three month retroactive Medicaid rule does not apply to QMB benefits.

8.111.16 Clients who would lose their QMB entitlement due to annual social security cost of living adjustments (COLA) will remain eligible for QMB coverage under Medicaid, as income disregard cases, until the next year's federal poverty guidelines are published.

8.112 SPOUSAL PROTECTION - TREATMENT OF INCOME AND RESOURCES FOR INSTITUTIONALIZED SPOUSES

A. 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.

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

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

2. Is first enrolled as a Medicaid client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or

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

C. A person is considered likely to remain in a medical institution, nursing facility, enrolled in the PACE program, or receiving HCBS when, at the beginning of the institutionalization there is a reasonable expectation, based on medical evidence, that he/she will remain institutionalized for at least 30 consecutive days.

D. A community spouse is defined as a spouse who:

1. Is not in a medical institution or nursing facility,

2. Is not enrolled as a Medicaid client in the Program of All Inclusive Care for the Elderly (PACE),

3. Is not receiving Home and Community Based Services (HCBS).

4. Is not in receipt of Medicaid other than coverage under a Medicare cost-sharing program such as QMB, SLMB, QI-1, or QI-2.

8.112.1 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 Medicaid 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.

8.112.11 CALCULATION OF THE COMMUNITY SPOUSE RESOURCE ALLOWANCE

A. A Community Spouse Resource Allowance (CSRA) shall be allocated based on the total resources owned by the couple as of the time of Medicaid application. 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.

1. For persons whose Medicaid 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 is $87,000 in 2001; or

    b. The increased CSRA calculated pursuant to 8.112.24; 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. If the transfer is not completed within this time period, the resources shall be attributed to the institutionalized spouse and shall affect his/her Medicaid eligibility. Verification of the transfer of assets to the community spouse shall be provided to the county department.

    a. 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 Medicaid, where:

    a. The institutionalized spouse has assigned to the Colorado Department of Health Care Policy & Financing (CDHCPF) 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 CDHCPF has the right to bring a support proceeding against the community spouse without such assignment; or

    c. The county 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 Medicaid eligibility criteria except for resource eligibility, has no alternative living arrangement other than the medical institution or nursing facility.

8.112.12 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 “FINANCIAL ELIGIBILITY REQUIREMENTS FOR INDIVIDUALS ELIGIBLE FOR THE COLORADO MEDICAID PROGRAM” . However, for Spousal Protection there is no limit to the value of household goods and personal effects and one automobile.

8.112.13 DETERMINATION OF THE INSTITUTIONALIZED SPOUSE’S RESOURCE ELIGIBILITY

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

8.112.2 DETERMINATION OF INSTITUTIONALIZED SPOUSE'S INCOME ELIGIBILITY

The county department shall determine whether the institutionalized spouse is income eligible for Medicaid. The institutionalized spouse shall be income eligible if his/her gross income is at or below the Medicaid income limit for recipients of long-term care.

8.112.21 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:

A. 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.

B. 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.

C. 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.

D. 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.

8.112.22 CALCULATING THE COMMUNITY SPOUSE'S MONTHLY INCOME NEEDS

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

1. The current minimum monthly maintenance needs allowance (MMMNA) , which is equal to 1/12 of the federal poverty level for a family of two and is adjusted in July of each year;

2. 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:

    a. 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

    b. 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.

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

3. 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:

1. Provided by a medical practitioner licensed to furnish the care;

2. Not subject to payment by any third party, including Medicaid 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:

1. Limited to disability or income protection coverage;

2. Automobile medical payment coverage;

3. Supplemental to liability insurance;

4. Designed solely to provide payments on a per diem basis, daily indemnity or nonexpense-incurred basis; or

5. Credit life and/or accident and health insurance.

4. 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 esta blished through a fair hearing.

5. 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.

8.112.23 CALCULATING THE AMOUNT OF INCOME TO BE CONTRIBUTED BY THE INSTITUTIONALIZED SPOUSE FOR THE COMMUNITY SPOUSE'S MONTHLY NEEDS

A. 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.

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

2. 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.

3. The county department 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.

8.112.24 INCREASING THE COMMUNITY SPOUSE RESOURCE ALLOWANCE

A. 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:

1. The community spouse's MMMNA;

2. The community spouse's own income; and

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

4. 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:

   a. 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.

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

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

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

8.112.25 DEDUCTIONS FROM MONTHLY INCOME OF THE INSTITUTIONALIZED SPOUSE

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

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

2. 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;

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

a. 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.

b. 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.

4. Allowable deductions identified in the section “POST ELIGIBILITY TREATMENT OF INCOME” .

5. 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.

6. No other deductions shall be allowed.

8.112.3 RIGHT TO APPEAL

A. Both spouses shall be informed of the following:

(1) The amount and method by which the county department calculated the community spouse resource allowance (CSRA), community spouse monthly income allowance (MIA), and any family allowance;

(2) The spouses' right to a fair hearing concerning these calculations;

(3) The county department's conclusions with respect to the spouses' ownership and availability of income and resources, and the spouses' right to a fair hearing concerning these conclusions.

B. 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.

C. Appeals from decisions made by the county department shall be governed by the provisions under "RECIPIENT APPEALS PROTOCOLS/PROCESS” at 10 CCR 2505-10, §8.058.

8.121 QUALIFIED DISABLED AND WORKING INDIVIDUALS

8.121.1 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 the section on "SSI FINANCIAL ELIGIBILITY"; and

D. has income less than 200% of poverty, as defined by the Executive Office of Management and Budget, or at a poverty level otherwise determined by the Health Care Financing Administration.

8.121.10 Monthly payment of Medicare Part A premiums, and any other Medicare cost-sharing expenses determined necessary by the Health Care Financing Administration (HCFA), must be made on behalf of Qualified Disabled and Working Individuals.

8.121.11 An individual may be eligible under this section only if he/she is not otherwise eligible under another medical assistance category of eligibility.

8.121.12 All other general non-financial requirements or conditions of eligibility must also be met such as citizenship and residency requirements as well as reporting and redetermination requirements. These criteria are defined in the Income Maintenance Staff Manual.

8.121.13 Eligibility for QDWI benefits shall be effective the month of determination of entitlement.

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.

8.122 SPECIAL LOW INCOME MEDICARE BENEFICIARIES

8.122.1 Effective January 1, 1993, a Special Low Income Medicare Beneficiary (SLMB) is an individual who:

A. is entitled to Medicare Part A;

B. For an individual, who has resources at or below twice the SSI individual resource limit, or for a couple, who has resources at or below three times the SSI individual resource limit as described in the section "SSI FINANCIAL ELIGIBILITY REQUIREMENTS";

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 poverty, CY 1995 100-120% of poverty.

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.

For SLMB purposes, earned income of the applicant/recipient and/or the spouse, shall have the 65 plus 1/2 earned income disregard, in accordance with 8.110.57,B, applied before the earned income is considered toward the applicable income limit. If two or more individuals have earned income, the income of all the individuals shall be added together and the 65 plus 1/2 earned income disregard shall be applied to the total amount of earned income.

D. is not otherwise eligible for coverage under Medicaid (e.g., QMB, OAP, AND, etc.).

8.122.10 Medicaid coverage for SLMB clients is limited to payment of monthly Medicare Part B (Supplemental Medical Insurance Benefits) premiums.

8.122.11 All other general non-financial requirements or conditions of eligibility must also be met, such as citizenship and residency requirements, as well as reporting and redetermination requirements. These criteria are defined in the Income Maintenance Staff Manual.

8.122.12 Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.

8.122.13 Clients who would lose their SLMB entitlement due to annual Social Security cost-of-living adjustments (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.

8.123 MEDICARE QUALIFYING INDIVIDUALS 1

8.123.1 Eligibility for this benefit is limited by the availability of the allocation set by the Health Care Financing Administration (HCFA). 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.

8.123.11 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.

8.123.12 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 federal poverty level,

C. resources may not exceed twice the SSI limit, and

D. he/she cannot otherwise be eligible for Medicaid.

Eligibility for benefits 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.

8.130 PROVIDER PARTICIPATION

8.130.1 DEFINITION [Eff. 12/30/2008]

Requesting Agency means the United States Department of Health and Human Services, the Department or its designees, Department of Human Services, or the Medicaid Fraud Control Unit, acting through their representatives who have written or de facto designation as such.

8.130.2 MAINTENANCE OF RECORDS [Eff. 12/30/2008]

8.130.2.A. Each provider shall:

1. Maintain legible records necessary to disclose the nature and extent of goods and services provided to clients 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 clients and unaltered copies of original invoices for such items.

   e. Records of all payments received from the Medical Assistance program.

2. Maintain legible records, which fully substantiate or verify claims submitted for payment.

a. The records shall be created at the time the goods or services are provided.

8.130.2.B. Records of providers shall include employment records, including but not limited to shift schedules, payroll records and time cards of employees.

8.130.2.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.

8.130.2.D. Records must be maintained for six years unless an additional retention period is required elsewhere in 10 C.C.R. 2505-10, Sections 8.000 et seq. or in the provider agreement.

8.130.2.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 services provided (for example, superbills). All records must be legible, verifiable, and must comply with generally accepted accounting principles and auditing standards.

8.130.2.F. Each entry in a medical record must be signed and dated by the individual providing the medical service. Stamped signatures are not acceptable.

8.130.2.G. Providers utilizing electronic record-keeping may apply computerized signatures and dates to the 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) reports. 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.

8.130.2.H. At the discretion of the requesting agency, record verification may include but 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.

8.130.2.I. Nothing in Section 8.130 shall negate or modify any specific record keeping requirements contained in 10 C.C.R. 2505-10, Sections 8.000 et seq. or in individual provider agreements.

8.130.3 ADVANCE DIRECTIVES [Eff. 12/30/2008]

8.130.3.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.

8.130.3.B. Providers shall provide adult Medical Assistance program clients 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.

8.130.3.C. The provider shall maintain written policies and procedures with respect to all adult individuals receiving medical or personal care by or through the provider organization 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.

8.130.3.D. Providers shall provide education for staff and the patient/client community on issues concerning advance directives.

8.130.4 TERMINATION

Existing contracts shall be terminated if the provider fails to disclose requested information or if any person who has an ownership or control interest in the entity, or who is an agent or managing employee of the entity, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicare, or the Title XX services program. Person with an Ownership or Control Interest means a person, corporation, partnership, joint venture or other legal entity that:

A. Has an ownership interest equal to five percent or more in a Disclosing Entity, or

B. Has an indirect ownership interest equal to five percent or more in a Disclosing Entity, or

C. Has a combination of direct and indirect ownership interests equal to five percent or more in a Disclosing Entity, or

D. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the Disclosing Entity if that interest equals at least five percent of the value of the property or assets of the Disclosing Entity, or

E. Is an officer or director of a Disclosing Entity that is organized as a corporation, or

F. Is a partner in a Disclosing Entity that is organized as a partnership.

Convicted means that a federal, state, or local court, regardless of whether an appeal from that judgment is pending, has entered a judgment of conviction.

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

History

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