THIS PAGE IS NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-10-15-A, Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning the Amount, Scope, and Duration of the Outpatient Fee-for-Service Substance Use Disorder Treatment Services Benefit, Section 8.746
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.746, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date: 10/30/2015
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Remove all text beginning at §8.746 through the end of §8.746.4.1.f and replace with new text provided beginning at §8.746 through the end of §8.746.A. Also publish the attached Appendix A at the end of the 8.700 section in the CCR. This revision is effective 10/30/2015.

*to be completed by MSB Board Coordinator

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning the Amount, Scope, and Duration of the Outpatient Fee-for-Service Substance Use Disorder Treatment Services Benefit, Section 8.746
Rule Number:	MSB 14-10-15-A
Division / Contact / Phone:	HPO B&O / Amanda Forsythe / x6459

STATEMENT OF BASIS AND PURPOSE

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

The proposed revision amends 10 CCR 2505-10, Section 8.746 to incorporate the Outpatient Fee-for-Service Substance Use Disorder Treatment Services Benefit Coverage Standard into rule. The Benefit Coverage Standard, which went into effect April 8, 2015, will be incorporated directly into the Department's administrative rules as an appendix. The current Section 8.746 rule language will be struck and replaced with language indicating that Outpatient Fee-for-Service Substance Use Disorder Treatment benefits are provided in accordance with the provisions of Appendix A.

Additionally, the proposed revision to Section 8.746 makes the following substantive changes:

1) Adds Medication-Assisted Treatment as a covered service.

2) Increases the limit on Individual and Family Therapy from 25 sessions to 35 sessions per state fiscal year.

3) Increases the limit on Alcohol/Drug Screening Counseling specimen collections from 36 to 52 per state fiscal year.

4) Increases the limit on Targeted Case Management services from 36 contacts per state fiscal year to 52 units per state fiscal year. For consistency, the term "units" is used in place of the term "contacts;" no change in meaning is intended by this revision.

5) Increases the limit on Social/Ambulatory Detoxification from 7 days to 15 days per state fiscal year.

2. An emergency rule-making is imperatively necessary

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

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

Explain:

Initial Review	**08/14/2015**	Final Adoption	**09/11/2015**
Proposed Effective Date	**11/01/2015**	Emergency Adoption	

DOCUMENT #02

3. Federal authority for the Rule, if any:

   42 U.S.C. § 1396d(a)(2)(A) and 42 C.F.R. § 440.230.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   C.R.S. 25.5-5-202(1)(s)(I).

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning the Amount, Scope, and Duration of the Outpatient Fee-for-Service Substance Use Disorder Treatment Services Benefit, Section 8.746
Rule Number:	MSB 14-10-15-A
Division / Contact / Phone:	HPO B&O / Amanda Forsythe / x6459

REGULATORY ANALYSIS

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

This rule change will impact the providers of Outpatient FFS Substance Use Disorder Treatment services and Medicaid clients. Specifically, the incorporation of the Benefit Coverage Standard into rule as an appendix will increase the comprehensibility of the rule for Medicaid clients and providers.

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

Clearly-defined rules will provide assurance for persons receiving benefits that services are easy to understand and locate, meet established criteria, provide better guidance for service providers, assure that public funds are more responsibly allocated, and reduce the administrative burden on the Department. Additionally, clearly-defined rules will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers, and the Department, and will simplify the appeal process for all participants. By clearly defining clinical criteria in the Outpatient FFS Substance Use Disorder Treatment Services benefit, the Department hopes to achieve its goal to improve client access to cost-effective, high quality care, and to reduce inappropriate utilization and variations in care.

By directly incorporating the Department's Benefit Coverage Standard the rule will be more clearly-defined and further the Department's goals.

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

This rule does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

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

Enforceable policy rules will help the Department recover improper payments for inappropriate services rendered, uphold decisions based upon evidence-based criteria, and reduce the volume

of appeals. By being able to enforce evidence-based criteria, this rule may generate cost-savings as inappropriate utilization and appeal volumes are reduced.

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

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule because all benefits must be adequately described in rule.

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

   There are no alternative methods for achieving the purpose of the proposed rule. In order to have the force of law, the policies set forth in the benefit coverage standards must be written into the Department's administrative rules.

8.746 OUTPATIENT SUBSTANCE ABUSE TREATMENT

8.746.1 DEFINITIONS [Emer. Rule eff 9/ 8 /06; Perm. Rule eff 10/1/06]

Alcohol and/or drug screening means the collection of urine to test for the presence of alcohol and/or drugs.

Group Therapy means therapeutic substance abuse counseling and treatment services with more then one client.

Individual and Family Therapy means therapeutic substance abuse counseling services with one client per session. Family therapy shall be directly related to the client's treatment for substance abuse and/or dependence.

Social/Ambulatory Detoxification means services provided on a residential basis by a facility licensed by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services based on American Society of Addiction Medicine (ASAM) criteria.

Substance Abuse Assessment means an evaluation designed to determine the level of drug/alcohol abuse or dependence and the comprehensive treatment needs of a client.

Targeted Case Management means medically necessary coordination and planning services provided with or on behalf of a client with a substance abuse diagnosis.

8.746.2 Client Eligibility [Emer. Rule eff 9/8/06; Perm. Rule eff 10/1/06]

8.746.2.A. Clients identified as being appropriate for the Substance Abuse Treatment program shall be assessed as having drug/alcohol abuse or dependence.

8.746.3 Provider Requirements [Emer. Rule eff 9/8/06; Perm. Rule eff 10/1/06]

8.746.3.A. Outpatient substance abuse services shall be provided in an approved facility or by certain licensed health care practitioners with certification in addiction counseling.

8.746.3.B. Providers shall be one of the following:

a. Facilities licensed by ADAD to offer outpatient services.

b. Licensed physicians who are also:

i) Certified in Addiction Medicine by the American Society of Addiction Medicine (ASAM), or

ii) Certified Addiction Counselors (CAC II or CAC III) or Licensed Addiction Counselors (LAC) by Department of Regulatory Agencies (DORA), or

iii) Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC.

iv) Certified in Addiction Psychiatry by the American Board of Psychiatry and Neurology (ABPN).

c. Licensed non-physician practitioners are any of the following:

i) Psychologist, PhD.

ii) Nurse Practitioner.

iii) Licensed Clinical Social Worker (LCSW).

iv) Marriage and Family Therapist.

v) Licensed Professional Counselor (LPC).

vi) Licensed Addiction Counselor (LAC).

d. The above licensed non-physician practitioners shall also be certified addiction counselors with one of the following credentials:

i) Certified by DORA as a CAC II, CAC III.

ii) Certified by NAADAC as an NCAC II or MAC.

8.746.4 Covered Services [Emer. Rule eff 9/8/06; Perm. Rule eff 10/1/06]

1. Outpatient Substance Abuse Treatment services are limited to:

a. Substance Abuse Assessment, which shall be limited to three sessions per state fiscal year.

b. Individual and Family Therapy, which shall be limited to 25 sessions at 15 minutes per unit, up to four units per session per state fiscal year.

c. Group Therapy sessions, which shall be up to an including three hours per session and limited to 36 sessions per state fiscal year.

d. Alcohol/Drug Screening, which shall be limited to 36 specimen collections per state fiscal year. Substance abuse counseling services shall be provided along with screening to discuss results with client.

e. Targeted Case Management, which shall be limited to 36 contacts per state fiscal year. Services may include service planning, advocacy and linkage to other medical services related to substance abuse diagnosis, monitoring, and care coordination.

f. Social/Ambulatory Detoxification, which shall be limited to seven days per state fiscal year and includes supervision, observation and support for individuals whose intoxication/withdrawal signs and symptoms are severe enough to require a 24 hour structured program but do not require hospitalization.

8.746 OUTPATIENT FEE-FOR-SERVICE SUBSTANCE USE DISORDER TREATMENT

8.746.A. Outpatient Fee-for Service Substance Use Disorder Treatment benefits are provided in accordance with the provisions of Appendix A, which details the benefit coverage standards.

10 CCR 2505-10 § 8.746, APPENDIX A: OUTPATIENT FEE-FOR-SERVICE SUBSTANCE USE DISORDER TREATMENT SERVICES BENEFIT COVERAGE STANDARD

Capitalized terms within this Benefit Coverage Standard that do not refer to the title of a benefit, program, or organization, have the meaning specified in the Definitions section.

BRIEF COVERAGE STATEMENT

This Benefit Coverage Standard describes Outpatient Fee-For-Service (FFS) Substance Use Disorder (SUD) Treatment Services benefits for Colorado Medicaid clients who are not enrolled in the Community Behavioral Health Services program.

CONTENTS

RELATED BENEFITS ADDRESSED IN OTHER BENEFIT COVERAGE STANDARDS

1. Outpatient Fee-For-Service Mental Health
2. Laboratory Services
3. Pharmacy
4. Physician Services
5. Inpatient Hospital

ELIGIBLE PROVIDERS

Providers eligible to render services are limited to the following:

1. Licensed physicians who are also:
    a. Certified in addiction medicine by the American Society of Addiction Medicine (ASAM); or
    b. Certified as Certified Addiction Counselors (CAC II or CAC III) or Licensed Addiction Counselors (LAC) by the Department of Regulatory Agencies (DORA); or
    c. Certified as National Certified Addiction Counselors II (NCAC II) or Master Addiction Counselors (MAC) by the National Association of Alcohol and Drug Abuse Counselors (NAADAC); or
    d. Certified in addiction psychiatry by the American Board of Psychiatry and Neurology certified in Addiction Psychiatry (ABPN).
2. Licensed non-physicians who are also:
    a. Psychologists (PhD, PsyD),
    b. Nurse Practitioners,

c. Licensed Addiction Counselors, or

d. Master's Level Clinicians

i) Licensed Clinical Social Worker (LCSW)

ii) Licensed Professional Counselor (LPC), or

iii) Licensed Marriage and Family Therapist (LMFT);

and either:

a. Certified by DORA as a CAC II or CAC III; or

b. Certified by NAADAC as an NCAC II or MAC.

3. Licensed facilities that are supervised by one or more licensed physicians or non-physicians; supervised professional personnel who are:

a. Working at a facility licensed by the Office of Behavioral Health to provide substance use disorder treatment services; and

b. Supervised by one or more licensed physicians or licensed non-physicians found in Part 1 or 2 of this Eligible Providers section.

TREATMENT PLANNING

An approved treatment plan must be in place for each client prior to the client receiving services. An initial assessment is required to establish a treatment plan. Treatment plans require approval from the licensed provider indicated in the Eligible Providers section with the authority to approve treatment plans within their scope of practice.

All rendered services must be medically necessary, as defined in Colorado Medical Assistance Program rule at 10 C.C.R. 2505-10 Section 8.076.1.8., and must be detailed in the client's treatment plan and progress notes. Initial SUD Assessments are exempt from inclusion in the treatment plan.

ELIGIBLE MEDICAID CLIENTS

1. To be eligible for the FFS SUD Treatment Services benefit, client:

a. Must currently be enrolled in Colorado Medicaid; and

b. Must not be enrolled in the Community Behavioral Health Services program pursuant to 10 C.C.R. 2505-10 Section 8.212.

2. All Colorado Medicaid clients are automatically enrolled in the Community Behavioral Health Services program, unless one of the following is true:

   a. Client is not eligible for enrollment in the Community Behavioral Health Services program, per 10 CCR 2505-10 Section 8.212.1; or

   b. Client is approved for an individual enrollment exemption, as set forth at 10 CCR 2505-10 Section 8.212.2

LIMITATIONS

1. Clients are not required to obtain a referral from their Primary Care Physician (PCP) or Primary Care Medical Provider (PCMP) to receive these services.

2. Clients must have a treatment plan that is approved by a licensed practitioner listed in the Eligible Providers section.

3. FFS SUD services may only be rendered by providers outlined in the Eligible Providers section, with an exception for certain providers of Medication Assisted Treatment described below.

4. Services are covered only when client has been diagnosed with at least one of the following:

   a. Alcohol (use or induced) disorders

   b. Amphetamine (use or induced) disorders

   c. Cannabis (use or induced) disorders

   d. Cocaine (use or induced) disorders

   e. Hallucinogen (use or induced) disorders

   f. Inhalant (use or induced) disorders

   g. Opioid (use or induced) disorders

   h. Phencyclidine (use or induced) disorders

   i. Sedative Hypnotic or Anxiolytic (use or induced) disorders

   j. Tobacco Use Disorder

5. Additional medical and laboratory services, such as physical health monitoring, therapeutic drug monitoring, and alcohol/drug screenings, are covered services under the Physician Service benefit or Laboratory benefit, which are separate from the FFS SUD benefit.

COVERED SERVICES

Substance Use Disorder Assessment

SUD assessment is an evaluation designed to determine the most appropriate level of care based on criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug/alcohol use, abuse, or dependence and related problems, and the comprehensive treatment needs of a client with a SUD diagnosis.

a. Course of treatment and changes in level of care must be based on best practices as defined by the current ASAM Patient Placement Criteria.

b. Re-assessments must be spaced appropriately throughout the course of treatment to ensure the treatment plan is effectively managing the client's changing needs.

c. SUD assessments are limited to two encounter-based units of service per State Fiscal Year. Each complete assessment corresponds to one unit of service.

d. An assessment may involve more than one session and may span multiple days. If the assessment spans multiple days, the final day of the assessment is reported as the date of service.

Individual and Family Therapy

Individual and family therapy is the planned treatment of a client's problem(s) as identified by an assessment and listed in the treatment/service plan. The intended outcome is the management and reduction, or resolution of the identified problem(s).

a. Family therapy must be directly related to the client's treatment for SUD and/or dependence.

b. Individual and family therapy is limited to one client per session.

c. Individual and family therapy is limited to a combined 35 sessions per State Fiscal Year, and billed at 15 minutes per unit, with up to four units (one hour) per session. A session is considered a single encounter with the client that can encompass multiple timed units.

d. Individual therapy and family therapy sessions are allowed on the same date of service.

Group Therapy

Group therapy refers to therapeutic SUD counseling and treatment services, administered through groups of people who have similar needs, such as progression of disease, stage of recovery, and readiness for change.

a. Group therapy must include more than one patient.

b. Group therapy is limited to 36 sessions per State Fiscal Year. A session of group therapy may last up to three hours and is billed in units of one hour each (e.g., a three hour group session would consist of three units). A unit of service may be billed separately for each client participating in the group therapy session.

Alcohol/Drug Screening Counseling

Alcohol/drug screening counseling is the collection of urine followed by a counseling session with the client to review and discuss the results of the screening.

a. The laboratory analysis of the urine specimen (urinalysis) must be billed by a laboratory using that laboratory's Medicaid Provider ID.

b. SUD providers will only be reimbursed for collecting the urine specimen and providing a counseling session to review and discuss the results of the urinalysis. Claims submitted for the collection of the urine sample without the subsequent counseling of urinalysis results will not be reimbursed.

c. SUD counseling services to discuss and counsel the client on the test results must be provided by an eligible rendering provider, as outlined in the above Eligible Providers section.

d. If the client does not return for the counseling of their urinalysis results, the collection of the sample cannot be claimed.

e. The counseling portion of the service may be conducted during a session of individual or family therapy.

f. Multiple urine collections per date of service are not additionally reimbursed.

g. Alcohol/ drug screening counseling is limited to 52 specimen collections per State Fiscal Year.

h. Alcohol/ drug screening counseling is limited to one unit per date of service. A unit of service is the single collection and subsequent counseling session.

Targeted Case Management

Targeted case management refers to coordination and planning services provided with, or on behalf of, a client with a SUD diagnosis. The client does not need to be physically present for this service to be performed if it is done on their behalf.

a. Services are limited to service planning, advocacy, and linkage to other appropriate medical services related to SUD diagnosis, monitoring, and care coordination.

b. SUD targeted case management services are limited to 52 units of service per State Fiscal Year.

i) A unit of service consists of at least one documented contact with a client or person acting on behalf of a client, identified during the case planning process.

ii) A unit of service equals one 30-minute session of targeted case management. Up to four units of service may be rendered per date of service.

Social/Ambulatory Detoxification

Facilities licensed by the Office of Behavioral Health (OBH) are the only provider type eligible to render social/ambulatory detoxification services.

a. Social/ambulatory detoxification services:

i) Include supervision, observation, and support from qualified personnel for clients exhibiting intoxication or withdrawal symptoms.

ii) Are provided when there is minimal risk of severe withdrawal (including seizures and delirium tremens) and when any co-occurring mental health or medical conditions can be safely managed in an ambulatory setting.

b. Social/ambulatory detoxification is limited to five sessions per State Fiscal Year.

i) A session is defined as the continuous treatment time from the first day to the last day of social/ambulatory detoxification.

ii) Each session may last a maximum of three days.

c. Room and board is not a covered social/ambulatory detoxification service. Claims billed for room and board will not be reimbursed.

d. Social/ambulatory detoxification is divided into four distinct services—physical assessment of detoxification progress, evaluation of level of motivation, safety assessment, and provision of daily living needs—with corresponding procedure codes, which may be provided and billed on the same date of service if medically necessary, as defined in rule at 10 CCR 2505-10 Section 8.076.1.8.

Medication-Assisted Treatment (MAT)

MAT is a benefit for opioid addiction that includes a medication approved by the U.S. Food and Drug Administration (FDA) for opioid addiction detoxification or maintenance treatment.

For the purposes of the FFS SUD Treatment Services benefit, MAT is defined as the administration, acquisition, and dispensing of Methadone to the client.

a. Only licensed physicians, physician assistants, or nurse practitioners are eligible to administer MAT. All providers must comply with the Opioid Medication Assisted Treatment program requirements set forth by Office of Behavioral Health in rule at 2 C.C.R. 502-1 21.320.

b. MAT is limited to one unit per date of service. A unit is a single dose administered to the client.

c. Take-home dosing is permitted in accordance with OBH rules at 2 CCR 502-1 21.320.8. Therefore, one unit of MAT must be reported for each date of service the client ingests the dose of methadone.

d. If the client ingests their dose at the facility, the place of service must be reported as office. If the client ingests their dose at home, the place of service must be reported as home. Records must include documentation to substantiate claims for take-home doses.

e. Ongoing counseling and therapy services associated with MAT have the same respective benefit limitations as individual, family, and group therapy services listed previously in COVERED SERVICES, INDIVIDUAL AND FAMILY THERAPY, and GROUP THERAPY.

SPECIAL PROVISION: EXCEPTION TO POLICY LIMITATIONS FOR CLIENTS AGED 20 AND YOUNGER

For Medicaid clients ages 20 and younger, FFS SUD Treatment Services are covered in accordance with the provisions of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program found at 10 CCR 2505-10 Section 8.280.

PROCEDURE CODING

Current procedure coding is detailed in the Outpatient Behavioral Health FFS Billing Manual, found in the Billing Manual section of the Department of Health Care Policy and Financing website at colorado.gov/hcpf.

PRIOR AUTHORIZATION REQUIREMENTS

There are no prior authorization requirements for FFS SUD Treatment services.

SERVICES NOT COVERED BY THE OUTPATIENT FEE-FOR-SERVICE SUBSTANCE USE DISORDER TREATMENT BENEFIT

1. Day Treatment Program Services
2. Intensive Outpatient Psychiatric Rehabilitation
3. Peer Advocate Services
4. Residential treatment services, with the exception of Residential Child Care Facilities
5. Court-ordered DUI services that are independent of a substance use disorder diagnosis.
6. Services provided by a third party that is under contract with the provider.
7. Any SUD treatment service not specified as covered in this Benefit Coverage Standard.

The majority of Colorado Medicaid clients are enrolled in the Community Behavioral Health Services program and must receive services from a BHO network provider. The FFS SUD Treatment benefit is available to the small percentage of clients who are not enrolled in the Community Behavioral Health Service program, and whose service claims must be submitted to the Department of Health Care Policy and Financing's fiscal agent.

DEFINITIONS

The following definitions are applicable only within the scope of this Benefit Coverage Standard.

Colorado Medicaid. The free or low cost public health insurance program that provides health care coverage to low-income individuals, families, children, pregnant women, seniors, and people with disabilities. Colorado Medicaid is funded jointly by the federal and state government, and is administered by the Colorado Department of Health Care Policy and Financing.

Community Behavioral Health Services Program. The program described in rule at 10 CCR 2505-10 Section 8.212, by which program-enrolled Medicaid clients receive behavioral health treatment services.

Day Treatment Program Services. A non-residential treatment program designed for children and adolescents under the age of 21 who have emotional, behavioral, and neurobiological or SUD problems and may be at high risk for out-of-home placement. Day Treatment Program Services include family, group, and individual psychotherapy; parent-child education; skill and socialization training focused on improving functional and behavioral deficits; and intensive coordination with schools and/or other child service agencies.

Inpatient Hospital SUD Treatment. Organized service delivered by medical and nursing professionals in a facility licensed as a hospital by the state. Provides for 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting, specifically designed for acute medical detoxification. This is considered an inpatient hospital benefit and is not part of the FFS SUD benefit.

Intensive Outpatient Psychiatric Rehabilitation Services. Services that focus on maintaining and improving functional abilities for the client through a time-limited, multi-faceted approach to treatment.

Masters Level Clinician. A provider who is clinical social worker licensed pursuant to CRS 12-43-404, marriage and family therapist licensed pursuant to CRS 12-43-504, professional counselor licensed pursuant to CRS 12-43-603, or advanced practice nurse licensed pursuant to CRS 12-38-111.5.

Medicaid Provider ID. The unique eight-digit number assigned to a provider who enrolls in the Colorado Medical Assistance Program.

Peer Advocate Services. A scheduled therapeutic activity led by a trained client who is self-identified as receiving behavioral health services.

Psychologist, Psy.D/PhD. A provider who has a doctoral degree from an accredited program offering psychology courses approved by the American Psychological Association and is licensed as a psychologist by the State Board of Psychologist Examiners pursuant to CRS 12-43-304.

Physician Assistant. A provider who is a graduate of an education program accredited by the Accreditation Review Commission on Education for the Physician Assistant, certified by the National Commission on Certification of Physician Assistants, and licensed as a physician assistant pursuant to CRS 12-36-107.4.

Physician/Psychiatrist. A provider who has a Doctor of Medicine or Osteopathic Medicine degree, engages in the practice of medicine as defined by, and is licensed as a physician pursuant to CRS 12-36-107.

provider who serves as a medical home for Accountable Care Collaborative (ACC) Members. A PCMP may be a federally qualified health center, regional health center, clinic or other group practice that provides the majority of an ACC Member's comprehensive primary, preventive and sick care. A PCMP may also be individual or pods of PCMPs that are physicians, advanced practice nurses or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

Primary Care Physician (PCP). A physician who provides the majority of a Colorado Medicaid client's primary care.

Residential Child Care Facility (RCCF). A facility licensed to provide twenty-four-hour group care and treatment for five or more children operated under private, public, or nonprofit sponsorship. RCCF includes community-based residential child care facilities, shelter facilities, and therapeutic residential child care facilities as defined in rule by the state board, and psychiatric residential treatment facilities as defined in CRS 25.5-4- 103 (19.5). A RCCF may be eligible for designation by the executive director of the state department pursuant to Article 65 of Title 27, C.R.S.

Residential Treatment. A short-term residential treatment program offering 24-hour intensive residential treatment, habilitative, and rehabilitative services for up to 30 days in a highly structured, community-oriented environment.

State Fiscal Year (SFY). July 1 – June 30.

Targeted Case Management. Medically necessary coordination and planning services provided with or on behalf of a client with a substance use disorder diagnosis.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Information Office General Eligibility Rules, Sections 8.100.1 and 8.100.3
Rule Number:	MSB 15-07-08-A
Division / Contact / Phone:	Eligibility Division / Geoffrey Oliver / 303-866-2686

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 15-07-08-A, Revision to the Medical Assistance Health Information Office General Eligibility Rules, Sections 8.100.1 and 8.100.3
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.1 and 8.100.3, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace all current text beginning at §8.100.1 Definitions through the end of the last unnumbered paragraph in that section that begins with "VA - Veterans Affairs is The Department…" with the new text provided.

Replace all current text beginning at §8.100.3.A through the end of §8.100.3.A.11 with the new text provided.

Replace current at beginning at §8.100.3.D.1 with the new text provided.

Replace all current text beginning at §8.100.3.G.2.a. through the end of the table following §8.100.3.G.3.d.ii) with the new text provided.

Replace current text from §8.100.3.H.9.a. through the end of the table following §8.100.3.H.9.b.ii. with the new text provided.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Replace current text beginning at §8.100.3.J.2 through the end of §8.100.3.J.3 with the new text provided.

Replace current text beginning at §8.100.3.K.6 with the new text provided beginning at §8.100.K.6 through the end of §8.100.3.K.6.b..

Replace current text beginning at §8.100.3.K.8.b through the end of §8.100.3.K.8.b.i)1) with new text provided.

Replace current text at §8.100.3.K.10 through the end of §8.100.3.K.10.a.i)1) with the new text provided.

Replace current text beginning at §8.100.3.N.7 through the end of §8.100.3.N.7.h with the new text provided beginning at §8.100.3.N.7 through the end of §8.100.3.N.7.i.

All text indicated in blue is for clarification purposes only and should not be changed. All text not included in this document should remain as is with no changes. This revision is effective 10/30/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Information Office General Eligibility Rules, Sections 8.100.1 and 8.100.3
Rule Number:	MSB 15-07-08-A
Division / Contact / Phone:	Eligibility Division / Geoffrey Oliver / 303-866-2686

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule change is to incorporate revisions mandated by Executive Order D 2012-002 (EO 2), as codified at Section 24-4-103.3 CRS (2014). The governor has issued and an Executive Order which requires state agencies to review state rules every five years to ensure rules are effective, efficient and essential. A regulatory review is solely for the purpose of identifying those rules which are duplicative, overlapping, outdated and inconsistent. The Colorado Benefits Management System (CBMS) does not need to be updated for sections 8.100.1 and 8.100.3 since all CBMS algorithms are in alignment with our federal regulations.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR §435.949, 42 CFR §435.603, 42 CFR §435.907, 42 CFR §431.305, 42 CFR §435.4, 26 USC §131, and IRS Notice 2014-7.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   Executive Order D 2013-002 (EO 2), as codified at section 24-4-103.3 C.R.S. (2014);
   25.5-4-104 C.R.S. (2014).

Initial Review	**08/14/2015**	Final Adoption	**09/11/2015**
Proposed Effective Date	**11/1/2015**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Information Office General Eligibility Rules, Sections 8.100.1 and 8.100.3
Rule Number:	MSB 15-07-08-A
Division / Contact / Phone:	Eligibility Division / Geoffrey Oliver / 303-866-2686

REGULATORY ANALYSIS

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

   The proposed rule will impact all Medical Assistance covered groups. The benefit to the proposed langue is to eliminate duplicative, overlapping, outdated and inconsistent rules.

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

   To achieve regulatory review goals, sections 8.100.1 and 8.100.3 has been revised and updated to assure state rules are current and are in alignment with federal regulations. This will have a positive impact on all Medical Assistance covered groups by eliminating any confusion on duplicative, overlapping, outdated and inconsistent rules.

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

   While the majority of the changes provide clarifying language that codifies current practice, and subsequently have no fiscal impact, two changes have a potential to increase state expenditures; specifically, changes in treatment of home care allowance income and treatment of business expenses effectively expand Medicaid eligibility under very specific circumstances. However, the Department anticipates a de minimus increase in caseload as a result of the rule change would only occur when an individual received enough income from these sources to put them over income for Medicaid eligibility previously, but that they would fall under income after the rule change was implemented. Given the sources of income and type of business expenses in question, such cases should be relatively rare and will not drive a significant fiscal impact.

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

   Proposed changes with associated costs are required for compliance with federal regulations; inaction is not a viable option.

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

Proposed changes with associated costs are required for compliance with federal regulations; alternative methods are not available.

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

   There are no alternative methods for the proposed rules the Department considered.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community Spouse is the spouse of an institutionalized spouse.

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

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

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

Dependent Cchild is defined in this volume as a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 19, a full-time student, and expected to graduate by age 19. residing in the home or between the ages of 18 and 19 who is a full-time student in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19.

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

Difficulty of Ccare Ppayments is a payment to an individual as compensation for providing additional care to an individual who qualifies for foster care and lives in the home of the care provider. This additional care must be e State must determine that the care required is due to a physical, mental, or emotional handicap suffered by the foster care individual.

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

Dual Eeligible clients are Medicare beneficiaries who are also eligible for Medical Assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MAGI-equivalent Equivalent is the resulting standard identified through a process that converts a state's net-income standard to equivalent MAGI standards.

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

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

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

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

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

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

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

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

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

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

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

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

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 185% FPL, including women who are 60 days post-partum.

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

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

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

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

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

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

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

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

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

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

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a General Educational Development (GED) certificateHigh School Equivalency Diploma (HSED).

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

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

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

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

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

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

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

TANF - Temporary Aassistance to Nneedy Ffamilies is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. The program began on July 1, 1997, and succeeded the Aid to Families with Dependent Children program. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

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

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

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

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

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

ULTC 100.2 is an assessment tool used to determine level of functional limitation and eligibility for Long-Term Care services in Colorado.

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

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

8.100.3. Medical Assistance General Eligibility Requirements [Eff. 03/30/2009]

8.100.3.A. Application Requirements

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

2. If the applicant applied for Medical Assistance on the Single Streamlined Application and was found ineligible, this application shall be reviewed for all other Medical Assistance eligibility programs, the Child Health Plan Plus (CHP+) program and premium and cost-sharing assistance for purchasing private health insurance through the state insurance marketplace.

    a. The application data and verifications shall be automatically transferred to the state insurance marketplace through a system interface when applicants are found ineligible for Medical Assistance eligibility programs. If an individual is pending for a Non-MAGI Medical Assistance eligibility program but has been found financially ineligible for MAGI Medical Assistance eligibility programs, the application data and verifications shall be transferred to the state insurance marketplace.

~~3. The applicant must sign the application form, give declaration in lieu of a signature by telephone, or may opt to use an electronic signature in order to receive Medical Assistance.~~

~~4~~3. Persons applying ~~to the eligibility site~~ for assistance need complete only one application form to apply for both Medical Assistance and Financial Assistance under the Federal or State Financial Assistance Programs administered in the county. The application will be the Application for Public Assistance.

~~5~~4. If an applicant is found to be ineligible for a particular program, the Application for Public Assistance shall be reviewed and processed for other financial programs the household has requested on the Application for Public Assistance and all other Medical Assistance Programs. Referrals to other community agencies and organizations shall be made for the applicant whenever available or requested.

5. The applicant must sign the application form, give declaration in lieu of a signature by telephone, or may opt to use an electronic signature in order to receive Medical Assistance.

~~8~~6. A family member, adult in the applicant's Medical Assistance Required Household or authorized representative may submit an application and request assistance on behalf of an applicant.

~~6~~7. If the applicant is not able to participate in the completion of the application forms because they are a minor (as defined in C.R.S. § 13-22-101) ~~,~~ or due to physical or mental incapacity, the spouse, other relative, friend, or representative acting responsibly on behalf of the applicant may complete the forms. When no such person is available to assist in these situations, the eligibility site shall assist the applicant in the completion of the necessary forms. This type of situation should be identified clearly in the case record.

~~7~~8. For the purpose of Medical Assistance, when an applicant is incompetent or incapacitated and unable to sign an application, or in case of death of the applicant, the application shall be signed, under penalty of perjury, by someone acting responsibly on behalf of the applicant either:

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

b. For a person in a medical institution for whom none of the above in ~~A~~ 8.a. are available, an authorized official of the institution may sign the application.

~~8. Any family member or specified representative may submit an application and request assistance on behalf of an applicant.~~

9. Application interviews or requested visits to the eligibility site for Medical Assistance shall not be required. All correspondence may occur by mail, email or telephone.

10. During normal business hours, eligibility sites shall not restrict the hours in which applicants may file an application. The eligibility site must afford any individual wishing to do so the opportunity to apply for Medical Assistance without delay.

11. The applicant has the right to withdraw his or her application at any time. ~~Each person's household composition shall be calculated separately under the MAGI category rules. Each MAGI Medical Assistance Household shall be budgeted using the appropriate need standard/income level for that unit. See section 8.100.4.E for more information on MAGI household composition.~~

8.100.3.D. Processing Requirements

1. The eligibility site shall process a Ssingle Sstreamlined Aapplication for Medical Assistance Program benefits within the following deadlines:

   a. 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.

   b. 45 days for all other Medical Assistance Program applicants.

   c. The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.

   d. In unusual circumstances, documented in the case record and in CBMS case comments, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or an administrative or other emergency beyond the agency's control.

2. Upon request, applicants will be given an extension of time within the application processing timeframe to submit requested verification. Applicants may request an extension of time beyond the application processing timeframe to obtain necessary verification. The extension may be granted at the eligibility site's discretion. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

3. The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.

4. For clients who apply for the Medical Assistance Program and a disability determination is required, the eligibility site shall send a notice informing the applicant of the reason for a delay beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay. The eligibility site shall send this notice no later than 91 days following the application for the Medical Assistance Program.

5. For information regarding continuation of benefits during the pendency of an appeal to the Social Security Administration (SSA) based upon termination of disability benefits see section 8.057.5.C.

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

7. Eligibility sites at which an individual is able to apply for Medical Assistance benefits shall also provide the applicant the opportunity to register to vote.

   a. The eligibility site shall provide to the applicant the prescribed voter registration application.

   b. The eligibility site shall not:

i) Seek to influence the applicant's political preference or party registration;

ii) Display any political preference or party allegiance;

iii) Make any statement to the applicant or take any action, the purpose or effect of which is to discourage the applicant from registering to vote; and

iv) Make any statement to an applicant which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

c. The eligibility site shall ensure the confidentiality of individuals registering and declining to register to vote.

d. Records concerning registration and declination to register to vote shall be maintained for two years by the eligibility site. These records shall not be part of the public assistance case record.

e. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the eligibility site is located not later than ten (10) days after the date of acceptance; except that if a registration application is accepted within five (5) days before the last day for registration to vote in an election, the application shall be transmitted to the county clerk and recorder for the county not later than five (5) days after the date of acceptance.

8. Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote in the new county of residence. The new county of residence shall follow the above procedure. The new county of residence shall notify its county clerk and recorder of the client's change in address within five (5) days of receiving the information from the client.

8.100.3.G. General and Citizenship Eligibility Requirements

1. To be eligible to receive Medical Assistance, an eligible person shall:

   a. Be a resident of Colorado;

   b. Not be an inmate of a public institution, except as a patient in a public medical institution or as a resident of an Long Term Care Institution or as a resident of a publicly operated community residence which serves no more than 16 residents;

   c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

   d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;

   e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;

   f. Meet all other requirements of the Medical Assistance Program for which application is being made; and

   g. Fall into one of the following categories:

      i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or

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

      iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:

         1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");

         2) paroled into the United States for at least one year under section 212(d)(5) of the INA; or

         3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

         4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. sec. 1641, has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or

5) lawfully admitted for permanent residence under the INA with 40 qualifying quarters as defined under Title II of the Social Security Act. 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

6) The statutes and acts listed at 8.100.3.G.1.g.iii.1 through 8.100.3.G.1.g.iii.5 are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

7) 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 for seven years after the date of entry into the United States; or

d) refugee under section 207 of the INA for seven years after the date of entry into the United States; 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 for seven years after the date of entry into the United States; 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; 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); 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) for seven years after the date of entry into the United States; or

i) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict; 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; or

k) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA for seven years after the date of entry into the United States; or

l) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA for seven years after the date of entry into the United States.

m) The statutes and acts listed at 8.100.3.G.1.g.iii.7.c through 8.100.3.G.1.g.iii.7.l are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

iv) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergency medical care only. The rules on confidentiality prevent the Department or eligibility site from reporting to the United States Citizenship and Immigration Services persons who have applied for or are receiving assistance. These persons need not select a primary care physician as they are eligible only for emergency medical services.

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

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

1) placing the patient's health in serious jeopardy;

2) serious impairment of bodily function; or

3) serious dysfunction of any bodily organ or part.

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

2. For determinations of eligibility for Medical Assistance, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 8.100.3.G(1)(g)(ii) or (iii) and has declared that he or she has a legal immigration status.

a. ~~An electronic interface with a federally approved electronic data source will be used to verify legal immigration status.~~

~~b.~~ The Verify Lawful Presence (VLP) interface ~~is an acceptable interface~~will be used to verify immigration status. The VLP interface connects to the ~~Department of Homeland Securities~~ Systematic Alien Verification for Entitlements (SAVE) Program. The VLP interface has three steps to verify legal immigration status.

i) An automated response from VLP confirms that the ~~data~~ information submitted is consistent with VLP data for immigration status verification requirements. No further action is required for the individual and no additional documentation of immigration status is required. If Step 1 does not verify the legal immigration status of the individual and the VLP interface indicates additional information is required, Step 2 will automatically be initiated.

ii) Step 2: A response from the VLP interface confirms that the information submitted verifies the legal immigration status of the individual. No further action is required for the individual and no additional documentation of immigration status is required. If Step 2 does not verify the legal immigration status of the individual and the VLP interface indicates additional information is required Step 3 will automatically be initiated.

iii) Step 3: The individual will be contacted by a state appointed designee with a request for additional documents and/or information needed to verify their legal immigration status through the VLP interface. A response from the VLP interface confirms that the documents and/or information received from the individual verifies their legal immigration status. No further action is required for the individual and no additional documentation of immigration status is required.

3. Reasonable Opportunity Period

a. If the verification through Step 1 of the electronic interface is unsuccessful then the applicant will be provided a reasonable opportunity period, of 90 calendar days, to submit documents indicating a legal immigration status. The reasonable opportunity period will begin as of the date of the N~~n~~otice of A~~a~~ction. The required documentation must be received within the reasonable opportunity period.

b. If the verification through Step 2 of the electronic interface is unsuccessful and Step 3 is initiated, the reasonable opportunity period will be reset to 90 calendar days which will commence on the date of the failure of Step 2.

~~b~~c. If the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

~~c~~d. The reasonable opportunity period ~~is 90 calendar days and~~ applies to MAGI, Adult and Buy-In Programs.

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

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

~~d.~~ii) ~~The reasonable opportunity period is 90 calendar days; and applies to Adult Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715.~~ For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715. ~~include~~ the following:

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

8.100.3.H. Citizenship and Identity Documentation Requirements

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

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

      i) SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity

verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.

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

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

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

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

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

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

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

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

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

2) Special Provisions for Retroactive Reversal of a Previous Denial

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

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

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

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

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

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

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

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

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

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

1) includes the applicant or recipient, and

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

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

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

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

1) Special Provisions for Retroactive Reversal of a Previous Denial

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

(1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity

documentation requirements as they existed during that period;

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

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

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

b. Secondary Evidence of Citizenship. If primary evidence from the list in 8.100.3.H.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 the documents listed in section 8.100.3.H. 3. to establish identity. Secondary evidence of citizenship includes:

i) A U.S. public birth certificate.

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

a) One of the 50 States,

b) The District of Columbia,

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

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

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

f) American Samoa,

g) Swain's Island, or

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

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

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

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

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

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

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

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

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

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

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

viii) A final adoption decree that:

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

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

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

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

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

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

material that has been incorporated by reference in this rule may be examined at any state publications repository library.

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

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

2) The child is under the age of 18;

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

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

5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

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

i) Extract of a hospital record on hospital letterhead.

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

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

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

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

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

ii) Life, health, or other insurance record.

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

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

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

iii) Religious record.

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

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

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

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

iv) Early school record that meets the following criteria:

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

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

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

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

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

d. Fourth Level Evidence of Citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence shall only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained within 10 business days, and the applicant alleges U.S. citizenship. The affidavit process described in 8.100.3.H.2.d.ii.~~5~~v. may be used by U.S. citizens or nationals born inside or outside the U.S. In addition, a second document establishing identity shall be presented as described in 8.100.3.H.3.

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

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

1) Seneca Indian tribal census record;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 8.100.3.H.3. to establish identity shall also be presented.

i) Puerto Rico:

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

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

ii) US Virgin Islands:

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

2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

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

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

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

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

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

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

f) Referrals for Colorado Birth Certificates

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

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

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

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

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

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

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

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

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

iii) All documents used must contain consistent identifying information.

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

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

i) Clinic, doctor, or hospital records; or

ii) School records.

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

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

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

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

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

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

d) The affidavit is not required to be notarized.

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

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

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

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

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

3) The affidavit is not required to be notarized.

k) Expired identity documents.

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

l) Referrals for Colorado Identification Cards

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

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

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

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

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

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

4. Documentation Requirements

a. Effective January 1, 2008, all citizenship and identity documents must either be originals or copies certified by the issuing agency, except as provided in 8.100.3.H.4.b. Uncertified copies, including notarized copies, are not acceptable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Record Retention Requirements

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

6. Name Change Provisions

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

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

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

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

7. Reasonable Level of Assistance

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

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

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

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

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

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

8. Individuals Requiring Additional Assistance

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

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

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

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

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

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

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

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

9. Reasonable Opportunity Period

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

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

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

Commonly Used Program Name	Rule Citation
Parent and Caretaker Relative Medical Assistance Children's Medical Assistance	8.100.4.G.38.100.4.G.2
Transitional Medical Assistance Parent and Caretaker Relative Medical Assistance	8.100.4.I.1-58.100.4.G.3
Children's Medical AssistanceAdult Medical Assistance	8.100.4.G.28.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Adult Medical Assistance Transitional Medical Assistance	8.100.4.G.48.100.4.I.1-5

c. ii) The reasonable opportunity period is 90 calendar days; and applies to Adult Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715. For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715 include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Breast and Cervical Cancer Program (BCCP) Medicaid Buy-In Program for Working Adults with Disabilities	8.7158.100.6.P

~~Medicaid Buy-In Program for Working Adults with Disabilities~~ Medicaid Buy-In Program for Children with Disabilities	~~8.100.6.P~~8.100.6.Q
~~Medicaid Buy-In Program for Children with Disabilities~~Breast and Cervical Cancer Program (BCCP)	~~8.100.6.Q~~8.715

10. Good Faith Effort

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

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

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

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

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

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

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

1. Persons who may be eligible for benefits under either MAGI Medical Assistance or SSI:

   a. shall be advised of the benefits available under each program;

   b. may apply for a determination of eligibility under either or both programs, 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 advantageous to receive benefits from the other program.

2. Any family member who is receiving financial assistance from SSI or OAP-A is not considered a member of the Medical Assistance required household, is not counted as a member of the household, and the individual's income and resources are disregarded in making the determination of need for Medical Assistance.

   a. Exception: For MAGI Medical Assistance a family member who is receiving SSI, when appropriate can be counted as a member of the household and their income when appropriate can be considered in making the determination of eligibility for MAGI Medical Assistance. For treatment of income and household construction for MAGI Medical Assistance cases, see section 8.100.4.

3. An individual receiving Aid to the Needy Disabled (AND) may also receive MAGI Medical Assistance~~. An AND recipient shall be eligible for MAGI Medical Assistance~~, if the recipient meets ~~all~~ the eligibility requirements ~~of~~ for MAGI Medical Assistance. For these individuals, eligibility sites shall not include the applicant's AND payment when calculating ~~as unearned~~ income to determine the household's financial eligibility for MAGI Medical Assistance.~~the Medical Assistance required household along with all other income. If the AND individual's AND payment and other income makes the Medical Assistance required household ineligible, eligibility sites shall disregard the AND individual and give the remaining members MAGI Medical Assistance as long as they meet the income requirements for the appropriate MAGI Medical Assistance category.~~

8.100.3.K. Consideration of Income

1. Income or resources of an alien sponsor or an alien sponsor's spouse shall be countable to the sponsored alien effective December 19, 1997. Forms used prior to December 19, 1997, including but not limited to forms I-134 or I-136 are legally unenforceable affidavits of support. The attribution of the income and resources of the sponsor and the sponsor's spouse to the alien will continue until the alien becomes a U.S. citizen or has worked or can be credited with 40 qualifying quarters of work, provided that an alien crediting the quarters to the applicant/client has not received any public benefit during any creditable quarter for any period after December 31, 1996.

2. Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.

3. Earned income is payment in cash or in kind for services performed as an employee or from self-employment.

4. Earned in kind income shall be income produced as a result of the performance of services by the applicant/client, for which he/she is compensated in shelter or other items in lieu of wages.

5. Received means "actually" received or legally becomes available, whichever occurs first; the point at which the income first is available to the individual for use. For example, interest income on a savings account is counted when it is credited to the account.

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

   a. Exception: When a HCA recipient lives in the home of the Medical Assistance applicant/client, HCA ~~income paid~~payments made to the ~~a~~ Medical Assistance applicant/client ~~by the~~ for providing home care services to the HCA recipient ~~to provide home care services~~ is not countable income for the purpose of calculating the ~~MAGI~~ Medical Assistance applicant/client's MAGI-based income. ~~when the HCA recipient lives in the home of the Medical Assistance applicant/client.~~

   b. This exception does not apply ~~if~~when the Medical Assistance applicant/client receives HCA and/or difficulty of care foster care payments for caring for more than 10 individuals under the age of 19, or for more than 5 individuals age 19 or older. Under such circumstances, income derived from HCA and/or difficulty of care payments is countable as earned income.~~is caring for more than 10 individuals receiving HCA and/or difficulty of care foster care payments under the age of 19; or for more than 5 individuals receiving HCA and/or difficulty of care foster care payments age 19 or older.~~

7. Participation in the Workforce Investment Act (WIA) affects eligibility for Medical Assistance as follows:

   a. Wages derived from participation in a program carried out under WIA (work experience or on-the-job training) and paid to a caretaker relative is considered countable earned income.

   b. Training allowances granted by WIA to a dependent child or a caretaker relative of a dependent child to participate in a training program is exempt.

c. Wages derived from participation in a program carried out the under Workforce Investment Act (WIA) and paid to any dependent child who is applying for or receiving Medical Assistance are exempt in determining eligibility for a period not to exceed six months in each calendar year.

8. An individual involved in a profit making activity as a sole proprietor, partner in a partnership, independent contractor, or consultant shall be classified as self-employed.

a. To determine the net profit of a self-employed applicant/client deduct the cost of doing business from the gross income. These business expenses include, but are not limited to:

i) the rent of business premises,

ii) wholesale cost of merchandise,

iii) utilities,

iv) taxes,

v) labor, and

vi) upkeep of necessary equipment.

b. The following are not allowed as business expenses:

i) Depreciation of equipment;

1.) Exception: For the purpose of calculating MAGI-based income, depreciation of equipment is an allowable business expense if the equipment is not used for capital improvements. ~~Depreciation of equipment is an allowable business expense for MAGI Medical Assistance so long as the equipment is not used for capital improvements.~~

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

iii) Personal expenses such as personal income tax payments, lunches, and transportation to and from work.

c. Appropriate allowances for cost of doing business for Medical Assistance clients who are licensed, certified or approved day care providers are (1) $ 55 for the first child for whom day care is provided, and (2) $ 22 for each additional child. If the client can document a cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.

d. When determining self employment expenses and distinguishing personal expenses from business expenses it is a requirement to only allow the percentage of the expense that is business related.

9. Self-employment income includes, but is not limited to, the following:

a. Farm income - shall be considered as income in the month it is received. When an individual ceases to farm the land, the self-employment deductions are no longer allowable.

b. Rental income - shall be considered as self-employment income only if the Medical Assistance client actively manages the property at least an average of 20 hours per week.

c. Board (to provide a person with regular meals only) payment shall be considered earned income in the month received to the extent that the board payment exceeds the maximum food stamp allotment for one-person household per boarder and other documentable expenses directly related to the provision of board.

d. Room (to provide a person with lodging only) payments shall be considered earned income in the month received to the extent that the room payment exceeds documentable expenses directly related to the provision of the room.

e. Room and board payments shall be considered earned income in the month received to the extent that the payment for room and board exceeds the food stamp allotment for a one-person household per room and boarder and documentable expenses directly related to the provision of room and board.

10. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes, but is not limited to, the following:

a. Pensions and other period payments, such as:

i) Private pensions or disability benefits

1.) Exception: Refer to section 8.100.4 for treatment of private disability benefits for MAGI Medical Assistance.

ii) Social Security benefits (Retirement, survivors, and disability)

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).

vii) Alimony and support payments

viii) Interest, dividends and certain royalties on countable resources

8.100.3.N. Confidentiality

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

2. A signature on the Single Streamlined Application and the Application for Public Assistance allows an eligibility site worker to consult banks, employers, or any other agency or person to obtain information or verification to determine eligibility. The identification of the worker as an eligibility site employee will, in itself, disclose that an application for the Medical Assistance Program has been made by an individual. In this type of contact, as well as other community contacts, the eligibility site should strive to maintain confidentiality. The signature on the Single Streamlined Application and the Application for Public Assistance also provides permission for the release of the client's medical information to be provided by health care providers to the State and its agents for purpose of administration of the Medical Assistance Program.

3. Eligibility site staff may release a client's Medical Assistance state identification number and approval eligibility spans to a Medical Assistance provider for billing purposes.

   Eligibility site staff may inform a Medical Assistance provider that an application has been denied but may not inform them of the reason why.

4. Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State and the eligibility site.

5. The eligibility site must obtain permission from a family, individual, or authorized representative, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of Medical Assistance payment. This permission must be obtained unless the request is from State authorities, federal authorities, or State contractors acting within the scope of their contract. If, because of an emergency situation, time does not permit obtaining consent before release, the eligibility site must notify the family or individual immediately after supplying the information.

6. The eligibility site policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials. If a court issues a subpoena for a case record or for any eligibility site representative to testify concerning an applicant or recipient, the eligibility site must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

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

   a. Names and addresses of applicants for and recipients of the Medical Assistance Program;

   b. Medical services provided;

   c. Social and economic conditions or circumstances;

   d. Agency evaluation of personal information;

   e. Medical data, including diagnosis and past history of disease or disability;

   f. All information obtained through the Income and Eligibility Verification System (IEVS), Colorado Department of Labor and Employment, SSA and~~or~~ Internal Revenue Service;

g. Any information received in connection with identification of legally liable third party resources;

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

i. Social Security Numbers.

8. The confidential information listed above may be released to persons outside the eligibility site only as follows:

a. In response to a valid subpoena or court order;

b. To State or Federal auditors, investigators or others designated by the Federal or State departments on a need-to-know basis;

c. To individuals executing Income and Eligibility Verification System;

d. Child Support enforcement officials;

e. To a recipient or applicant themselves or their designated representative.

f. To a Long Term Care institution on the AP-5615 form.

9. The applicant/recipient may give a formal written release for disclosure of information to other agencies, such as hospitals, or the permission may be implied by the action of the other agency in rendering service to the client. Before information is released, the eligibility site should be reasonably certain the confidential nature of information will be preserved, the information will be used only for purposes related to the function of the inquiring agency, and the standards of protection established by the inquiring agency are equal to those established by the State Department. If the standards for protection of information are unknown, a written consent from the recipient shall be obtained.

THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 15-07-08-B, Revision to the Medical Assistance Health Information Office Eligibility Rule Concerning MAGI Eligibility, §8.100.4
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.4, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date: 10/30/2015
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace all current text beginning at §8.100.4. through the end of §8.100.4.J.2.a.ii with the new text provided.

This revision is effective 10/30/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Information Office Eligibility Rule Concerning MAGI Eligibility, §8.100.4
Rule Number:	MSB 15-07-08-B
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 3038663558

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule change is to incorporate revision mandated by Executive Order D 2012-002 (EO 2), as codified at Section 24-4-103.3 CRS (2014). The governor has issued an Executive order which requires states agencies to review state rules every five years to ensure rules are effective, efficient and essential. A regulatory review is solely for the purpose of identifying those rules which are duplicative, overlapping, outdated and inconsistent. The Colorado Benefits Management System (CBMS) does not need to be updated for section 8.100.4 since all rules are in alignment with our federal regulations.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 435.603, 42 CFR § 435.910,42 CFR § 435.406-407, 42 CFR § 435.940, 42 CFR § 435.495, 42 CFR § 435.910, 42 CFR § 435.112, 42 CFR § 435.116-119, 42 CFR § 435.952, 42 CFR § 435.222, 42 CFR § 435.308, 42 CFR § 435.1109, 42 CFR § 435.145, 42 CFR § 435.965, 42 CFR § 435.1101, 42 USC § 1396 a(a)(10)(A)(i),(ii)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   § 25.5-4-104 C.R.S. (2014).

Initial Review	**08/14/2015**	Final Adoption	**09/11/2015**
Proposed Effective Date	**11/01/2015**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Information Office Eligibility Rule Concerning MAGI Eligibility, §8.100.4
Rule Number:	MSB 15-07-08-B
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 3038663558

REGULATORY ANALYSIS

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

   The proposed rule will impact all MAGI-covered groups such as children, adults and pregnant women eligible for Medical Assistance. The benefit to the proposed language updates is to eliminate duplicative, overlapping, outdated and inconsistent rules.

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

   To achieve regulatory review goals, section 8.100.4 has been revised and updated to assure state rules are current and are in alignment with federal regulations. This will have a positive impact on all MAGI-covered groups by eliminating any confusion on duplicative, overlapping, outdated and inconsistent rules.

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

   Of the proposed rule changes, only the change for Social Security Disability Insurance (SSDI) for children's eligibility is anticipated to drive additional costs. The Department estimates that between 40 and 50 children would gain eligibility as a result of this change in treatment of income, driving a fiscal impact of approximately $40,000 annually for Medical Assistance programs.

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

   The component of the rule changes driving fiscal impacts is federally required; no alternatives action is available.

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

   No alternative methodology for achieving federal compliance is available.

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

   There are no alternative methods for the proposed rule the Department considered.

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

8.100.4.A. MAGI Application Requirements

1. Persons requesting a MAGI Medical Assistance category need only to complete the Single Streamlined Application.

2. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults may apply for Medical Assistance at ~~eligibility~~ sites other than the County Department of Social Services, including eligibility sites and ~~C~~Certified Application Assistance Sites (CAAS). The Department shall approve these sites to receive and initially process these applications. The application used shall be the Single Streamlined Application. The eligibility site shall determine eligibility.

3. The eligibility sites shall refer Medical Assistance clients who are pregnant and/or age 20 and under to EPSDT offices (designated by the Department) by:

   a. ~~C~~Copying the page of the Single Streamlined Application that includes the EPSDT benefit questions. The eligibility site will then forward this page to the EPSDT office within five working days from the date of application approval; or by:

   b. Means of secure, electronic data transfer approved by the Department~~.~~

8.100.4.B. MAGI Category Verification Requirements

1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:

   a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number, or each shall submit proof of an application to obtain a Social Security Number. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number.

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

   c. Earned Income: Income shall be self-attested by an applicant and verified through an electronic data source. Individuals who provide self-attestation of income must also provide a Social Security Number for wage verification purposes.

      If earned income is not or cannot be ~~an applicant cannot provide verification through~~ self-attested~~ed~~ation~~~, it~~income~~ shall be verified by wage stubs, tax documents, written documentation from the employer stating the employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

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

d. Unearned income: Unearned income can be self--attested by an applicant. Certain types of unearned income, such as unemployment and survivor benefits may be verified through electronic data sources.

ed. Verification of Legal Immigrant Status: Immigrationnt status can be self-declared -by registration cards or papers, if applicable, shall be provided for an applicant applying for Medical Assistance, to determine if the household members are eligibleeligibilitye for full Medical Assistance benefits.. This declaration of legal immigration status will then -bemust be verified through the Verify Lawful Presence (VLP) interface.-. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) Pprogram and has three steps to verify legal immigration status. See section 8.100.3.G for these three steps. If status cannot be verified, or if the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements

2. Additional Verification: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

4. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.

5. The criteria of age, school attendance, and relationship can be declared by the client unless questionable. 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.

6. Establishing that a dependent child meets the eligibility criteriaion of:

   a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;

   b. school attendance, if questionable requires (1) obtaining confirmation from the school by phone or in writing, and (2) documenting the means of verification in the case file and CBMS case comments;

   cb. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.

8.100.4.C. MAGI Methodology for Income Calculation

1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon

request. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from all derived sources, The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:

a. Earned~~Gross~~ Income: ~~Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from whatever source derived, including (but not limited to) the following items:~~

i) Wages, salaries, tips;~~Compensation for services, including fees, commissions, fringe benefits and similar items;~~

ii) Gross income derived from business;

iii) Gains derived from dealings in property;

iv) Distributive share of partnership gross income (not a limited partner);

v) Compensation for services, including fees, commissions, fringe benefits and similar items;and~~.~~

vi) Taxable private disability income.

b. Unearned Income:

i~~v~~) Interest (includes tax exempt interest);

ii~~v~~) Rents;

iii~~vi~~) Royalties;

iv~~v~~ii~~)~~ Dividends;

iv~~viii~~) Alimony ~~-~~payments made directly to the household from a non-household member and separate maintenance payments;

vi~~ix~~) Pensions and a~~A~~nnuities;

vii~~x~~) Income from life insurance and endowment contracts;

~~xi) Pensions;~~

viii~~xii~~) Income from discharge of indebtedness;

~~xiii) Distributive share of partnership gross income;~~

~~viiii~~x~~xiv~~) Income in respect of a decedent; and

i~~x~~~~xv~~) Income from an interest in an estate or trust.

xi) Social Security (SSA) income

xii) Distributive share of partnership gross income (limited partner)

c~~b~~. Additional Income: In addition to the types of ~~gross~~ income identified in section 8.100.4.C.1.a~~-b.~~, the following income is included in the MAGI calculation. ~~if applicable~~:

i) Any tax exempt interest income

ii) Untaxed foreign wages and salaries

iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits)

dc. The following are Income exclusionseptions: There are three exceptions to gross income in the MAGI income calculation:

i) An amount received as a lump sum is counted as income only in the month received.

ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses.

iii) Child support received.

iv) Worker's Compensation.

v) Supplemental Security Income (SSI).

vi) Veteran's Benefits

vii) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e). 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

ed. Allowable Deductions: For an in depth treatment of allowable deductions from gross income, please refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request. The following deductions are allowed to be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income including (but not limited to):

i) Student loan interest deductions

ii) Certain Self- employment expenses (SEP, SIMPLE and qualified plans, and health insurance deductions)

iii) Deductible part of self-employment tax

iv) Health savings account deduction

v) Certain Business expenses of reservists, performing artist, and fee-basis government officials

vi) Certain reimbursed expenses of employees

vii) Moving expenses

viii) IRA deduction

ix) Penalty on early withdrawal

x) Domestic production activities deduction

xi) Alimony paid outside the home

f. Income of children and tax dependents:

i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income sufficient to require that the child file a tax return.

1) Income from ~~t~~Title II ~~s~~Social ~~s~~Security benefits and ~~t~~Tier I ~~r~~Railroad benefits are excluded when determining if a child is required to file taxes.

ii) The income of a person, other than a child or spouse, who expects to be claimed as a tax dependent will not be included in the household income of the taxpayer unless that tax dependent has income sufficient to require that the tax dependent file a tax return.

1) Income from ~~t~~Title II ~~s~~Social ~~s~~Security benefits and ~~t~~Tier I ~~r~~Railroad benefits are excluded when determining if a tax dependent is required to file taxes.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see ~~refer to~~ section 8.100.3.H.9.

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

i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 10%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall be determined ineligible due to income.

b. If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data

source, a reasonable explanation of the discrepancy shall be requested. If the applicant is unable to provide a reasonable explanation, paper documentation shall be requested.

i) The Department may request paper documentation only if the Department does not find income to be reasonably compatible and if the applicant does not provide a reasonable explanation or if electronic data are not available.

3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application.~~Medical Assistance application~~ shall be sufficient verification of earnings, unless questionable.

4. Budget Periods for MAGI-based Income determination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.

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

8.100.4.D. Income Disregard

1. ~~Household income is calculated by including the MAGI-based~~ countable ~~income of those~~every ~~individuals~~ in the household, ~~minus an amount equivalent to five percentage points of the Federal Poverty Level for the applicable family size. The income disregard is only applied when the individual would otherwise not be eligible for Medical Assistance due to excess income.. This five percent (5%) disregard is applied~~ the following ~~for each of the four MAGI programs: Parents and Caretaker Relatives, Pregnant Women, Children and Adults.~~ An income disregard equivalent to five percentage points of the Federal Poverty Level for the applicable family size will be subtracted from MAGI-based income.

   a. If an individual's ~~countable~~MAGI-based countable income is above the income threshold for the applicable MAGI program under title XIX (Medicaid) or title XXI (CHP+) of the Social Security Act, the five percent (5%) disregard will be applied for each qualifying MAGI program as the last step ~~in~~to determin~~ing~~e eligibility.

   b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be appl~~y~~ied ~~in~~ to determin~~ing~~e eligibility.

8.100.4.E. Determining MAGI Household Composition.

1. MAGI household composition is similar to, but not necessarily the same as ~~one's~~a tax household. To determine MAGI household composition, ~~t~~The individual's relationship to the tax filer ~~and~~ must be established as declared on the Single Streamlined Application. ~~is determined by relationships of tax dependency as declared on the Single Streamlined Application.~~

   a. In the case of an applicant who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and does not expect to be claimed as a tax dependent by anyone else, then the applicant's MAGI household shall consist of the following:

      i) The Tax-Filer;

ii) The Tax-Filer's spouse if living in the home;

iii) All persons whom the Tax-Filer expects to claim as a tax dependent on their personal income tax return

b. In the case of an applicant who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, ~~than the. The~~ applicant's MAGI household shall be ~~the household of the taxpayer claiming that applicant as a tax dependent, except in the following circumstances~~:

i) The Tax Dependent;

ii) The Tax-Filer and ~~'s~~ their spouse if living in the home;

iii) The Tax-Filer's other tax dependents;

iv) The Tax Dependent's spouse, if living with the Tax Dependent.

c. The MAGI household of an applicant who expects to be claimed as a tax dependent is as outlined in 8.100.4.E.b above, except in the following circumstances:

i) The applicant expects to be claimed as a tax dependent by~~of~~ someone other than a spouse, biological, adoptive or step parent.

ii) The applicant is a child under 19 who is expected to be claimed by one parent as a tax dependent and is living with both parents, but the parents do not expect to file a joint tax return.

iii) The applicant is a child under 19 and who expects to be claimed ~~by~~ as a tax dependent by a ~~non-custodial~~ parent.

d~~c~~. If the applicant meets one of the exceptions in 8.100.4.E.c above or is a ~~Non~~non-~~Filer~~filer, household composition shall be determined using the following ~~Non~~non-~~Filer~~ filer rules and the applicant's household shall consist of the following:

i) The applicant;

ii) The applicant's spouse who lives in the household~~, if not living separately~~;

iii) The applicant's natural, adopted, and step children under the age of 19, who live in the household~~if not living separately~~; and

iv) In the case of applicants under the age of 19, the applicant's natural, adoptive, and step parents and natural, adoptive, and step siblings under age 19, who live in the household~~if not living separately~~.

2. When ~~calculating the composition of a MAGI~~ a h~~H~~ousehold ~~which~~ includes a pregnant wom~~e~~an~~-~~, regardless of the ~~for all~~ Medical Assistance categor~~y~~,~~ies~~ ~~the~~ the pregnant wom~~e~~an is counted as herself plus the ~~shall include the~~ number of ~~unborn~~ child~~ren~~(ren) she is expected to deliver. ~~as a child(ren) living in the home. for the purposes of determining eligibility. However, Medical Assistance is not available for an~~to the unborn child, but only ~~for~~to the pregnant ~~women~~mother.

3. Medical Assistance is available to the father of an unborn child under the Adult MAGI category when there are no other children in the household.

4. Dependent children are eligible through the end of the month in which they turn 19 years old.

5. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even 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 home as of the time the foster care plan is changed.

63. Married couples living together will each be included in the other's MAGI household regardless of whether or not they expect to file taxes jointly, separately or if one expects to be claimed as a tax dependent of the other.

74. If a child is claimed as a tax dependent by hisboth parents who are married and who will file taxes jointly but one parent lives outside of the household due to separation or pending divorce, the child's household composition is determined by non-filer rules. The parent living outside of the household will not be counted as part of the household.

85. An individual who is both a tax dependent and a tax filer will be considered a tax dependent for the purpose of determining eligibility for Medical Assistance.

8.100.4.F. MAGI Category Presumptive Eligibility

1. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medical Assistance presumptive eligibility sites. A child under the age of 19nineteen may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites.

2. To be eligible for presumptive eligibility:

   a. a pregnant woman shall have an attested pregnancy, declare that her household's income shall not exceed 185% of the federal poverty level (MAGI-equivalent) and declare that she is a United States citizen or a documented immigrant. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website.

   b. a child under the age of 19 shall have a declared household income that does not exceed 133% of federal poverty level (MAGI-equivalent) and declare that the child is a United States citizen or a documented immigrant. of at least five years.

3. Presumptive eligibility sites shall be certified by the Department to make presumptive eligibility determinations. Sites shall be re-certified by the Department every 2 years to remain approved presumptive eligibility sites.

~~4. The presumptive eligibility sites shall attempt to obtain all necessary documentation to complete the application within fourteen calendar days of application.~~

~~5~~4. 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.~~

~~6~~5. The presumptive eligibility period begins on the date the applicant is determined eligible ~~-~~and ends with the earlier of:

a. The day an eligibility determination for Medical Assistance is made for the applicant(s); or

b. The last day of the month following the month in which a determination for presumptive eligibility was made.

~~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 Medical Assistance eligibility determination within 45 days from receipt of the application. The effective date of Medical Assistance eligibility shall be the date of application.~~

~~7~~6. A presumptive eligible client may not appeal the end of a presumptive eligibility period.

~~8~~7. Presumptively eligible women and Medical Assistance clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in the State Hearings section of this volume.

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website.

a. ~~Medical Assistance eligibility is guaranteed for 12 continuous months from the application month regardless of changes in income or household size.~~ Children are eligible for Children's MAGI Medical Assistance through the end of the month in which they turn 19 years old. After turning 19, the individual may be eligible for a different Medical Assistance category.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 60% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household receiving Medical Assistance.

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

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

ii) Legal custody is held by an agency that does not have physical possession of the child;

iii) The child is in regular attendance at a school away from home;

iv) Either the child or the relative is away from the home to receive medical treatment;

v) Either the child or the relative is temporarily absent from the home;

vi)~~.~~ The child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.

4. ~~Effective January 1, 2014,~~ Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level (MAGI-equivalent) ~~-~~are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage ~~must~~ will be provided regardless of changes in the woman's financial circumstances.

6. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for Medical Assistance if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.6~~3~~. This population is referred to as Legal Immigrant Prenatal.

7. A child ~~born to a~~ whose mother ~~woman~~ is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as “Eligible Needy Newborn”. This ~~provision~~ coverage also applies in instances wher~~e~~n the mother ~~woman~~ received Medical Assistance to cover the child’s birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

a. To receive Medical Assistance under this category, the birth must be reported ~~,~~verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby’s name~~-~~, date of birth, and mother’s name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother’s Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, t~~Please review the Department User Reference Guide for the timeline. T~~he newborn’s agent ~~individua~~l ~~-~~does not need to ~~not~~ file an application ~~n~~or provide a S~~s~~ocial S~~s~~ecurity N~~n~~umber or proof of

application for a Ssocial Ssecurity Nnumber for the newborn~~. Anyone can report the birth of the baby verbally or in writing. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time. Once reported, a newborn meeting the above criteria shall be added to the Medical Assistance case according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes. This population is referenced as Eligible Needy Newborn.~~

8.100.4.H. Needy Persons

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

   a. Those receiving care in a Long Term Care Institution eligible for Medical Assistance reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement and whose household income is less than the MAGI needs standard for his/her family size when the client applies for assistance. Clients that are receiving benefits under this category and are still receiving active inpatient treatment in the facility at age 21 shall be eligible to age 22. This population is referenced as Psych <21.

   b. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. A child shall be the responsibility of the county, even if the child may be in a medical institution at that time. See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR § 2509-1). 12 CCR § 2509-1 (2013) is hereby incorporated by reference. The incorporation of 12 CCR § 2509-1 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

   c. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.

   d. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose household income is less than the MAGI needs standard for his/her family size.

   e. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.

   f. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medical Assistance for the child.

   g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments

from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the date the individual attained 18 years of age or was emancipated. Eligibility shall be extended until the individual's 21st birthday for these individuals with the exception of those receiving subsidized adoption payments.

2. Medical Assistance shall be extended to certain needy persons until the end of the month of the individual's 26th birthday, including the following:

a. Those individuals that were formerly in foster care under the responsibility of the State or Tribe on their 18th, 19th, 20th or up to their 21st birthday and were receiving Medical Assistance.

i) This extension does not apply to youth that are receiving subsidized adoption payments or

ii) To youth that are enrolled in mandatory Medical Assistance.

b) Former Foster Care youth are not subject to either an income or resource test.

c) Former Foster Care youth's newborn shall be considered a needy newborn.

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

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

The extension shall be applied to ~~a~~ individuals ~~family~~ who:

a. Were~~ls~~ eligible ~~and receiving assi~~for~~stance~~ the Parent/Caretaker Relative category in at least three~~3~~ of the six~~6~~ months ~~immediately~~ preceding the month in which the individual~~family~~ would have become ineligible ~~Medical Assistance~~, and

b. ~~Becomes~~ Are~~ls~~ no longer ~~in~~eligible for coverage under the Parent/Caretaker Relative category ~~or Medical Assistance~~ ~~solely~~ because of new or increased income from employment ~~,~~ or hours of employment~~.~~

i) At least one Parent/Caretaker Relative ~~adult member of the family~~ must continue to be employed and cannot terminate employment without good cause. This does not need to be the same person ~~,~~ for the whole period the family is receiving Transitional Medical ~~,~~Assistance. ~~provided an employed member of the family continues to be employed.~~

2. ~~Required members of the Medical Assistance household who come into the household~~ Any dependent child or Parent/Caretaker Relative who was or becomes part of the Medical Assistance household after the ~~unit is~~ individual~~family~~ has begun receiving T~~t~~ransitional Medical Assistance is~~are~~ eligible for the remaining months of Transitional Medical Assistance.

a. A dependent child in the household who received Medical Assistance through continuous eligibility, but is no longer eligible for Medical Assistance~~id~~ based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance ~~applies to the members of the Medical Assistance required household~~.

b. An individual in the household who received Medical Assistance, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance

3. To become or remain eligible for Transitional Medical Assistance:

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

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

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

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

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

8.100.4.J. Express Lane Eligibility

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

1. Free/Reduced Lunch Program

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

      i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

      ii) Children who meet all necessary eligibility requirements as outlined in this volume shall be automatically enrolled.

      iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity shall receive 9~~3~~0days of eligibility while awaiting this verification.

      iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

      v) Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in this volume.

      vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the Single Streamlined Application for Medical Assistance.

b. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district-

i) Families who are automatically enrolled Free/Reduced Lunch recipient children shall not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

ii) These families must apply for Medical Assistance in order to give consent for request of benefits.

2. Direct Certification

a. Individuals who have submitted a Food Assistance or Colorado Works application

i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

ii) Children who meet all necessary eligibility requirements as outlined throughout 8.100.4 shall be automatically enrolled.

iii) Children who meet all necessary eligibility requirement~~7~~s except verification of U.S. citizenship and identity will receive 9~~3~~0 days of eligibility while awaiting this verification.

iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

v) Eligibility is based on income declared on the Food Assistance or Colorado Works application as well as eligibility requirements outlined throughout this volume.

vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility shall be evaluated using the Single Streamlined Application for Medical Assistance.

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