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Title of Rule: Revision to the Special Financing Division Colorado Indigent Care Program rules concerning HB21-1198 Implementation and CICP Alignment, Section 8.900.
Rule Number: MSB 21-11-05-A
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

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 21-11-05-A, Revision to the Special Financing Division Colorado Indigent Care Program rules concerning HB21-1198 Implementation and CICP Alignment, Section 8.900.

3. This action is an adoption of: an amendmentand new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.900, 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)? Yes
   If yes, state effective date: Apr 1, 2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.900 with the proposed text beginning at 8.900 through the end of 8.929. This rule is effective April 01, 2022.

*to be completed by MSB Board Coordinator

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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).

   During the 2021 session, the Colorado General Assembly passed House Bill (HB) 21-1198 which moved the Health Care Billing Requirements for indigent patients from the Department of Public Health and Environment to the Department of Health Care Policy and Financing for creation and implementation. HB 21-1198, also known as Hospital Discounted Care, allows uninsured individuals the opportunity to apply for financial assistance or charity care programs through the Health Care Facility where they receive treatment. Health Care services covered include any services received in a general acute care or critical access hospital or free-standing emergency department.

   HB21-1198 requires designated providers to establish a monthly payment plan for indigent patients under which payments for health care facility charges may not exceed 4% of the patient's monthly household income, and payments for each licensed health care professional charges may not exceed 2% of the patient's monthly household income. After 36 cumulative payments, the patient's bill is considered paid in full. The Department determines the rates used by all health care providers which cannot be less than 100% of the Medicare rate or 100% of the Medicaid base rage, whichever is greater. This rulemaking process will simultaneously create rules for Hospital Discounted Care and update the Colorado Indigent Care Program (CICP) rules in order to minimize administrative burden for participating CICP hospital providers. Hospital Discounted Care must be implemented by April 1, 2022 per HB21-1198.

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:

   HB 21-1198 mandates The Department of Health Care Policy and Financing to implement Hospital Discounted Care by April 1, 2022 in order for the providers to begin abiding by them by June 1, 2022.

3. Federal authority for the Rule, if any:

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4. State Authority for the Rule:

   Sections 25.5-3-501 through 25.5-3-506, C.R.S. (2021); Sections 25.5-3-101 through 25.5-3-112

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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 will impact low-income households that are at or below 250% of the federal poverty level as well as all general acute and critical access hospitals, all free-standing emergency departments, and all licensed health care professionals who work within those settings. Low-income households will benefit from this rule because it requires all affected health care service providers to assess income uniformly and sets limits on payment plan amounts.

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

   The rule change is intended to help low-income households access health care services under an affordable payment plan to prevent bankruptcy filings due to medical costs. The impact on the health care service providers may be an increased workload to ensure all eligible patients are screened for discounted care.

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

   The General Assembly has appropriated funds to the Department for implementation of HB 21-1198. It is unknown whether the transfer of responsibility under HB21-1198 from the Department of Public Health and Environment will result in any cost-avoidance for that agency. The Department anticipates no other effect on state revenues.

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

   The cost of the proposed rule is limited to the costs of implementation of HB21-1198 related to rule-making. The benefit of the proposed rule is that by setting uniform income assessment and billing standards, indigent patients are expected to be less likely to file bankruptcy because of insurmountable medical debt. The cost of

inaction is that the Department would be out of compliance with the requirements of HB21-1198 and resulting statutes, and there would be no real benefit to inaction.

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

   The Department does not foresee any fiscal impact from this rule change, and no less costly methods exist when the legislature has mandated rulemaking.

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.

   No alternative methods were considered because legislation directs the Medical Services Board to establish rules for the implementation of HB 21-1198.

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW AND LEGAL BASIS

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate Qualified Health Care Providers for uncompensated costs associated with services rendered to uninsured or underinsured patients. Qualified Health Care Providers who receive this funding render discounted health care services to Colorado residents, migrant workers and lawfully present immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to Qualified Health Care Providers who serve eligible persons. The CICP issues procedures to ensure the funding is used to serve the uninsured and underinsured population in a uniform method. Any significant departure from these procedures will result in termination of the approval of, and the funding to, a health care provider. The CICP is authorized by state law at Title 25.5, Article 3, Part 1~~, (2020)~~.

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in section 10-16-102~~-~~(34), C.R.S. Eligible persons receiving discounted health care services from Qualified Health Care Providers are subject to the limitations and requirements imposed by Title 25.5, Article 3, Part 1, C.R.S.

8.901 DEFINITIONS

A. Applicant means an individual who has applied at a Qualified Health Care Provider to receive discounted health care services.

B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.~~ (2020).~~

C. Client means an individual whose application to receive discounted health care services has been approved by a Qualified Health Care Provider.

D. Clinic Provider means any Qualified Health Care Provider that is a community health clinic licensed or certified by the Department of Public Health and Environment pursuant to C.R.S §25-1.5-103, a federally qualified health center as defined in 42 U.S.C. sec. 1395x (aa)(4)~~ (2020)~~, or a rural health clinic, as defined in 42 U.S.C. sec. 1395x (aa)(2)~~ (2020)~~.

E. Colorado Indigent Care Program or CICP or Program means the Colorado Indigent Care Program as authorized by state law at Title 25.5, Article 3, Part 1, C.R.S.~~ (2020).~~

F. Denver Metropolitan Area means the Denver-Aurora-Lakewood, CO metropolitan area as defined by the Bureau of Labor Statistics.

G. Department means the Department of Health Care Policy and Financing established pursuant to ~~Title~~section 25.5-1-104, C.R.S.~~ (2020).~~

H. Doubled-up means a person who has no permanent housing of their own and who is temporarily living with a person who has no legal obligation to financially support them.

I. Emergency Care means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

J. General Provider means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. sec. 1395x-(aa)(4) ~~(2020)~~, a rural health clinic, as defined in 42 U.S.C. sec. 1395x-(aa)(2)~~(2020)~~, a health maintenance organization issued a certificate authority pursuant to Section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to Section 25.5-3-108-(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the Program, General Provider includes associated physicians.

42 U.S.C. sec. 1395x-(aa)(2) (~~2020~~2021)is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to Section 24-4-103-(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203.

K. Homeless means a person who lacks a fixed, regular, and adequate night-time residence, or is in a doubled-up situation, or is in imminent danger of losing their primary night-time residence, and who lacks resources or support networks to remain in housing, or has a primary night-time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

L. Hospital Discounted Care means Health Care Billing for Indigent Patients as defined in Title 25.5, Article 3, Part 5, C.R.S.

M. Hospital Provider means any Qualified Health Care Provider that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103, C.R.S. and which operates inpatient facilities.

~~M~~N. Liquid Resources means resources that can be readily converted to cash, including but not limited to checking and savings accounts, health savings accounts, prepaid bank cards, certificates of deposit less the penalty for early withdrawal.

~~N~~O. Medicaid means the Colorado medical assistance program as defined in Title 25.5, Article 4, C.R.S.

~~O~~P. Qualified Health Care Provider means any General Provider who is approved by the Department to provide, and receive funding for, discounted health care services under the CICP.

~~P~~Q. Spend Down means when an Applicant uses his or her available Liquid Resources to pay off part or all of a medical bill to lower his or her financial determination to a level that will allow him or her to qualify for the Program.

~~Q~~R. Transitional housing means housing designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing.

~~R~~S. Uniform Application means the application for discounted care created pursuant to Section 8.922.

T. Urgent Care means treatment needed because of an injury or serious illness that requires treatment within 48 hours.

8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Requirements for Qualified Health Care Providers

1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.

2. Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:

a. Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.

b. Hospital Providers shall provide Emergency Care to all Clients throughout the Program year at discounted rates.

c. Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.

This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

d. Using the information submitted by an Applicant and the Uniform Application developed and distributed by the Department, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within three business days of receipt of the missing documents. Hospital Providers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older;

II. Household size, where all non-spouse or civil union partner, non-student adults ages 18 to 64 included on the application must have financial support demonstrated or attested to

i. An applicant must include their spouse or civil union partner in their household for purposes of the application.

ii. Any additional person living at the same address as the applicant may also be included in the household.

iii. An applicant may include household members who live in other states or countries if the applicant attests that they provide at least 50% of the household member's support..; and

III. Liquid Resources. Including Liquid Resources in the financial eligibility determination is optional for Hospital Providers. If a Hospital Provider chooses to include Liquid Resources in the financial eligibility determination, at least $2,500 must be excluded for each family member counted in household size, and the Hospital Provider must include a Spend Down opportunity.

e. Hospital Providers shall use the Sliding Fee Scale developed by the Department or submit for Department approval with their annual application a Sliding Fee Scale that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty level. Copayments shall be expressed in dollar amounts and shall not exceed the copayments in the Standard Client Copayment Table found in Appendix A. Hospital Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

f. Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.

3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:

a. Licensed or certified as a community health clinic by the Department of Public Health and Environment or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

b. Using the information submitted by an Applicant, the provider shall use the Uniform Application developed and distributed by the Department to determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Clinic Providers may develop their own application and submit it to the Department for approval. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within three business days of receipt of the missing documents. Clinic Providers who are federally qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally qualified health centers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older, and

II. Household size.

c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty level shall be nominal or $0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty level.

I. Sliding fee scales used by federally qualified health centers approved by the federal government meet all requirements of the Program.

II. Copayments for Clients between 101 and 250% of the federal poverty level may not be less than the copayments for Clients between 0 and 100% of the federal poverty level.

III. The same sliding fee scale shall be used for all Clients eligible for the Program.

IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.

d. Clinic Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

e. Clinic Providers shall submit Program data and quality metrics with their annual application. Specific quality metrics are listed in Section 8.905.B. The data and quality metrics shall be submitted in a format determined by the Department and provided as part of the annual application.

4. Determination of Lawful Presence

a. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence in order to be eligible for the CICP.

b. Qualified Health Care Providers shall develop procedures for handling original lawful presence documents to ensure that the documents are not lost, damaged or destroyed. Qualified Health Care Providers shall develop and follow procedures for returning or mailing original documents to Applicants within five business days of receipt.

~~b~~c. Qualified Health Care Providers shall accept copies of an Applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter.

~~c~~d. Qualified Health Care Providers shall retain photocopies of the Applicant's affidavit and lawful presence documentation.

~~d~~e. Qualified Health Care Providers shall assist applicants who have a disability, are homeless, or who lack proficiency in English with obtaining documentation to establish citizenship or lawful presence.

I. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the Applicant may provide the required documentation; or referring the Applicant to other agencies or organizations which may be able to provide assistance.

II. Examples of additional assistance that shall be provided to Applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers

who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the Applicant.

III. The Qualified Health Care Provider shall not be required to pay for the cost of obtaining required documentation.

IV. The Qualified Health Care Provider shall document its efforts of providing additional assistance to the Applicant and retain such documentation.

5. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice in the Applicant's preferred language of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the dates of eligibility and the Applicant's copay responsibilities. If eligibility to receive discounted health care services is denied, the notice shall include a brief, plain language explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.

6. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.

7. Qualified Health Care Providers shall not discriminate against Applicants or Clients based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

B. Client Appeals

1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CICP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.

2. Instructions for Filing an Appeal

The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.

An Applicant or Client who wishes to appeal a denial must:

a. Submit a letter requesting appeal within ~~15 business~~30 calendar days of the date of the denial notice. Appeals submitted after the deadline may be denied for being submitted untimely;

b. Enclose any supporting documentation;

If no denial notice is received earlier, an appeal letter may be submitted within ~~30~~45 ~~business~~ calendar days of the date the application was completed.~~;~~

The deadline for an appeal letter may be extended for good cause.

3. Appeals

a. An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.

b. Each Qualified Health Care Provider must designate a manager to review appeals and supporting documentation.

c. If the initial financial determination is found to be inaccurate,

I. the financial determination will be corrected, with eligibility effective retroactive to the initial date of application, and

II. services provided during the applicable backdating period must be discounted.

d. A decision shall be issued to the Applicant or Client and the Department in writing within 15 ~~business~~ calendar days following receipt of the appeal request.

4. Provider Management Exception

a. An Applicant or Client may request a provider management exception simultaneously with an appeal, or within 15 ~~business~~ calendar days of the date of the Qualified Health Care Provider's decision regarding an appeal.

b. A provider management exception may be granted at the Qualified Health Care Provider's discretion if the Applicant or Client can demonstrate that there are circumstances that should be taken into consideration when establishing the household financial status.

c. Each Qualified Health Care Provider must designate a manager to review provider management exceptions and supporting documents.

I. The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 ~~business~~ calendar days of receipt of the Client's written request.

II. The Qualified Health Care Provider must note provider management exceptions on the application.

d. A financial determination from a provider management exception is effective as of the initial date of application.

e. Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.

C. Financial Eligibility

General Rule: An Applicant shall be financially eligible for discounted health care services under the CICP if ~~his or her~~their household income is no more than 250% of the current Federal Poverty Guidelines~~federal poverty level~~ (FPG~~L~~)for a household of that size.

1. Qualified Health Care Providers determine eligibility for the CICP and shall maintain auditable files of applications for discounted health care services under the CICP until June 30 of the seventh state fiscal year following the eligibility determination.

2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that an application is started. In the event that an applicant is applying to cover a past individual visit or admission, or a string of visits, admissions, or both that occurred in a short amount of time~~,~~ and is either not going to be applying for CICP going forward or the date(s) of service are outside of the standard 90 day backdating window, the household financial status is considered as of the date of service instead of the date of the application.

3. All Qualified Health Care Providers must accept each other's CICP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.

4. CICP eligibility is retroactive for services received from a Qualified Health Care Provider up to 90 days prior to application.

5. Documentation concerning the Applicant's financial status shall be maintained by the provider until June 30 of the seventh state fiscal year following the eligibility determination.

6. Beyond the distribution of available funds made by the CICP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICP discounted health care services to the Client.

7. Emergency Application for Providers

    a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:

        I. Use the regular application to receive discounted health care services under the CICP but indicate emergency application on the application.

        II. Ask the Applicant to give spoken answers to all questions and determine a federal poverty level based on the spoken information provided. If the Applicant appears eligible for Medicaid or CHP+, the Applicant will need to apply for the applicable program prior to being placed on CICP.

        III. .Ask the Applicant to sign the application indicating their understanding of their federal poverty level and eligibility determination made using their spoken information.

    b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken

information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.

c. In emergency circumstances, an Applicant is not required to provide identification or execute an affidavit as specified at Section 8.904.D.

D. Audit Requirements

The Department will conduct audits of Qualified Health Care Providers. Qualified Health Care Providers shall comply with requests for data and other information from the Department. Qualified Health Care Providers shall complete corrective actions when required by the Department. The Department's intention is to audit one-third of the participating Qualified Health Care Providers each year. After any Qualified Health Care Provider discontinues participation in the program, the provider must maintain compliance with audit requirements for the records created during the period during which the Qualified Health Care Provider was participating.

E. HIPAA

The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 C.F.R. sec. 160.103. The CICP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are uninsured or underinsured. The state personnel administering the CICP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.

8.903 DISCOUNTED HEALTH CARE SERVICES

A. Funding provided under the CICP shall be used to provide Clients with discounted health care services determined to be medically necessary by the Qualified Health Care Provider.

B. All health care services normally provided at the Qualified Health Care Provider should be available at a discount to Clients. If health care services normally provided at the Qualified Health Care Provider are not available to Clients at a discount, Clients must be informed that the services can be offered without a discount prior to the rendering of such services. Service availability is to be applied uniformly for all Clients.

C. Qualified Health Care Providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:

1. Emergency Care;

2. Urgent Care; and

3. Any other medical care.

D. Additional discounted health care services may include:

1. Emergency mental health services if the Qualified Health Care Provider renders these services to a Client at the same time that the Client receives other medically necessary services.

2. Qualified Health Care Providers may provide discounted pharmaceutical services. The Qualified Health Care Provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the Qualified Health Care Provider. Qualified Health Care Providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible Clients who are also eligible for Medicare.

3. Qualified Health Care Providers may provide packages of services to patients with modified copayment requirements.

   a. Packages of services benefit Clients who need to utilize services more often than average Clients. Things that would be beneficial to the client include but are not limited to charging a lower copay, charging the copay on an alternative schedule (i.e. once a week, or ever other time), or setting a cap on the amount or number of copayments made towards the packaged services. Examples of packages may include but are not limited to oncology treatments, physical therapy, and dialysis.

   b. Qualified Health Care Providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for uninsured or underinsured women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The Qualified Health Care Provider is responsible for providing a description of the services included in the prenatal benefit to the Client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.

2. Nursing home care.

3. Chiropractic services.

4. Cosmetic surgery.

5. Experimental and non-United States Federal Drug Administration approved treatments.

6. Elective surgeries that are not medically necessary.

7. Court ordered procedures, such as drug testing.

8. Abortions - Except as specified in ~~S~~section 25.5-3-106, C.R.S.

9. Mental health services in clinic settings pursuant to section 25.5-3-110, C.R.S., Title 27, Article 66, Part 1, any provisions of Title 23, Article 22, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an Applicant shall satisfy the following requirements:

1. Execute an affidavit regarding citizenship status;

   a. Beginning on July 1, 2022, applicants are no longer required to execute an affidavit regarding citizenship status.

2. Be lawfully present in the United States;

   a. Beginning on July 1, 2022, applicants are no longer required to be lawfully present in the United States.

3. Be a resident of Colorado;

4. Meet all CICP eligibility requirements as defined by state law and procedures; and

5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, or meet one of the following exceptions:

   a. individual is an unborn child;

   b. individual is homeless and unable to provide a SSN;

   c. individual is ineligible for a SSN:

   d. individual may only be issued a SSN for a valid non-work reason in accordance with 20 C.F.R. sec. 422.104;

   e. individual refuses to obtain a SSN because of well-established religious objections.

B. Applicants

1. Any adult age 18 and older may apply to receive discounted health care services on behalf of themselves and members of the Applicant's family household.

2. If an Applicant is deceased, the ~~executor~~ personal representative of the estate or a family member may complete the application on behalf of the Applicant. ~~The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.~~

3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the Applicant's family household. All non-spouse or civil union partner, non-student adults ages 18-64 must have financial support demonstrated or attested to in order to be included in household size. All minors and those 65 or older do not need documentation of financial support to be counted in household size. Income from spouses or civil union partners and all non-student adults must be included in the application.

4. A minor shall not be rated separately from his or her parents or guardians unless he or she is emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Signing the Application

The Applicant or an authorized representative of the Applicant must sign the application to receive discounted health care services submitted to the Qualified Health Care Provider within 90 calendar days of the date of health care services. If an Applicant is unable to sign the application or has died, a spouse, civil union partner, relative, or guardian may sign the application. Until it is signed, the application is not complete, the Applicant cannot receive discounted health care services under the CICP, and the Applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

D. Affidavit

1. Each first-time Applicant, or Applicant seeking to reapply, 18 years of age or older shall execute an affidavit stating:

   a. That he or she is a United States citizen, or

   b. That he or she is a legal permanent resident or is otherwise lawfully present in the United States pursuant to 1 CCR 204-30; Rule 5.

2. For an Applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall verify lawful presence through the Federal Systematic Alien Verification for Entitlements (SAVE) Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security within three business days of receipt of the lawful presence documentation. A SAVE verification is not needed for Applicants who provide an ID issued by a REAL ID Act compliant state that bears the REAL ID Act indicator.

3. Effective July 1, 2022, Applicants are no longer required to execute an affidavit of lawful presence.

E. Establishing Lawful Presence

1. Each first-time Applicant, or Applicant seeking to reapply, eighteen years of age or older shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30; Rule 5 (effective September 17, 2020), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30; Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to Section 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, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

2. Submission of Documentation

   Lawful presence documentation may be accepted from the Applicant, the Applicant's spouse, civil union partner, parent, guardian, or authorized representative in person, by mail, by email, or facsimile.

3. Expired or absent documentation for non-U.S. citizens

   a. If an Applicant is unable to present any documentation evidencing his or her immigration status, refer the Applicant to the local Department of Homeland Security office to obtain documentation of status.

b. In unusual circumstances involving Applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the Applicant can provide an alien registration number, the provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.

c. If an Applicant does not present documentation proving their lawful presence but instead presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.

4. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence.

F. Residence in Colorado

An Applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;

2. Meet the lawful presence criteria, as defined in paragraph E of this Section; and

3. Employed in Colorado.

G. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under the CICP:

a. Individuals for whom lawful presence cannot be verified.

I. Effective July 1, 2022, lawful presence is no longer a requirement for CICP, and these individuals are no longer ineligible for discounted services.

b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

e. Persons who qualify for Medicaid. However, Applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

I. QMB benefits described at Section 8.100.6.L ~~(2016)~~ of these regulations;

II. SLMB benefits described at Section 8.1006.M ~~(2016)~~, or

III. The QI1 benefits described at Section 8.100.6.N ~~(2016)~~.

f. Individuals who are eligible for the Children's Basic Health Plan.

H. Health Insurance Information

The Applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

I. Subsequent Insurance Payments

If a Client receives discounted health care services under the CICP, and their insurance subsequently pays for services, or if the Client is awarded a settlement, the insurance company or patient shall reimburse the Qualified Health Care Provider for discounted health care services rendered to the Client.

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually.

a. The application will be updated annually to incorporate any necessary changes and update any Program information.

b. The application will include data and quality metric submission templates.

2. The Department shall determine Qualified Health Care Providers annually through the application process.

3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108 (5)(a)(I), C.R.S.

4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108 (5)(a)(II), C.R.S.

5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with Sections 8.300 and 8.905.B.3.

2. Clinics

a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item. Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:

I. 75 percent of the funding will be distributed based on Clinic Providers' write off costs relative to the total write off costs for all Clinic Providers.

II. 25 percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.

b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):

I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up

II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan

III. Diabetes: Hemoglobin A1c Poor Control

IV. Controlling High Blood Pressure

c. Write off costs will be calculated as follows:

I. Distribution of available funds for CICP care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate CICP charges.

II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.

III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.

IV. CICP charges will be converted to CICP costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.

d. The Department shall notify Clinic Providers of their expected payment no later than August 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.

3. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with CICP care days (days of care provided under the CICP) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

   a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.s;

   b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.s per licensed bed;

   c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations;

   d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

   e. Participates in the CICP.

   The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider's first level appeal must be filed within five business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten business days of receipt of the appeal.

3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five business days of the receipt of the first level appeal determination. The Department's Executive Director will respond to the second level appeal within ten business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;

2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;

3. A representative from a federally qualified health center as defined at 42 U.S.C. sec. 1395x (aa)(4) ~~(2020)~~;

4. A representative from a rural health clinic as defined at 42 U.S.C. sec. 1395x (aa)(2) ~~(2020)~~, or a representative from a clinic licensed or certified as a community health clinic

by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;

5. A representative from either Denver Health or University Hospital;

6. A representative from an urban hospital;

7. A representative from a rural or critical access hospital;

8. A representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b ~~(2020)~~;

9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall at least annually select a chair for the council to serve for a maximum period of twelve months. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. ~~Of the members initially appointed to the advisory council, the executive director shall appoint six for two-year terms and five for three-year terms.~~ In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program

2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.

2. The report shall at minimum include charges for each Qualified Health Care Provider, numbers of Clients served, and total payments made to each Qualified Health Care Provider.

10 CCR 2505-10 § 8.900 APPENDIX A: STANDARD CICP CLIENT COPAYMENT

A. Client Copayments - General Policies

A Client is responsible for paying a portion of his or her medical bills. The Client's portion is called the Client Copayment. Qualified Health Care Providers are responsible for charging the Client a copayment. Qualified Health Care Providers may require Clients to pay their copayment prior to receiving care (except for Emergency Care). Qualified Health Care Providers may charge copayments in accordance with the Standard Client Copayment Table or an alternate sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department.

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%
Ambulatory Surgery	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600
Inpatient Facility	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600
Hospital Physician	$0	$7	$35	$55	$80	$110	$150	$195	$270	$300
Emergency Room	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45
Emergency Transportation	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45
Outpatient Hospital Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35
Clinic Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35
Specialty Outpatient	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45
Prescription	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30
Laboratory	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30
Basic Radiology & Imaging	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30
High-Level Radiology & Imaging	$0	$30	$90	$130	$185	$250	$335	$425	$580	$645

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related Client Copayments under the Standard Client Copayment Table.

1. Inpatient facility charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.

2. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.

3. Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.

4. Clinic Services charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.

5. Emergency Room charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).

6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

7. Emergency Transportation charges are for transportation provided by an ambulance.

8. Laboratory Service charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

9. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

10. Prescription charges are for prescription drugs received by a Client at a Qualified Health Care Provider’s pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

11. High-Level Radiology and Imaging Service charges are for Clients receiving a Magnetic Resonance Imaging, Computed Tomography, Positron Emission Tomography or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory in the outpatient hospital, emergency room, or clinic setting.

12. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

13. Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

B. Homeless Clients, Clients living in transitional housing, “doubled-up” Clients, or recipients of Colorado’s Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level are exempt from Client Copayments.

1. Homeless Clients are exempt from Client Copayments, the income verification requirement, and providing proof of residency when completing the CICP application.

2. Transitional housing is designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing Clients are exempt from the income verification requirement when completing the CICP application.

3. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the Client are considered doubled-up. The individual allowing the Client to reside with him or her may be asked to provide a written statement confirming that the Client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.

4. Recipients of Colorado’s Aid to the Needy Disabled financial assistance program are exempt from Client Copayments, and the income verification requirement when completing the CICP application.

C. Client Annual Copayment Cap

1. Homeless Clients whose financial determination is between 0 and 40% of the federal poverty level are exempt from copayments, so their copayment cap is $0. Clients whose financial determination is between 0 and 40% of the federal poverty level who are not homeless have a copayment cap that is the lesser of 10% of the family’s net income or $120. Clients who are also Old Age Pension Health and Medical Care Program clients have a copayment cap of $300 as mandated by Section 8.941.10. For all other CICP Clients, annual copayments shall not exceed 10% of the family’s financial determination.

2. Clients who are also Old Age Pension Health and Medical Care Program clients have annual copayment caps based on a calendar year. All other Client annual copayment caps (annual caps) are based on the Client’s date of eligibility.

3. Clients are responsible for any charges incurred prior to the determination of the Client’s financial eligibility.

4. Clients are responsible for tracking their CICP copayments and informing the provider in writing, including documentation, within 90 days after meeting or exceeding their annual cap. If a Client overpays the annual cap and informs the Qualified Health Care Provider of that fact in writing, the Qualified Health Care Provider shall reimburse the Client for the overpayment.

5. A CICP Client is eligible to receive a new determination if his or her financial or family situation has changed since the initial financial determination. CICP copayments made under the prior financial determination will not count toward a new CICP copayment cap and the Client's annual copayment cap resets when the Client completes a new application.

6. An annual cap applies only to charges incurred after a Client is eligible to receive discounted health care services and applies only to discounted services incurred at a CICP Qualified Health Care Provider, including services discounted under Hospital Discounted Care.

D. The Client must pay the lower of the copayment listed, the patient responsibility portion if the Client is insured, or actual charges. Payment plans must be offered to Clients and must follow the requirements set forth in Section 8.923 of the Hospital Discounted Care rule.

E. Clients shall be notified at or before time of services rendered of their copayment responsibility and available payment plan option.

F. Grants from foundations to Clients from non-profit, tax exempt, charitable foundations specifically for Client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

8.920 Hospital Discounted Care

PURPOSE AND LEGAL BASIS

The Health Care Billing for Indigent Patients Act of 2021, C.R.S. § 25-3-501, et. seq., referred to as Hospital Discounted Care, establishes the maximum rate a Health Care Facility and Licensed Health Care Professional may bill low-income patients for Discounted Care provided in the hospital, requires written description of patient's rights, establishes patient appeals and complaint processes, and imposes requirements on hospitals before assigning or selling patient debt to a medical creditor or before pursuing collection action.

8.921 DEFINITIONS

A. Billing Statement means any patient-facing communication, whether electronic or in writing, that specifies an amount due for services and instructions for making payment.

B. Children's Basic Health Plan or the Child Health Plan *Plus* (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.

C. Colorado Indigent Care Program or CICP means the safety net program established in Title 25.5, Article 3, Part 1, C.R.S.

D. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.

E. Discounted Care means the amount a Provider may charge a Qualified Patient for Medically Necessary Health Care Services rendered.

F. Emergency Medicaid means short--term Medicaid coverage for eligible people who do not meet immigration or citizenship requirements for Medicaid and need treatment for life- and/or limb-threatening emergencies.

G. Federal Poverty Guidelines or FPG means a measure of income level issued annually by the United States Department of Health and Human Services. For Hospital Discounted Care, the FPG is updated annually every April 1.

H. Health Care Facility means a hospital licensed as a general hospital pursuant to Title 25, Article 3, Part 1, C.R.S., a hospital established pursuant to section 23-21-503, C.R.S. or section 25-29-103, C.R.S., any freestanding emergency department licensed pursuant to section 25-1.5-114, C.R.S., or any outpatient health care facility that is licensed as an on-campus department or service of a hospital or that is listed as an off-campus location under a hospital's license, but does not include a federally qualified health center as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x-(aa)(4), or a student-learning medical or dental clinic that is established for the purpose of student learning, offering Discounted Care as part of a program of student learning that is physically situated within a health sciences school.

I. Health Care Services has the same meaning as set forth in section 10-16-102-(33), C.R.S.

J. Impermissible Extraordinary Collection Action means initiating foreclosure on an individual's primary residence or homestead, including a mobile home, as defined in section 38-12-201.5-(5), C.R.S.

K. Licensed Health Care Professional means any health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. or who provides services under the supervision of a health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. and who provides Health Care Services in a Health Care Facility.

L. Medicaid means the Colorado Medical Assistance Act set forth in Title 25.5, Articles 4, 5, and 6, C.R.S.

M. Medical Creditor means any entity that attempts to collect on a medical debt, including a Provider or Provider's billing office, a collection agency as defined in section 5-16-103-(3), a debt buyer as defined in section 5-16-103-(8.5), C.R.S. and a debt collector as defined in 15 U.S.C. sec. 1692a (6).

N. Non-CICP Health Care Services means Health Care Services provided in a Health Care Facility for which reimbursement under the Colorado Indigent Care Program, established in Title 25.5, Article 3, Part 1, C.R.S. is not available.

O. Patient Contact Best Efforts means the process of communication efforts completed by the Provider to contact a patient. This includes phone calls, SMS messages, emails, and portal messages.

P. Permissible Extraordinary Collection Action means an action other than an Impermissible Extraordinary Collection Action that requires a legal or judicial process, including but not limited to placing a lien on an individual's real property, attaching or seizing an individual's bank account or any other personal property, or garnishing an individual's wages. A Permissible Extraordinary Collection Action does not include the attachment of a hospital lien pursuant to section 38-27-101, C.R.S.

Q. Provider means any Health Care Facility or Licensed Health Care Professional subject to Title 25.5, Article 3, Part 5, C.R.S.

R. Qualified Patient means an individual whose household income is not more than two hundred fifty percent of the Federal Poverty Level and who received a Health Care Service at a Health Care Facility.

S. Screen or Screening means a process identified in rule by the Department whereby Health Care Facilities assess a patient's circumstances related to eligibility criteria and determine whether the patient is likely to qualify for public health care coverage or Discounted Care, inform the patient of the Health Care Facility's determination, and provide information to the patient about how the patient can enroll in public health care coverage.

T. SMS means short messaging service messages, commonly referred to as text messages

U. Uninsured means an uninsured individual, as defined in section 10-22-113-(5)(d), C.R.S.

8.922 SCREENING AND APPLICATION

A. Screening, Application, and Determination Notice

1. Beginning June 1, 2022, using the single uniform application developed and distributed by the Department, a Health Care Facility shall screen~~,~~ each uninsured patient and any insured patients who request to be screened for:

a. Public health insurance programs including but not limited to Medicare, Medicaid, Emergency Medicaid, and the Children's Basic Health Plan.

b. Eligibility for the CICP, if the patient receives or is scheduled to receive a service eligible for reimbursement through the CICP.

c. Discounted Care, as described in section 25.5-3-503, C.R.S.

2. Uninsured Patients

a. Health Care Facilities must complete the screening process using the uniform application within 45 days from the uninsured patient's date of service or date of discharge, whichever is later.

b. The screening process consists of completing the first page of the uniform application using self-attested information provided by the patient or their guardian.

c. If the self-attested screening process results in a determination that the patient may be eligible for Discounted Care, then, at the time of the screening, the Health Care Facility must provide the patient or their guardian with a list of information and documents required to complete the application process. The patient is permitted 45 days to provide the documentation required to complete the application. When all necessary documentation has been received from the patient, the Health Care Facility must determine the patient's eligibility for Discounted Care and send written notice of the determination to the patient or guardian within 14 days.

d. If the self-attested screening process results in a determination that a patient likely is ineligible for Discounted Care, the patient may request to complete the application process and receive an official determination of eligibility for Discounted Care.

3. Insured Patients

a. If the insured patient or their guardian requests to be screened for public health insurance programs, CICP, and Discounted Care, Health Care Facilities must

screen insured patients within 45 days of their date of service or date of discharge, or within 45 days of the date of their first bill after their insurance adjustment, whichever is later.

b. The request to be screened may be made in person, by telephone, email, or by using the portal, if available. Health Care Facilities must contact the insured patient or their guardian to schedule the screening within three business days after receiving the insured patient's request.

c. Patients believed to have health insurance coverage when services were rendered and who are subsequently determined to be uninsured on their date of service are considered Uninsured. Within 45 days from the date of the notification that the patient was not insured on the date of service, ~~T~~the Health Care Facility must complete the screening.

4. Health Care Facility Determination Notice

a. The Health Care Facility must provide the patient written notice of the determination within 14 days of the determination of the patient's eligibility for Discounted Care. A copy of the determination must be sent to any and all applicable Licensed Health Care Professionals.

b. The determination shall be written in plain language and in the patient or their guardian's preferred language.

c. If no determination notice is received, an appeal letter must be submitted within 45 calendar days of the date the application was completed.

c. For patients determined to be eligible, the determination notice must include but is not limited to:

1. The determination of eligibility or ineligibility for the various programs and discounts, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, subsidies through Connect for Health Colorado, Hospital Discounted Care, and CICP.

i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply for to that program for their services to be covered, that date must be included in the determination notice.

2. The service date the determination covers.

3. The household size and income used to determine eligibility and the household calculated FPG.

4. The patient's 4% and 2% limits based on their calculated gross household income.

5. If the patient was applying and approved for CICP, the patient's CICP rating.

6. If the patient was applying and approved for CICP, the patient's CICP copay cap.

7. If the Health Care Facility is not a CICP Provider, information on where the patient may obtain CICP services.

8. Information on how to file a complaint or appeal with the Health Care Facility and the Department.

d. The determination notice for patients determined not eligible for Discounted Care must include but is not limited to:

1. The basis for denial of Discounted Care.

2. The determination of eligibility or ineligibility for the various programs and discounts, including but not limited to CHP+, Medicare, and subsidies through Connect for Health Colorado.

i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply to that program for their services to be covered, that date must be included in the determination notice.

3. The service date the determination covers.

4. The household size and income used to determine eligibility and the household calculated FPG.

5. Information on how to file a complaint or appeal with the Health Care Facility and the Department.

5. A Health Care Facility is no longer obligated to screen an uninsured patient if the patient or their guardian signs the Decline Screening Form developed by the Department except when a patient or guardian who opted out of screening subsequently requests to complete the screening, if the subsequent request is made prior to starting Permissible Extraordinary Collections Actions.

a. The Health Care Facility must keep on file a Decline Screening Form signed by the patient, or their guardian until June 30 of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later.

6. For patients who are discharged without being screened or signing the Decline Screening Form, the Health Care Facility must attempt to contact the patient by phone call, SMS message, email, and portal message at least once a month for six months after the patient's date of discharge with the first contact sent prior to the expiration of 45 days after screening. The Health Care Facility may commence billing 46 days after the patient's date of service or date of discharge, whichever is later. If the patient requests that the Health Care Facility cease contacting them by phone, SMS message, or email, the provider may consider those requirements as fulfilled. The Health Care Facility must document the patient's request and maintain the request as part of the patient record.

7. If a Health Care Facility has attempted to contact the patient in accordance with Patient Contact Best Efforts, and the patient does not respond within 182 days of their date of service or date of discharge, whichever is later, the Facility may conclude that the patient has made an informed decision to decline screening. Patient Contact Best Efforts, at a minimum, must include:

a. Notice that the failure to respond may result in the loss of their right to be screened for cost saving options.

b. Calling any phone numbers provided by the patient and leaving detailed voice messages if the calls are unanswered,

c. SMS messages to any of the patient's phone numbers identified as a mobile number if the Health Care Facility has the ability to send SMS messages,

d. Sending emails to any email address provided by the patient, and

e. Sending messages through any patient portal the patient has access to.

8. Documentation of the attempts to contact the patient or guardian to complete the screening must be maintained as part of the patient record. This may include call logs, message logs, copies of sent emails, portal messages sent, and copies of bills.

9. Providers shall maintain all Discounted Care--related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the creation of the documentation.

B. Patients

1. Any patient or patient's guardian aged 18 and older may apply to receive Discounted Care.

2. The decision regarding eligibility for Discounted Care applies to both the patient and the members of the patient's household.

3. If a patient is deceased, the personal representative of the estate or a family member may complete the screening and application on behalf of the patient.

4. The application to receive Discounted Care shall include the names, birth dates, and relationship to the patient of all members of the patient's household.

a. A patient must include their spouse or civil union partner in their household for the application.

b. Any additional person living at the same address as the patient may also be included in the household.

c. A patient may include household members who live in other states or countries if the patient attests to the fact that they provide at least 50% of the household member's support.

4. A minor shall not be screened separately from his or her parents or guardians unless they are emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Household Income

1. Using the information submitted by a patient or patient's guardian, the Health Care Facility shall determine whether the patient meets all requirements to receive Discounted

Care. Health Care Facilities must follow the income counting methodology determined by the Department. Health Care Facilities shall determine Qualified Patient financial eligibility based on income from each household member 18 and older and household size. The Health Care Facility may not consider assets in determining eligibility.

2. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the patient or patient's guardian will be notified of the missing documentation within three business days after receipt of the application. An eligibility determination shall be made within 14 calendar days after the application is complete.

3. Documentation required to establish household income may include but is not limited to pay stubs, employer letter, tax returns, and business financial statements. The Health Care Facility may not require more than the minimum amount of documentation to substantiate declared income.

8.923 HEALTH CARE SERVICE DISCOUNTS

A. Beginning June 1, 2022, if a patient screened pursuant to section 8.922 is determined to be a Qualified Patient, a Health Care Facility and a Licensed Health Care Professional shall:

1. Limit the amounts billed for Health Care Services to no more than the rate established in Department rule pursuant to section 8.929

2. Enter into a payment plan with the Qualified Patient in which the Qualified Patient pays for care in monthly installments. For services provided by a Health Care Facility, monthly installments shall not exceed four percent of the patient's gross monthly household income. For services provided by each Licensed Health Care Professional, monthly installments shall not exceed two percent of the patient's gross monthly household income; and

3. After a cumulative thirty-six months of payments, The Health Care Facility shall treat the Qualified Patient's bill as paid in full and must permanently cease collection activities on any balance that remains unpaid.

4. Providers shall not suggest or require that patients obtain loans to pay for services in lieu of setting up a payment plan directly with the Health Care Facility or Licensed Health Care Professional. This includes loans from banking institutions and other creditors, like CareCredit.

a. If the Provider offers loans for patients related to their medical bills, the monthly payments, including the interest and principal, must follow the established limits on monthly amounts and the loan can be no longer than 36 months of payments.

b. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section.

B. A Health Care Facility shall not:

1. Deny Discounted Care on the basis that the patient has not applied for any public benefits program; or

2. Adopt or maintain any policies that result in the denial of admission or treatment of a patient because the patient lacks health insurance coverage, may qualify for Discounted Care, requires extended or long-term treatment, or has an unpaid medical bill.

8.924 PATIENT RIGHTS

A. Beginning June 1, 2022, a Health Care Facility shall make available to the public and to each patient information developed by the Department about patient's rights pursuant to Part 5 of Article 3 of Title 25.5 C.R.S. (2021) and the uniform application developed by the Department pursuant to section 25.5-3-505 (2)(i), C.R.S.

B. At a minimum, the Health Care Facility shall:

1. Post the information in all languages spoken by ten percent or more of the population in any Colorado county conspicuously on the Health Care Facility's website, including a link to the information on the Health Care Facility's main landing page;

2. Make the information available in patient waiting areas;

3. Make the information available to each patient, or the patient's legal guardian, before the patient is discharged from the Health Care Facility, verbally or in writing in the patient's or legal guardian's preferred language, which may include using professional interpretation and/or translation services; and

4. Inform each patient on the patient's Billing Statement of the patient's rights pursuant to Part 5 of Article 3 of Title 25.5, C.R.S. (2021) including the right to apply for Discounted Care, and provide the website, email address, and telephone number where the information may be obtained in the patient's preferred language.

C. Providers shall not present the patient's rights in a format that differs from the format in which the material is distributed by the Department without Department approval.

1. Providers may not make any part of the patient's rights information part of a footnote or use any other format that may minimize its importance.

8.925 REPORTING REQUIREMENTS

A. Beginning June 1, 2023, and each June 1 thereafter, each Health Care Facility shall report to the Department data that the Department determines is necessary to evaluate compliance across race, ethnicity, age, and primary--language--spoken patient groups with the screening, Discounted Care, payment plan, and collections practices required by Title 25.5, Article 3, Part 5, C.R.S. (2021). The Department shall distribute a compliance data reporting template to each Health Care Facility.

1. If a Health Care Facility is not capable of disaggregating the required data by race, ethnicity, age, and primary language spoken, the Health Care Facility shall report to the Department the steps the Health Care Facility is taking to improve race, ethnicity, age, and primary language spoken data collection and the date by which the facility will be able to disaggregate the reported data.

B. Beginning June 1, 2023 and each June 1 thereafter, each Health Care Facility shall submit Discounted Care utilization and charge data in a format and timeline determined by the Department.

8.926 COLLECTIONS

A. Beginning June 1, 2022, before assigning or selling patient debt to a collection agency or a debt buyer, or before pursuing, either directly or indirectly, any Permissible Extraordinary Collection Action:

1. A Health Care Facility shall meet the screening requirements in section 8.922;

2. A Provider shall provide Discounted Care to a Qualified Patient pursuant to section 8.920;

3. A Provider shall provide a plain language explanation of the health care services and fees and notify the patient or their guardian of potential collection actions in their preferred language on the timeline developed by the Department; and

4. A Provider shall bill any third-party payer that is responsible for providing health care coverage to the patient. If a Licensed Health Care Professional is an out-of-network provider under a Qualified Patient's health insurance plan, the Licensed Health Care Professional and health insurance carrier shall comply with the out-of-network billing requirements described in sections 10-16-704 (3) and 12-30-113, C.R.S.

B. A Health Care Facility must complete the Patient Contact Best Efforts in their attempts to contact a patient who has not signed a Decline Screening Form or who has not been screened as described in Section 8.922 prior to starting Permissible Extraordinary Collections Actions.

C. Documentation of Patient Contact Best Efforts communication attempts with the patient as outlined in section 8.922 satisfies the screening requirements for Health Care Facilities.

D. For a Qualified Patient with an established payment plan, Permissible Extraordinary Collections Actions may not be started until the patient has failed to remit three consecutive payments and has not communicated with the Provider asking for a deferment or to be redetermined prior to or during those three months of missed payments. Providers must notify Qualified Patients with established payment plans at least 30 days prior to the commencement of Permissible Extraordinary Collections Actions.

E. Providers shall not commence collection proceedings against a patient for any amount in excess of the rates established at Section 8.923.A.2, and must reduce the amount owed by the amount of any payments received from the patient or a third-party payer.

8.927 APPEALS AND COMPLAINTS

A. If a patient is determined ineligible for Discounted Care after the uniform application has been completed, the patient may appeal the decision as follows:

1. No later than 30 calendar days from the date on the Health Care Facility's eligibility determination letter, the patient or their guardian may submit an appeal in writing via U.S. Mail, email, or patient portal message if available to the Health Care Facility that made the determination.

2. Within 15 calendar days from the date of the appeal, the Health Care Facility shall complete a redetermination of eligibility and respond to the patient or guardian and the Department.

3. If the Health Care Facility upholds its initial eligibility determination, the patient or guardian may proceed to the next step of the appeals process as described in Section 8.927.A.4.

4. No later than 15 calendar days from the date of the Health Care Facility's initial appeal decision, the patient shall submit a written appeal to the Department. Email submissions must be addressed to hcpf_HospDiscountCare@state.co.us. Letters must be mailed to:

Department of Health Care Policy and Financing
Attention: Hospital Discounted Care
c/o State Programs Unit, Special Financing Division
1570 Grant Street
Denver, CO 80203

5. Within 15 calendar days from date of receipt of the appeal, the Department shall issue a final determination letter to both the patient and the Health Care Facility. If the Department deems that the redetermination was inaccurate, the Health Care Facility must resend a determination letter to the patient and the Department stating the patient is/was eligible for Discounted Care on the date of service.

B. A patient or guardian who believes a Health Care Facility has improperly calculated a payment plan based on inaccurate income information may appeal the payment plan offered by the Facility to the Department using the process described in Section 8.927.A.4.

C. The Department shall maintain records of all appeals and its final determinations for each Health Care Facility. If the Department determines a Health Care Facility has a repeated pattern of errors in patient eligibility determinations, the Department will require the Health Care Facility to attend training with the Department. The Health Care Facility may be subject to random application checks for 12 months following the training to ensure that the errors have been corrected.

D. Patients and their guardians may file complaints against Providers directly with the Department. Patients are not required to file a complaint with the Provider prior to filing a complaint with the Department.

1. Patients may submit complaints via U.S. Mail, email, or phone as follows:

Phone: 303-866-2580

Email: hcpf_HospDiscountCare@state.co.us

U.S. Mail: Department of Health Care Policy and Financing
Attention: Hospital Discounted Care
c/o State Programs Unit, Special Financing Division
1570 Grant Street
Denver, CO 80203

2. The Department shall review complaints within 30 calendar days of receipt.

3. The Department shall maintain records of all complaints for each Provider. If the Department determines there is a repeated pattern in the complaints filed against the Provider, the Provider may be subject to a corrective action plan.

a. Providers will have 90 days to submit a corrective action plan. Extensions may be made at the Department's discretion up to no more than 120 days.

8.928 REVIEW OF PROVIDERS FOR NONCOMPLIANCE

A. The Department shall periodically review Providers to ensure compliance with Part 5 of Article 3 of Title 25.5, C.R.S. (2021) and these rules. If the Department finds that a Provider is not in compliance with these rules, the Department shall notify the Provider.

B. The Provider will have 90 days to file a corrective action plan with the Department that must include measures to inform impacted patients about the noncompliance and provide financial corrections consistent with these rules.

1. At the Department's discretion, a Provider may be permitted up to 120 days to submit a corrective action plan upon request.

2. The Department may require a Provider that is not in compliance with Title 25.5, Article 3, Part 5, C.R.S. or these rules to develop and operate under a corrective action plan until the Department determines the Provider is in compliance.

C. If a Provider's noncompliance with these rules is determined by the Department to be knowing or willful or there is a repeated pattern of noncompliance, the Department may fine the Provider no more than $5,000. If the Provider fails to take corrective action or fails to file a corrective action plan with the Department pursuant to this section, the Department may fine the Provider no more than $5,000 per week until the Provider takes corrective action. The Department shall consider the size of the Health Care Facility and the seriousness of the violation in setting the fine amount.

D. The Department shall make the information reported pursuant to this section and any corrective action plans for which fines were imposed pursuant to this section available to the public and shall annually report the information as part of its presentation to its committees of reference at a hearing held pursuant to section 2-7-203 (2)(a), C.R.S. of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act".

E. For audit purposes, Providers shall maintain all Discounted Care related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the screening or determination.

8.929 RATES

The Department shall annually establish rates for Discounted Care. The rates will approximate and not be less than one hundred percent of the Medicare rate or one hundred percent of the Medicaid rate, whichever is greater. The Department shall publicly post the established rates on the Department's website pursuant to section 25.5-3-505, C.R.S.

8.930 [Repealed effective 8/12/2011.]

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765
Rule Number: MSB 22-03-03-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 22-03-03-A, Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765

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) 8.765, 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)? Yes
   If yes, state effective date: 03/11/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.765 with the proposed text beginning at 8.765 through the end of 8.765.1. Insert the newly proposed text beginning at 8.765.14 through the end of 8.765.14.F. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765
Rule Number: MSB 22-03-03-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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).
   Revises the rules for child-serving residential facilities to include the new Qualified Residential Treatment Program (QRTP) license type. The new license type will take effect October 1, 2021 in accordance with the federal Family First Prevention Services Act (FFPSA) and there will be a grace period until June 30, 2022 for all facilities enrolled with Medicaid to be in compliance. The revision will allow the Department to reimburse new QRTP facilities in compliance with the FFPSA and align Department rule with the Colorado Department of Human Services' new QRTP license type. QRTPs will provide a trauma-informed model of care to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

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: The Qualified Residential Treatment Program provisions of the Family First Prevention Services Act, Pub.L. 115-123, Div. E, Title VII, § 50734, Feb. 9, 2018, 132 Stat. 252, were to go into effect October 1, 2018. However, the U.S. Department of Health and Human Services issued Program Instruction PI-18-07 permitting requests for delayed effective dates up to two years past the statutory deadline. The Colorado Department of Human Services applied for, and received, an extension until December 31, 2020, but no later than September 29, 2021. This rule is imperatively necessary to comply with federal law to implement the delayed effective date for the Family First Prevention Services Act provisions pertaining to Qualified Residential Treatment Programs and to align with the parallel Colorado Department of Human Services license and is imperatively necessary for the preservation of public health safety, and welfare.

3. Federal authority for the Rule, if any:

   Pub.L. 115-123, Div. E, Title VII, § 50734, Feb. 9, 2018, 132 Stat. 252

   42 CFR 440.160 (2021)

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   CRS § 25.5-5-202(1)(i) (2021)

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765
Rule Number: MSB 22-03-03-A
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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.

   Members currently residing in Residential Child Care Facilities (RCCF), and RCCF providers, will be impacted by the proposed rule.

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

   RCCF providers will have costs associated with changing their model of care and the requirement that QRTPs be 16 beds or less. For our members, services provided in a QRTP will be trauma-informed and designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances, in a setting limited to 16 beds. Members who require this level of care will receive services within the state and better tailored to their needs.

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.

   The Department anticipates the proposed rule to be budget neutral because RCCF services will be phased out and the same funds will be applied QRTP payment.

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

   The probable costs of the proposed rule are RCCF providers being required to obtain the Qualified Residential Treatment Program license. The probable benefit of the proposed rule is aligning with the Federal Family First Prevention Services Act (FFPSA) and aligning with Colorado Department of Human Services license requirements. The probable cost of inaction is non-compliance with the FFPSA. There are no probable benefits to inaction.

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 methods or less intrusive methods to align Department rule with the FFPSA and with Colorado Department of Human Services license requirements.

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 to align Department rule with the FFPSA and with Colorado Department of Human Services license requirements.

8.765 SERVICES FOR CLIENTS IN ~~PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES OR RESIDING IN~~ RESIDENTIAL CHILD CARE FACILITIES AS DEFINED BELOW

8.765.1 DEFINITIONS

Assessment means the process of continuously collecting and evaluating information to develop a client's profile on which to base a Plan of Care, service planning, and referral.

Clinical Staff means medical staff that are at a minimum licensed at the level of registered nurse, performing within the authority of the applicable practice acts.

Colorado Client Assessment Record (CCAR) means a clinical instrument designed to assess the behavior/mental health status of a medically eligible client. The CCAR is used to identify current diagnosis and clinical issues facing the client, to measure progress during treatment and to determine mental health medical necessity. This instrument is used for children in the custody of a county department of human/social services or Division of youth corrections and for those children receiving mental health services in an RCCF through the Child Mental Health Treatment Act.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the Colorado Medicaid program's benefit under Section 8.280 for children and adolescents that provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21.

Emergency Safety Intervention means the use of Restraint and Seclusion as an immediate response to an Emergency Safety Situation.

Emergency Safety Situation means unanticipated behavior of the client that places the client or others at serious threat of violence or injury if no intervention occurs and that calls for Emergency Safety Intervention.

Emergency Services means emergency medical and crisis management services.

Independent Assessment means a process to assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool. The assessment determines whether treatment in a Qualified Residential Treatment Program (QRTP) provides the most effective and appropriate level of care for the child in the least restrictive environment, in accordance with Colorado Department of Human Services regulations.

Independent Team means a team certifying the need for Psychiatric Residential Treatment Facility (PRTF) services that is independent of the Referral Agency and includes a physician who has competence in the diagnosis and treatment of mental illness and knowledge of the client's condition.

Interdisciplinary Team means staff in a PRTF comprised of a physician, and a Licensed Mental Health Professional, registered nurse or occupational therapist responsible for the treatment of the client.

Licensed Mental Health Professional means a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a psychiatrist licensed pursuant to part 1 of article 36 of title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S., or a social worker licensed pursuant to part 4 of article 43 or title 12, C.R.S., that is supervised by a licensed clinical social worker. Sections 12-43-301, et seq, 12-36-101, et seq, 12-43-401, et seq, 12-43-501, et seq and 12-43-601, et seq, C.R.S. (2005) 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 repository library.

Medication Management Services means review of medication by a physician at intervals consistent with generally accepted medical practice and documentation of informed consent for treatment.

Multidisciplinary Team means staff in a Residential Child Care Facility (RCCF) providing mental health services comprised of at least one Licensed Mental Health Professional and other staff responsible for the treatment of the client and may include a staff member from the Referral Agency.

Plan of Care means a treatment plan designed for each client and family, developed by an Interdisciplinary or Multidisciplinary Team.

Prone Position means a client lying in a face down or front down position.

Psychiatric Residential Treatment Facility (PRTF) means a facility that is not a hospital and provides inpatient psychiatric services for individuals under age 21 under the direction of a physician, licensed pursuant to part 1 of article 36 of title 12, C.R.S.

Qualified Residential Treatment Programs (QRTP) means a facility that provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

Referral Agency means the Division of Youth Corrections, County Departments of Human/Social Services who have legal custody of a client, Behavioral Healthcare Organization or Community Mental Health Center that refers the client to a PRTF or RCCF for the purpose of placement through the Child Mental Health Treatment Act.

Restraint includes Drug Used as a Restraint, Mechanical Restraint and Personal Restraint.

Drug Used as a Restraint means any drug that is administered to manage a client's behavior in a way that reduces the safety risk to the client or to others; has the temporary affect of restricting the client's freedom of movement and is not a standard treatment for the client's medical or psychiatric condition.

Mechanical Restraint means any device attached or adjacent to the client's body that the client cannot easily remove that restricts freedom of movement or normal access to the client's body.

Personal Restraint means personal application of physical force without the use of any device, for the purpose of restraining the free movement of the client's body. This does not include briefly holding a client without undue force in order to calm or comfort, or holding a client's hand to safely escort the client from one area to another. This does not include the act of getting the client under control and into the required position for Restraint.

Residential Child Care Facility (RCCF) means any facility that provides out-of-home, 24-hour care, protection and supervision for children in accordance with 12 C.C.R. 2509-8, Section 7.705.91.A.

Seclusion means the involuntary confinement of a client alone in a room or an area from which the client is physically prohibited from leaving.

[SECTIONS 8.765.2-13 ARE UNAFFECTED BY THIS RULE CHANGE]

8.765.14 QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)

8.765.14.A CLIENT ELIGIBILITY

1. Children up to age eighteen (18) years old and for those persons up to twenty-one (21) years old who consent to the placement or are placed by court order, for whom an Independent Assessment determines that the child's needs cannot be met in a less restrictive, family-based setting because of their serious emotional or behavioral disorders or disturbances.

2. Managed Care Entities must use the Independent Assessment to inform medical necessity determinations.

3. For children in the custody of a county department of human/social services or Division of ~~youth corrections~~Youth Services and for those children receiving mental health services in a Qualified Residential Treatment Program (QRTP) through the Child and Youth Mental Health Treatment Act, the Independent Assessment will determine mental health medical necessity.

8.765.14.B QRTP AND PROVIDER ELIGIBILITY

1. Beginning October 1, 2021, to be eligible for Colorado Medicaid reimbursement, a QRTP must:

   a. Be enrolled with Colorado Medicaid;

   b. Be licensed by the Colorado Department of Human Services (CDHS), Provider Services Unit (PSU), as a Child Care Facility with QRTP indicated~~s~~ as the Service Type in accordance with CDHS regulations;

   c. Be accredited by:

      i. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO),

      ii. The Commission on Accreditation of Rehabilitation Facilities (CARF),

      iii. The Council on Accreditation of Services for Families and Children, or

      iv. Any other independent, not-for-profit accrediting organization approved by the Secretary of Health and Human Services.

   d. Submit an attestation form to the Department with the facility's Colorado Medicaid enrollment application with Colorado Medicaid that attests:

      i. The facility has no more than sixteen (16) beds, including all beds at a single address or on adjoining properties regardless of program or facility type;

      ii. The facility does not share a campus with a Psychiatric Residential Treatment Facility (PRTF);

      iii. For facilities more than one (1) mile but less than ten (10) miles apart by road from another overnight facility controlled by the same ownership or governing body, the other overnight facility meets the following criteria:

         1. The facility maintains its own license;

2. The facility has dedicated staff that ensures a stable treatment environment;

3. Residents do not move between the facility and another during the episode of care

iv. For facilities less than one (1) mile apart, but not on the same campus or adjoining properties, the QRTP is in a home-like structure (cottage, house, apartment) located farther than 750 feet from another overnight facility within a community setting that includes publicly used infrastructure (roads, parks, shared spaces, etc.).

2. Provider Qualifications.

a. The rendering provider for the following services must be an enrolled Licensed Mental Health Professional in a QRTP:

i. Individual therapy,

ii. Group therapy, and

iii. Family therapy.

8.765.14.C COVERED SERVICES

1. Medically necessary services pursuant to Section 8.076.1.8 that are not excluded in Section 8.765.14.D and are:

a. Included in the member's stabilization plan created by the QRTP in accordance Colorado Department of Human Services (CDHS) regulations.

b. Included in the member's individual child and family plan created by the QRTP in accordance with CDHS regulations.

c. Included in the member's discharge and aftercare plan created by the QRTP in accordance with CDHS regulations.

2. All EPSDT services not specified in Sections 8.765.14.C.1-3 are covered under Section 8.280.

8.765.14.D NON-COVERED SERVICES

1. The following services are not covered for members in a QRTP:

a. Room and board;

b. Educational, vocational, and job training services;

c. Recreational or social activities; and

d. Services provided to inmates of public institutions or residents of Institutions of Mental Disease (IMD).

8.765.14.E PRIOR AUTHORIZATION REQUIREMENTS

1. Prior authorization may be required for this benefit.

8.765.14.F REIMBURSEMENT.

1. QRTPs are reimbursed a per diem rate, as determined by the Department, if the following conditions are fulfilled:

   a. Rendered services are documented in the treatment record at the frequencies specified in the member's care plan(s);

   b. A care plan(s) is on record for the time period reported in the reimbursement claim; and

   c. The care meets professionally recognized standards for care in a QRTP.

2. QRTPs must enroll as a Colorado Medicaid provider to act as a billing entity for Licensed Mental Health Professionals rendering mental health services in the QRTP.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 22-02-29-A
Division / Contact / Phone: Office of Community Living / Colin Laughlin / 303-866-2549

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 22-02-29-A, Novel Coronavirus Disease (COVID-19) Rules
3. This action is an adoption of:	new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.6000, 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)?	Yes
If yes, state effective date:	March 11, 2022
Is rule to be made permanent? (If yes, please attach notice of hearing).	No

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.6000. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 22-02-29-A
Division / Contact / Phone: Office of Community Living / Colin Laughlin / 303-866-2549

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this emergency rule is to temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic

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:

   The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary fo the preservation of public health safety, and welfare.

3. Federal authority for the Rule, if any:

   Social Security Act Section 1135, Social Security Act 1115 (Pending), and Social Security Act 1915(c), Appendix K.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2021); 25.5 Article 6, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 22-02-29-A
Division / Contact / Phone: Office of Community Living / Colin Laughlin / 303-866-2549

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.

   Individual's receiving services in community-based settings, provider-owned community-based residential settings, provider-owned facility settings, and case management will all be benefitting from an increase in available funding to respond to the COVID-19 crisis.

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

   Those rendering services in facilities, the community, or even remotely from their office or home may receive additional payment to do so during this critical time. Those receiving services are likely to continue with more likely to experience uninterrupted services as direct care workers/direct support professionals will be incentivized to continue to provide these services.

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.

   Many of the changes the Department is asking for are cost neutral. Additionally, the Department has sought, and in some cases, received approval from the Centers for Medicare and Medicaid to increase payments or rates. However, the Department also must work with its partners at the Office for State Planning and Budget as well as prioritize the many different areas of Medicaid that are impacted by COVID-19. Accordingly, the Department continues to estimate potential costs.

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

   The comparison between direct cost and cost of inaction is hard to quantify. However, it is highly likely that the cost of doing nothing could be higher costs associated with more costly forms of care, significant impact to member's quality of life, and, in some cases – the loss of life or limb.

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

   At this time, the Department is also pursuing additional alternatives to ensure health, safety, and welfare but a key component of this effort is to ensure providers, agencies, and direct support professionals have the money they need to continue to go out in a time of crisis and provide services.

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.

   As mentioned above, the Department is also partnering with community organizations, non-profits, advocacy organizations, other executive agencies, and the governor's office to work towards prioritizing Colorado's most vulnerable citizens receiving long-term care health, safety, and welfare.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

8.6001.1 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Section 8.420

Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

Sections 8.404.3; 8.404.1; 8.405.2.22; 8.405.2.23; 8.405.2.24; 8.405.2.25.

Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

Sections 8.443.16.A; 8.443.1.C-D.

Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

8.6001.2 Nursing Facilities

Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

COVID-19 Mitigation Emergency Supplemental Payment

Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.

1. In order to be eligible for this payment facilities must be:

a. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

b. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

c. Cooperative with State or National efforts to mitigate the emergency

2. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

3. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

Establishment of Section 8.430.6 – Temporary Medicaid Nursing Facility Expansion

1. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

2. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

3. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

4. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

5. After the 60 days has expired, the facility will receive no further reimbursement.

8.6001.3 Case Management

Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

8.6001.4 Level of Care Assessment

Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

Sections 8.390.3.A.2; 8.393.1.M.1.C; 8.393.2.C.5.; 8.393.2.D.1-3; 8.401.11 through 8.401.15; 8.485.61.B; 8.485.71.C; 8.486.201; 8.603.5.D; 8.500.18.B.3; 8.500.108.B.1; 8.503.70.3; 8.503.80.A; 8.506.3;

8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments. For initial assessments, the level of care assessment will be limited to the Activities of Daily living which determines the functional eligibility/LOC for the member. Members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted. For yearly re-assessments, the members existing eligibility will continue through the duration of 1135. Then the yearly re-assessment set to occur within six (6) months following the conclusion of the Section 1135 Waiver.

8.6001.5 Termination from Waiver Eligibility - Adverse Action

Sections 8.393.3.A.1.a through 8.393.A.1.d; 8.485.61.A through 8.485.61.D.3.b; 8.500.16.A.1 through 8.500.16.A.4; 8.500.16.E.1 and E.2; 8.503.160.A.1 through 8.500.160.A.4; 8.503.160.E.1 through 8.503.160.E.9; 8.508.190.A.1-4; 8.508.190.E.1 and E.2 ; 8.508.190.H.1-4; 8.508.190.I.3 and I.4; 8.509.15.A.1 through 8.509.15.A.4.c.1; 8.555.5.D.2

Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

8.6001.6 Preadmission Screening and Resident Review (PASRR)

Section 8.401.18.181.A

PASRR Level I Screening and Level II Evaluations will be suspended for 30 days in accordance with Section 1919(e)(7) for new admissions.

8.6001.7 Personal Care

Sections 8.485.61.D.2-3; 8.489.10.11; 8.510.4.A

Temporarily waive the restriction of personal care services provided in Hospital, Nursing Facility, or other acute-like setting.

Sections 8.510.18; 8.552.1.B

Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

8.6001.8 Guidelines for Institutions for Mental Diseases (IMD's)

Section 8.401.4

Temporarily waive the IMD requirements for nursing facilities that exceed 50% of patient-census with a primary diagnosis of major mental illness.

8.6001.9 Retainer Payments

Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

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Section 8.420

Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

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Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

Sections 8.443.16.A; 8.443.1.C-D.

Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

8.6001.2 Nursing Facilities

Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

COVID-19 Mitigation Emergency Supplemental Payment

Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.

4. In order to be eligible for this payment facilities must be:

d. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

e. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

f. Cooperative with State or National efforts to mitigate the emergency

5. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

6. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

Establishment of Section 8.430.6 – Temporary Medicaid Nursing Facility Expansion

6. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

7. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

8. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

9. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

10. After the 60 days has expired, the facility will receive no further reimbursement.

8.6001.3 Case Management

Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

8.6001.4 Level of Care Assessment

Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

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8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments. For initial assessments, the level of care assessment will be limited to the Activities of Daily living which determines the functional eligibility/LOC for the member. Members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted. For yearly re-assessments, the members existing eligibility will continue through the duration of 1135. Then the yearly re-assessment set to occur within six (6) months following the conclusion of the Section 1135 Waiver.

8.6001.5 Termination from Waiver Eligibility - Adverse Action

Sections 8.393.3.A.1.a through 8.393.A.1.d; 8.485.61.A through 8.485.61.D.3.b; 8.500.16.A.1 through 8.500.16.A.4; 8.500.16.E.1 and E.2; 8.503.160.A.1 through 8.500.160.A.4; 8.503.160.E.1 through 8.503.160.E.9; 8.508.190.A.1-4; 8.508.190.E.1 and E.2 ; 8.508.190.H.1-4; 8.508.190.I.3 and I.4; 8.509.15.A.1 through 8.509.15.A.4.c.1; 8.555.5.D.2

Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

8.6001.6 Preadmission Screening and Resident Review (PASRR)

Section 8.401.18.181.A

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Sections 8.485.61.D.2-3; 8.489.10.11; 8.510.4.A

Temporarily waive the restriction of personal care services provided in Hospital, Nursing Facility, or other acute-like setting.

Sections 8.510.18; 8.552.1.B

Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

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Section 8.401.4

Temporarily waive the IMD requirements for nursing facilities that exceed 50% of patient-census with a primary diagnosis of major mental illness.

8.6001.9 Retainer Payments

Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1
Rule Number: MSB 22-02-29-B
Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

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 22-02-29-B, Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1

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) 8.125.11, 8.125.12, 8.125.13 and 8.126.1, 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)? Yes
   If yes, state effective date: 03/11/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Remove the current text beginning at 8.125.11 through the end of 8.125.13. Replace the current text at 8.126.1 with the proposed text beginning at 8.126.1 through the end of 8.126.1. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1
Rule Number: MSB 22-02-29-B
Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

STATEMENT OF BASIS AND PURPOSE

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

   This rule revision will temporarily remove current requirements for providers to comply with: Fingerprint Criminal Background Checks (10 CCR 2505-10 8.125.12), Site-Visits (10 CCR 2505-10 8.125.11) and payment of Application Fee's (10 CCR 2505-10 8.125.13), during the provider enrollment process. Alleviating these requirements will expedite the processing of provider-enrollment applications.

   These proposed changes bring Colorado regulations into alignment with the approved 1135 waiver which was granted by CMS, temporarily waiving these requirements at the Federal Level. If passed, the rule will become effective on the date the board adopts it and it will expire after 120 days. However, the Department has the option to bring the rule to MSB a second time within the 120 days to reinstate or further extend the timeframe, depending on prevailing conditions and current guidance at that time.

   The rule revision at 8.126.1 (10 CCR 2505-10 8.126.1), will allow providers enrolled as a Mass Immunizer with Medicare to temporarily enroll in Colorado to provide administration of COVID-19 vaccinations.

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:

   Removing these requirements will expedite the processing of provider enrollment applications during the COVID-19 pandemic, thereby increasing the number of approved providers during this emergency period.

   Allowing Mass Immunizers to enroll and administer COVID-19 vaccinations will increase the availability and administration of these critical vaccines.

3. Federal authority for the Rule, if any:

Initial Review
Proposed Effective Date
Final Adoption
Emergency Adoption

DOCUMENT #

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1
Rule Number: MSB 22-02-29-B
Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

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.

   Those seeking to be approved Medicaid providers and our member population will benefit from this proposed rule.

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

   Those seeking to become approved providers will benefit from a streamlined provider enrollment process. Members will benefit from increased access to care as more providers are enrolled and available to offer treatment and services, including COVID-19 vaccinations.

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

   There are no costs to the Department or to another agency to implement and enforce the proposed rule.

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

   There are no probable costs to providers.

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.

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.

DO NOT PUBLISH THIS PAGE

There are no alternative methods for achieving the purpose of the proposed rule.

8.125 PROVIDER SCREENING

~~8.125.11 SITE VISITS~~

~~8.125.11.A. All providers designated as "moderate" or "high" categorical risks to the Medicaid program must consent to and pass a site visit before they may be enrolled or re-validated as Colorado Medicaid providers. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements.~~

~~8.125.11.B. All enrolled providers who are designated as "moderate" or "high" categorical risks must consent to and pass an additional site visit after enrollment or revalidation. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements. Post-enrollment or post-revalidation site visits may occur anytime during the five-year period after enrollment or revalidation.~~

~~8.125.11.C. All providers enrolled in the Colorado Medicaid program must permit CMS, its agents, its designated contractors, the State Attorney General's Medicaid Fraud Control Unit or the Department to conduct unannounced on-site inspections of any and all provider locations~~

~~8.125.11.D. All site visits shall verify the following information:~~

~~1. Basic Information including business name, address, phone number, on-site contact person, National Provider Identification number and Employer Identification Number, business license, provider type, owner's name(s), and owner's interest in other medical businesses.~~

~~2. Location including appropriate signage, utilities that are turned on, the presence of furniture and applicable equipment, and disability access where applicable and where clients are served at the business location.~~

~~3. Employees with relevant training, designated employees who are trained to handle Medicaid billing, where applicable, and resources the provider uses to train employees in Medicaid billing where applicable.~~

~~4. Appropriate inventory necessary to provide services for specific provider type.~~

~~5. Other information as designated by the Department.~~

~~8.125.11.E. The Department shall give the provider a report detailing the discrepancies or insufficiencies in the information disclosed by the provider and the criteria the provider failed to meet during the site visit.~~

~~8.125.11.F. Providers that are found in full compliance shall be recommended for approval of enrollment or revalidation, subject to other enrollment or revalidation requirements.~~

~~8.125.11.G. Providers who meet the vast majority of criteria in 8.125.11.D but have small number of minor discrepancies or insufficiencies shall have 60 days from the date of the issuance of the report in 8.125.11.E to submit documentation to the Department attesting that the provider has corrected the issues identified during the site visit.~~

~~1. If the provider submits attestation within the 60 day timeframe and has met requirements, then the provider shall be recommended for enrollment or revalidation, subject to the verification of other enrollment or revalidation requirements.~~

~~2. If the provider fails to submit the attestation in 8.125.11.G.1 within the 60 day deadline, the Department may deny the provider's application for enrollment or revalidation.~~

~~3. If the provider submits an attestation within 60 days indicating that the provider is not fully compliant with criteria in 8.125.11.D, then the Department may,~~

~~a. For existing providers, suspend the provider, until the provider demonstrates compliance in a subsequent site visit, conducted at the provider's expense; or~~

~~b. For new providers, deny the application and require the provider to restart the enrollment process.~~

~~8.125.11.H. When site visits reveal major discrepancies or insufficiencies in the information provided in the enrollment application or a majority of the criteria described in 8.125.11.D are not met, the Department shall allow for an additional site visit for the provider.~~

~~1. Additional site visits shall be conducted at the provider's expense.~~

~~2. The provider shall have 14 days from the date of the issuance of the report listed in 8.125.11.E above to request an additional site visit.~~

~~3. The Department shall deny or terminate enrollment or revalidation of any provider subject to 8.125.11.G who does not request an additional site visit within 14 days.~~

~~4. If the Department determines that a provider is not in full compliance upon the additional site visit:~~

~~a. for a revalidating provider, the Department shall immediately suspend the provider until a subsequent site visit demonstrates provider is in compliance.~~

~~b. for an enrolling provider, deny the application and require the provider to restart the enrollment process.~~

~~8.125.11.I. The Department shall deny or terminate enrollment or revalidation of any provider who refuses to allow a site visit, unless the Department determines the provider or the provider's staff refused the on-site inspection in error. The provider must provide credible evidence to the Department that it refused the on-site inspection in error within in 7 days of the date of the issuance of the report in 8.125.11.E. Any provider who does not provide credible evidence to the Department that it refused the on-site inspection in error shall be denied or terminated from enrollment or revalidation.~~

~~8.125.11.J. The Department shall deny an application or terminate a provider's enrollment when an on-site inspection provides credible evidence that the provider has committed Medicaid fraud.~~

~~8.125.11.K. The Department shall refer providers in 8.125.11.J to the State Attorney General.~~

~~8.125.12 CRIMINAL BACKGROUND CHECKS AND FINGERPRINTING~~

~~8.125.12.A. As a condition of provider enrollment, any person with an ownership or control interest in a provider designated as "high" categorical risk to the Medicaid program, must consent to criminal background checks and submit a set of fingerprints, in a form and manner to be determined by the Department.~~

~~8.125.12.B. Any provider, and any person with an ownership or control interest in the provider, must consent to criminal background checks and submit a set of fingerprints, in a form and manner designated by the Department, within 30 days upon request from CMS, the Department, the Department's agents, or the Department's designated contractors.~~

~~8.125.13 APPLICATION FEE~~

~~8.125.13.A. Except when exempted in Sections 8.125.13.C and 8.125.13.D, enrolling and re-validating providers must submit an application fee or a formal request for a hardship exemption with their application.~~

~~8.125.13.B. The amount of the application fee is the amount calculated by CMS in accordance with 42 CFR § 424.514(d).~~

~~8.125.13.C. Application fees shall apply to all providers except:~~

~~1. Individual practitioners~~

~~2. Providers who have enrolled or re-validated in Medicare and paid an application fee within the last 12 months~~

~~3. Providers who have enrolled or re-validated in another State's Medicaid or Children's Health Insurance Program and paid an application fee within the last 12 months provided that the Department has determined that the screening procedures in the state in which the provider is enrolled are at least as comprehensive and stringent as the screening procedures required for enrollment in Colorado Medicaid.~~

~~8.125.13.D. The Department may exempt a provider, or group of providers, from paying the applicable application fee, through a hardship exemption request or categorical fee waiver, if:~~

~~1. The Department determines that requiring a provider to pay an application fee would negatively impact access to care for Medicaid clients, and~~

~~2. The Department receives approval from the Centers for Medicare and Medicaid Services to exempt the application fee.~~

~~8.125.13.E. A provider may not be enrolled or revalidated unless the provider has either paid any applicable application fee or obtained an exemption described at Section 8.125.13.D.~~

~~8.125.13.F. The application fee is non-refundable, except if submitted with one of the following:~~

~~1. A request for hardship exemption described at Section 8.125.13.D, that is subsequently approved;~~

~~2. An application that is rejected prior to initiation of screening processes;~~

~~3. An application that is subsequently denied as a result of the imposition of a temporary moratorium as described at Section 8.125.14.~~

8.126 COLORADO NPI RULE

8.126.1 Definitions

A. Billing Provider Field means the data field on a Claim that reflects the Health Care Provider to which the payer issues payment.

B. Campus means the physical area immediately adjacent to the Hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers of Medicare and Medicaid Services to be part of the provider's campus.

C. Claim means a request for payment for the delivery of medical care, services, or goods authorized under the Medical Assistance Program, submitted to the Department through its fiscal agent by a Health Care Provider. Claim includes the transmission of encounter information for the purpose of reporting the delivery of medical care, services, or goods.

D. Health Care Provider means any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Medical Assistance Program members.

1. A Health Care Provider includes an Organization Health Care Provider, Subpart of an Organization Health Care Provider, Off Campus Location, and a Site of an Organization Health Care Provider.

2. Unless specified otherwise in Subsection 8.126.1, a Health Care Provider may include a Health Care Provider located outside the state of Colorado (out-of-state provider) that is licensed and/or certified pursuant to their state laws.

E. Hospital means an Organization Health Care Provider that is enrolled in the Medical Assistance Program under the Provider Type of "Hospital - General" as defined in this Subsection 8.126.1.

F. Medical Assistance Program means the programs authorized under Articles 4, 5, 6, 8, and 10 of Title 25.5.

G. National Provider Identifier (NPI) means the standard, unique health identifier for Health Care Providers or Organization Health Care Providers that is used by the National Plan and Provider Enumeration System (NPPES) in accordance with 45 C.F.R. pt. 162.

H. Off-Campus Location means a facility that:

1. Has operations that are directly or indirectly owned or controlled by, in whole or in part, or affiliated with, a Hospital, regardless of whether the operations are under the same governing body as the Hospital;

2. Is not on the Hospital's Campus;

3. Provides services that are organizationally and functionally integrated with the Hospital;

4. Is an outpatient facility providing preventive, diagnostic, treatment, or emergency services; and

5. Is identified on the Hospital's State License Addendum issued by the Colorado Department of Public Health and Environment or, for Hospitals licensed outside of Colorado, documentation demonstrating direct or indirect ownership or control of the Off-Campus Location.

I. Organization Health Care Provider means a Health Care Provider that is not an individual.

J. Provider Type means a classification of Health Care Provider or Organization Health Care Provider to which the payer issues payment for services provided to individuals enrolled in the Medical Assistance Program, according to the Provider Type license, accreditation, certification, and/or service provided. The Provider Types recognized by the Department are as follows:

1. Administrative Services Organization (ASO) is an entity that has entered into a valid, active contract to provide ASO services with the Colorado Department of Health Care Policy and Financing.

2. Ambulatory Surgical Center (ASC) means a health care entity that is:

a. Licensed by the Colorado Department of Public Health and Environment as an Ambulatory Surgical Center; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as an Ambulatory Surgical Center.

3. Audiologist means an individual licensed as an audiologist by the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

4. Behavioral Therapy Clinic means any group practice that has at least one affiliated Behavioral Therapy Individual. The affiliated Behavioral Therapy Individual must be enrolled in the Colorado Medical Assistance Program.

5. Behavioral Therapy Individual means an individual that:

a. Is nationally certified as a Board-Certified Behavioral Analyst (BCBA); or

b. Meets one of the following:

(1) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology and is actively licensed by the State Board of Examiners; and has completed 400 hours of training; and/or has direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(2) Has a doctoral degree in one of the behavioral or health sciences; and has completed 800 hours of specific training; and/or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(3) Is nationally certified as a BCBA; or

(4) Has a master's degree or higher in behavioral or health sciences; and is a licensed teacher with an endorsement of school psychologist; or is a licensed teacher with an endorsement of special education or early childhood special education; or is credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist); and has completed 1,000 hours of direct supervised training or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

6. Birthing Center means a health care entity licensed as a Birth Center by the Colorado Department of Public Health and Environment. Out-of-state providers are not eligible for enrollment.

7. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers.

8. Certified Registered Nurse Anesthetist (CRNA) means an individual who is:

   a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

   b. Included within the advanced practice registry as a CRNA.

9. Clinic – Dental means any group practice that has at least one affiliated, licensed dentist or dental hygienist.

   a. The affiliated dentist or dental hygienist must be enrolled in the Colorado Medical Assistance Program; and

   b. A dental practice or clinic must be owned by a licensed dentist except if the dental practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.); and

   c. A dental hygiene practice or clinic must be owned by a licensed dentist or licensed dental hygienist except if the dental hygiene practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.)

10. Clinic – Practitioner means any group practice that has at least one affiliated, licensed physician, osteopath, or podiatrist. The affiliated practitioner must be enrolled in the Colorado Medical Assistance Program.

11. Community Clinic means a health care entity that is:

   a. Licensed as a Community Clinic or Community Clinic and Emergency Center (CCEC) by the Colorado Department of Public Health and Environment;

   b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program; and

c. Owned by a Medicare participating hospital.

12. Community Mental Health Center (CMHC) means a health care entity that:

    a. Is licensed as a Community Mental Health Center by the Colorado Department of Public Health and Environment;

    b. Has program approval to operate as a CMHC from the Colorado Department of Human Services; and

    c. If the CMHC delivers substance use disorder services, shall have Substance Use Disorder program approval from Colorado Department of Human Services.

13. Dental Hygienist means an individual who is licensed as a Dental Hygienist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

14. Dentist means an individual who is licensed as a Dentist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

15. Dialysis Treatment Clinic [Formerly Known as Dialysis Center] means a health care entity that is:

    a. Licensed as a Dialysis Treatment Clinic by the Colorado Department of Public Health and Environment; and

    b. Certified by Centers for Medicare and Medicaid Services to participate in the Medicare program as an End-Stage Renal Dialysis Facility (ESRD).

16. Federally Qualified Health Center (FQHC) means a health care entity that has been awarded a Section 330 Grant from the Health Resources and Services Administration. A health care entity that has been designated as a “look-alike” is also eligible to be enrolled as an FQHC.

17. Foreign Teaching Physician means an individual who is licensed as a distinguished foreign teaching physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

18. Home and Community Based Services (HCBS) means Health First Colorado (Colorado’s Medicaid Program)’s community-based care alternatives to institutional, Long-Term care. Providers enrolling as an HCBS provider shall meet all applicable state and federal requirements to provide HCBS by waiver and specialty type.

19. Home Health Agency means a health care entity that:

    a. Has a Class A Home Care Agency license from the Colorado Department of Public Health and Environment; and

    b. Is certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as Home Health Agency.

20. Hospice means a health care entity that is:

    a. Licensed as a Hospice by the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospice.

21. Hospital – General means a health care entity that is:

a. Licensed as a General Hospital by the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospital.

22. Hospital – Psychiatric [Formerly Known as Hospital - Mental] means a health care entity that is:

a. Licensed as a Psychiatric Hospital by the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Psychiatric Hospital.

23. Independent Laboratory means a laboratory that:

a. Has a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification; and

b. Is certified through the Centers for Medicare and Medicaid Services as a laboratory.

24. Indian Health Service – Federally Qualified Health Center (FQHC) means a health care entity that:

a. Is treated by the Centers for Medicare and Medicaid Services as a comprehensive Federally funded health center; and

b. Includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

25. Indian Health Service – Pharmacy means a health care entity that has evidence of participation in the Indian Health Service.

26. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Formerly Known as Nursing Facility – ICF/IID] means a health care entity that is:

a. Licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as an ICF/IID.

27. Licensed Behavioral Health Clinician means an individual that is licensed by the Colorado Department of Regulatory Agencies as either:

a. A Licensed Clinical Social Worker;

b. A Licensed Professional Counselor;

c. A Licensed Marriage and Family Therapist; or

d. A Licensed Addiction Counselor.

28. Licensed Psychologist means an individual who is licensed as a psychologist by the State Board of Psychologist Examiners within the Colorado Department of Regulatory Agencies.

29. Managed Care Entity [Formerly Known as Health Maintenance Organization (HMO)] means an entity that has a valid and comprehensive or all-inclusive risk contract with the Colorado Department of Health Care Policy and Financing.

30. Non-Physician Practitioner Group means any group practice consisting of any of the following:

a. Licensed Nurse Practitioners;

b. Licensed Audiologists;

c. Licensed Occupational Therapists;

d. Licensed Behavioral Health Clinicians;

e. Licensed Psychologists;

f. Licensed Speech Therapists; and/or

g. Licensed Physical Therapists.

h. Beginning on the effective date of this amended rule, and for the remainder of the COVID-19 Public Health Emergency (PHE), providers that have enrolled as a Mass Immunizer Roster Biller (provider specialty type 73) with Medicare may temporarily enroll in the medical assistance program as a Non-Physician Practitioner Group for the purpose of billing for the administration of COVID-19 vaccinations for medical assistance clients.

31. Non-Physician Practitioner Individual means a registered nurse, which means an individual licensed as a Registered Nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies.

32. Nurse Midwife means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Midwife.

33. Nurse Practitioner means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Practitioner.

34. Nursing Facility means a health care entity that is:

a. Licensed as a Nursing Care Facility through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as a Skilled Nursing Care Facility.

35. Occupational Therapist means an individual who is licensed as an Occupational Therapist by the Director of the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

36. Optical Outlet means a health care supplier that is qualified to make and supply eyeglasses and contact lenses for the correction of vision. If, in the performance of its duties, the Optical Outlet requires laboratory services, the laboratory is required to have a current and valid CLIA certification.

37. Optometrist means an individual who is licensed as an Optometrist by the State Board of Optometry within the Colorado Department of Regulatory Agencies.

38. Osteopath means an individual who holds a degree of “doctor of osteopathy,” and who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

39. Personal Care Agency means a health care entity that has a Class A or Class B Home Care Agency license from the Colorado Department of Public Health and Environment.

40. Pharmacist means an individual who is licensed as a Pharmacist by the State Board of Pharmacy within the Colorado Department of Regulatory Agencies.

41. Pharmacy means a pharmacy, pharmacy outlet, or prescription drug outlet registered by the Board of Pharmacy within the Colorado Department of Regulatory Agencies.

42. Physical Therapist means an individual who is licensed as a Physical Therapist by the Physical Therapy Board within the Colorado Department of Regulatory Agencies.

43. Physician means an individual who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

44. Physician Assistant means an individual who is licensed as a physician assistant by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

45. Podiatrist means an individual licensed as a podiatrist by the Colorado Podiatry Board within the Colorado Department of Regulatory Agencies.

46. Psychiatric Residential Treatment Facility (PRTF) means a health care entity that:

a. Is licensed by the Colorado Department of Human Services as a Residential Child Care Facility and a PRTF; and

b. Is certified as a qualified residential provider by the Department of Public Health and Environment; and

c. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children; and

d. Has provided an attestation to the Department that the PRTF is in compliance with the conditions of participation as required by Colorado Department of Human Services and the Centers for Medicare and Medicaid Services.

47. Qualified Medicare Beneficiary (QMB) Benefits Only means the provider type designation used for Chiropractors who participate under the QMB Program. Chiropractor means an individual licensed as a chiropractor by the Board of Chiropractic Examiners within the Colorado Department of Regulatory Agencies. QMB Benefits Only providers must also be certified as QMB Benefits Only providers through the Centers for Medicare and Medicaid Services.

48. Regional Accountable Entity (RAE) means an entity that has entered into a valid, existing contract with the Colorado Department of Health Care Policy and Financing to be a Regional Accountable Entity.

49. Rehabilitation Agency means a group practice that requires at least one affiliated and licensed professional enrolled in the Colorado Medical Assistance Program.

50. Residential Child Care Facility (RCCF) means a health care entity that is:

a. Designated by the Colorado Department of Human Services to provide Medicaid-reimbursable mental health services as an RCCF; and

b. Licensed by Colorado Department of Human Services as an RCCF.

51. Rural Health Clinic (RHC) means a clinic that is certified by the Centers for Medicare and Medicaid Services as a Rural Health Clinic.

52. School Health Services means a school district or Board of Cooperative Educational Services that has a valid, active contract with the Colorado Department of Health Care Policy and Financing to participate in the Colorado School Health Services Program.

a. The Site at which an Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program enrolled under the Provider Type of School Health Services is a school district.

53. Speech Therapist is an individual certified as a Speech Language Pathologist by the Director of the Divisions of Professions and Occupations within the Colorado Department of Regulatory Agencies.

54. Substance Use Disorder (SUD) – Clinic means a health care entity that:

a. Is licensed as a SUD Provider by the Colorado Department of Human Services;

b. Has program approval to operate as a SUD – Clinic from Colorado Department of Human Services; and

c. Has at least one affiliated advanced practice nurse, physician/psychiatrist, physician assistant, or behavioral health clinician who is certified in addiction medicine.

55. Supply means a Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider that meets one or both of the following definitions:

a. Complex Rehabilitation Technology (CRT) Supplier means a health care supplier that meets all the requirements of Section 8.590.5.D, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate;

(2) Has CRT Professional Certification; and

(3) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS and CRT.

b. Durable Medical Equipment (DME) means a health care supplier that meets the requirements of Sections 8.590.5.A and B, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate; and

(2) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS.

56. Transportation means a provider that meets one or both of the following definitions:

a. Emergency Medical Transportation (EMT) [Formerly Known as Emergency Medical Transportation and Air Ambulance] means providers that:

(1) Meet all provider screening requirements in Section 8.125.

(2) Comply with commercial liability insurance requirements.

(3) Maintain the appropriate licensure for:

(a) Ground ambulance license as required by Colorado Department of Public Health and Environment; and

(b) Air ambulance license as required by Colorado Department of Public Health and Environment.

(4) License, operate, and equip ground and air ambulances in accordance with federal and state regulations.

b. Non-Emergent Medical Transportation (NEMT) means a provider that:

(1) Has a Public Utilities Commission (PUC) common carrier certificate as a taxicab; or

(2) Has a PUC Medicaid Client Transport (MCT) Permit as required by the PUC; or

(3) Has a ground ambulance license as required by Department of Public Health and Environment; or

(4) Has an Air Ambulance license as required by Colorado Department of Public Health and Environment; or

(5) Is exempt from licensure requirements in accordance with the PUC.

57. X-Ray Facility means an imaging center that:

a. Has an X-Ray Facility and Machine Registration Report certified by the Colorado Department of Public Health and Environment; and

b. Is certified by the Centers for Medicare and Medicaid Services to participate in Medicare as an X-Ray facility.

K. Service Facility Location Field means the physical location specifically where services were rendered as identified on the Claim.

L. Site means the physical location by street address, including suite number, where goods and/or services are provided. The term Site when involving a Health Care Provider that voluntarily contracts with a RAE as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home, also includes the following requirements:

1. PCMP services must be identifiable from other goods and/or services, including services provided by specialists provided by the Health Care Provider in the same physical location through a separate and unique NPI.

2. PCMP services provided at a Campus or Off-Campus Location must be identifiable from other goods and/or services, including services provided by specialists, provided by the Health Care Provider on the same Campus or Off-Campus Location through a separate and unique NPI.

M. Subpart means a component or separate physical location of an Organization Health Care Provider that may be separately licensed or certified. This definition is intended to be consistent with the use of the term "Subpart" as defined in 45 C.F.R. pt. 162.

N. The definitions in Subsection 8.126.1 apply only to Section 8.126.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
Rule Number: MSB 22-02-29-C
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

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 22-02-29-C, Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1

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) 8.018.1.F and 8.018.4.D.1, 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)? Yes
   If yes, state effective date: 03/11/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.018 with the proposed text beginning at 8.018.1 through the end of 8.018.4. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
Rule Number: MSB 22-02-29-C
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STATEMENT OF BASIS AND PURPOSE

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

   This rule revision expands the definition of Facility in the existing EMT rule. The expanded definition will allow for ambulance transports to a wider range of care locations during the COVID-19 public health emergency, including alternative hospital sites and temporary facilities. The rule also allows for transports between facilities without requiring basic or advanced life support services.

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:

   Under the Department's current rule, ambulance trips may only be taken to a limited set of medical facilities, the "closest, most appropriate Facility." CMS recently issued an expanded list of allowable destinations for ambulance trips that qualify for Medicare reimbursement during the COVID-19 public health emergency. This rule will align the Department with that new CMS Medicare guidance by expanding our definition of Facility. The goal is to allow EMT providers to take members to a wider range of medical facilities that are appropriate to the member's condition but that are not necessarily hospitals. This will help prevent hospital overcrowding while also getting members the most appropriate medical care, and will allow utilization of temporary and alternative care sites.

   The second change relates to interfacility transportation, which is ambulance transportation from one facility to another, provided the member requires basic or advanced life support en route. This revision suspends the life support requirement. This will allow for members to be moved from one facility to another if they need continued COVID-19-related care, but do not require life support en route.

3. Federal authority for the Rule, if any:
4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
Rule Number: MSB 22-02-29-C
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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.

   Members utilizing or eligible for EMT services (nearly all members are eligible), EMT providers, and facilities treating COVID-19 patients will all benefit from the proposed revisions.

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

   Affected members will benefit from increased access to care, and transportation providers will benefit from greater flexibility in their ability to transport patients. Medical providers and facilities will benefit from an increased ability to transport patients to prevent any one facility from becoming overloaded.

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

   There are no costs to the Department or to any other agency to implement and enforce the proposed rule.

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

   The probable benefits of implementation are greater flexibility for EMT providers and the avoidance of overcrowding at hospitals. The benefit to members is that they can receive care in the most appropriate setting. The potential costs are an increase in EMT trips, however EMT trips occur as they are needed. The costs of inaction are potential overcrowding at hospitals and a reduction in willing EMT providers.

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.

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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 for the proposed rule.

8.018 EMERGENCY MEDICAL TRANSPORTATION

8.018.1. DEFINITIONS

8.018.1.A. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.018.1.B. Client means a person enrolled in the Medical Assistance Program.

8.018.1.C. Emergency Medical Services (EMS) Provider means an individual who has a current and valid emergency medical service provider certificate issued by the Department of Public Health and Environment (CDPHE) and includes Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), Emergency Medical Technician Intermediate (EMT-I), and Paramedic, in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

8.018.1.D. Emergency Medical Technician (EMT) means an individual who has a current and valid EMT certificate issued by CDPHE and who is authorized to provide basic emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

8.018.1.E. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation during which Clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route.

8.018.1.F. Facility means a general hospital, hospital unit, psychiatric hospital, rehabilitation hospital, Acute Treatment Unit (ATU), or Crisis Stabilization Unit (CSU), as well as any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH) or Skilled Nursing Facility (SNF), community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), any other location furnishing dialysis services outside of the End Stage Renal Disease (ESRD) facility, and the beneficiary's home..

8.018.1.G. Fixed-Wing Air Ambulance means a fixed-wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.018.1.H. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.018.1.I. Interfacility Transportation means transportation of a Client from one Facility to another Facility.

8.018.1.J. Life-Sustaining Supplies means oxygen and oxygen supplies required for life-sustaining treatment during transport via ambulance.

8.018.1.K. Mileage means the number of miles the Client is transported in the ambulance.

8.018.1.L. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment that is covered by the Colorado Medical Assistance Program under Section 8.014. Non-emergency care may be scheduled or unscheduled. This may include urgent care transportation and hospital discharge transportation.

8.018.1.M. Paramedic means an individual who has a current and valid Paramedic certificate issued by CDPHE and who is authorized to provide acts of advanced emergency medical care in

accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two. For the purposes of these rules, Paramedic includes the historic Emergency Medical Service Provider level of EMT-Paramedic (EMT-P).

8.018.1.N. Paramedic with Critical Care Endorsement means an individual who has a current and valid Paramedic certificate issued by CDPHE and who has met the requirements in CDPHE rule to obtain a critical care endorsement from CDPHE and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to critical care, as set forth in C.R.S. § 25-3.5-206.

8.018.1.O. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.018.1.P. Specialty Care Transport (SCT) means interfacility Ground Ambulance transportation of a critically injured or ill Client from a stabilizing hospital to a hospital with full capabilities to treat the Client's case. SCT is necessary when a Client's condition requires ongoing care during transport at a level of service beyond the scope of the EMT, that must be furnished by one or more health professionals in an appropriate specialty area including, but not limited to, nursing, emergency medicine, respiratory care, cardiovascular care, or a Paramedic with Critical Care Endorsement.

8.018.2. CLIENT ELIGIBILITY

8.018.2.A. Emergency Medical Transportation is a benefit for all Colorado Medical Assistance Program Clients who are ill, injured, or otherwise mentally or physically incapacitated and in need of immediate medical attention to prevent permanent injury or loss of life.

8.018.3. PROVIDER ELIGIBILITY

8.018.3.A. Providers must enroll with the Colorado Medical Assistance Program as an Emergency Medical Transportation provider to be eligible for reimbursement. Enrolled Emergency Medical Transportation providers must:

1. Meet all provider screening requirements in Section 8.125.

2. Comply with commercial liability insurance requirements.

3. Maintain and comply with the appropriate licensure:

   a. Ground Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-301 and 6 CCR 1015-3, Chapter Four.

   b. Air Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-307 and 6 CCR 1015-3, Chapter Five.

4. License, operate, and equip Ground and Air Ambulances in accordance with federal and state regulations.

8.018.4. COVERED SERVICES

8.018.4.A. Emergency Medical Transportation is a covered service when medically necessary, as defined in Section 8.076.1.8., and in accordance with this Section 8.018.4.

8.018.4.B. Ground Ambulance

1. The following Ground Ambulance Emergency Medical Transportation services are covered:

    a. Transportation to the closest, most appropriate Facility.

    b. Basic life support (BLS) or advanced life support (ALS) required to maintain life during transport from the Client's pickup point to the treating Facility.

        i. BLS includes:

            1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

            2. Suctioning en route (not deep suctioning); and

            3. Airway control/positioning.

        ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference. This incorporation by reference excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), 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.

            1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

            2. ALS Level 2 includes:

                a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

                b. The provision of at least one of the following ALS procedures:

                i. Manual defibrillation/cardioversion.

                ii. Endotracheal intubation.

                iii. Central venous line.

                iv. Cardiac pacing.

                v. Chest decompression.

                vi. Surgical airway.

                vii. Intraosseous line.

c. Specialty Care Transport when medically necessary to reach the closest, most appropriate Facility.

d. Department-approved supplies used during Emergency Medical Transportation, including Life-Sustaining Supplies, are separately reimbursable when medically necessary.

8.018.4.C. Air Ambulance

1. Air Ambulance Emergency Medical Transportation services are covered when:

a. They meet the criteria at Section 8.018.4.B.1.a.-b.; and

b. The point of pick up is inaccessible by a Ground Ambulance, or great distances or other obstacles prohibit transporting the Client by land to the nearest appropriate medical Facility.

8.018.4.D. Interfacility Transportation

1. Interfacility Transportation is covered when:

a. The Client requires a transfer from one Facility to another.~~; and~~

~~b. The Client requires ALS or BLS services.~~

2. Interfacility Transportation can be provided via Ground or Air Ambulance.

8.018.5. NON-COVERED SERVICES AND GENERAL LIMITATIONS

8.018.5.A. The following services are not covered or reimbursable to Emergency Medical Transportation providers as part of an Emergency Medical Transportation service:

1. Waiting time and cancellations.

2. Transportation of additional passengers.

3. Response calls when determined no transportation is needed or approved.

4. Charges when the Client is not in the vehicle.

5. Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary.

6. Transportation which is covered by another entity.

7. Transportation to local treatment programs not enrolled in Colorado Medical Assistance Program.

8. Transportation of a Client who is deceased prior to transport.

9. Pick up or delivery of prescriptions or supplies.

10. Transportation arranged for a Client's convenience when there is no reasonable risk of permanent injury or loss of life.

11. Transportation to non-emergency medical appointments or services. See Section 8.014 for NEMT services.

8.018.6. PRIOR AUTHORIZATION

8.018.6.A. Prior Authorization is not required for Emergency Medical Transportation.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 22-02-29-D
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

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: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.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) 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.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)? Yes
   If yes, state effective date: 03/11/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.014 with the proposed text beginning at 8.014 through the end of 8.014.8. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 22-02-29-D
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

STATEMENT OF BASIS AND PURPOSE

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

   This rule revision permits NEMT services for covered Medicaid services to locations that are not enrolled with the Colorado Medical Assistance Program. The purpose of this rule is to expand the list of allowable NEMT destinations to include alternative care sites (e.g., the Colorado Convention Center) that are not covered places of service. By temporarily waiving the covered place of service requirement, members can receive treatment for COVID-19 at a wider range of locations. This will potentially increase hospital capacity by shifting patients to sites that are not enrolled with the Colorado Medical Assistance Program.

   In addition, the revision suspends the ability for NEMT providers to transport more than one member at a time, unless the additional passenger is an approved Escort.

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:

   Permitting NEMT trips to non-covered places of service will prevent hospital overcrowding while ensuring that members receive treatment for COVID-19. The change allows flexibility and takes advantage of newly established alternative care sites that may be temporary in nature and thus not enrolled in the Colorado Medical Assistance Program. If members with COVID-19 can only receive care at covered places of service, those sites may become overcrowded and may see a shortage of available beds.

   Suspending multi-loading will ensure compliance with social distancing guidelines by limiting a vehicle's occupants.

3. Federal authority for the Rule, if any:

   42 CFR 440.170 (2020)

4. State Authority for the Rule:

DO NOT PUBLISH THIS PAGE

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
25.5-5-324, C.R.S. (2019)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 22-02-29-D
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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.

   Members utilizing or eligible for NEMT services (nearly all members with State Plan/Title XIX are eligible), NEMT providers, and facilities treating COVID-19 patients will all benefit from the proposed revisions.

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

   Affected members will benefit from increased access to care, and transportation providers will benefit from a slight uptick in utilization when trip volumes have fallen. Medical providers and facilities will benefit from an increased ability to transport patients to prevent any one facility from becoming overloaded.

   For the multi-loading revision, members and drivers will benefit from a reduction in potential exposure to COVID-19. Drivers will not see a reduction in trip volume because the Department previously issued guidance that suspended multi-loading during the public health emergency. This rule simply formalizes that guidance.

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

   There are no costs to the Department or to any other agency to implement and enforce the proposed rule.

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

   For the covered place of service requirement, the probable cost of the proposed rule is a potential minimal increase in utilization, which is more than offset by the reduction in NEMT utilization during the stay at home order. The benefits of the proposed rule are increased access to care and the ability to move members to different sites as they recover, which frees up hospital beds.

The cost of inaction is that members in a hospital for COVID-19 will continue to tie up beds if they cannot be moved to an alternate location as they recover. This will potentially strain hospital resources.

For multi-loading, the cost of the revision is a small increase in claims. One driver will have to take one patient at a time rather than multiple patients on the same route. As a result, the Department will need to dispatch more drivers. The cost will be offset by the substantial reduction in NEMT utilization for March and April. The benefit to implementation is that drivers and passengers will maintain social distancing standards and reduce the spread of COVID-19.

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.

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 for the proposed rule.

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

8.014.1.A. Access means the ability to make use of.

8.014.1.B. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.C. Ambulatory Vehicle means a passenger-carrying vehicle available for those clients able to walk and who do not rely on wheelchairs or other mobility devices, during boarding or transportation, which would necessitate a vehicle with a lift or other accommodations.

8.014.1.D. Ancillary Services mean services incurred indirectly when a client authorized to receive NEMT also requires the assistance of an Escort or financial assistance for meals or lodging.

8.014.1.E. At-Risk Adult means an adult who is unable to make personal or medical determinations, provide necessary self-care, or travel independently.

8.014.1.F. Child means a minor under the age of 18.

8.014.1.G. Day Treatment means facility-based services designed for Children with complex medical needs. Services include educational or day care services when the school or day care system is unable to provide skilled care in a school setting, or when the Child's medical needs put them at risk when around other Children.

8.014.1.H. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation under Section 8.018 during which clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route

8.014.1.I. Escort means a person who accompanies an At-Risk Adult or minor client.

8.014.1.J. Fixed-Wing Air Ambulance means a fixed wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.014.1.K. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at Section 40-10.1-302, C.R.S.

8.014.1.M. Mode means the method of transportation.

8.014.1.N. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment~~ that is covered by the Colorado Medical Assistance Program.~~ Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.

8.014.1.O. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Section 8.497.

8.014.1.P. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.014.1.Q. State Designated Entity (SDE) means the organization responsible for administering NEMT. For the purposes of this rule, the responsible SDE is determined by the client's county of residence.

8.014.1.R. Stretcher Van means a vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.

8.014.1.S. Taxicab means a motor vehicle operating in Taxicab Service, as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.T. Taxicab Service has the same meaning as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.U. Trip means one-way transportation from the point of origin to the point of destination.

8.014.1.V. Urgent Care means an appointment for a covered medical service with verification from an attending physician or facility that the client must be seen or picked up from a discharged appointment within 48 hours.

8.014.1.W. Wheelchair Vehicle means a motor vehicle designed and used for the non-emergent transportation of individuals with disabilities who use a wheelchair. These vehicles include vans modified for wheelchair Access or wheelchair accessible minivans.

8.014.2. CLIENT ELIGIBILITY AND RESPONSIBILITIES

8.014.2.A. All Colorado Medical Assistance Program clients are eligible for NEMT services unless the client falls within the following eligibility groups on the date of the Trip:

1. Qualified Medicaid Beneficiary (QMB) Only
2. Special Low Income Medicare Beneficiary (SLMB) Only
3. Medicare Qualifying Individual-1 (QI-1) Only
4. Old Age Pension- State Only (OAP-state only)

8.014.2.B. Child Health Plan Plus clients are not eligible for NEMT.

8.014.2.C. PACE clients receive transportation provided by their PACE organization and are not eligible for NEMT.

8.014.2.D. NEMT services may be denied if clients do not observe the following responsibilities:

1. Comply with applicable state, local, and federal laws during transport.
2. Comply with the rules, procedures and policies of the SDE.
3. Obtain authorization from their SDE.
4. Clients must not engage in violent or illegal conduct while utilizing NEMT services.
5. Clients must not pose a direct threat to the health or safety of themselves or others, including drivers.

6. Clients must cancel their previously scheduled NEMT Trip if the ride is no longer needed, except in emergency situations or when the client is otherwise unable to cancel.

8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES

8.014.3.A. Providers must enroll with the Colorado Medical Assistance Program as an NEMT provider.

8.014.3.B. Enrolled NEMT providers must:

1. Meet all provider screening requirements in Section 8.125;

2. Comply with commercial liability insurance requirements and, if applicable, PUC financial responsibility requirements established in the PUC statute at C.R.S. § 40-10.1-107;

3. Refrain from attempting to solicit clients known to have already established NEMT service with another provider;

4. Maintain and comply with the following appropriate licensure, or exemption from licensure, requirements:

   a. PUC common carrier certificate as a Taxicab;

   b. PUC MCT Permit as required by the PUC statute at C.R.S. § 40-10.1-302;

   c. Ground Ambulance license as required by Department of Public Health and Environment (CDPHE) rule at 6 CCR 1015-3, Chapter Four;

   d. Air Ambulance license as required by CDPHE rule at 6 CCR 1015-3, Chapter Five; or

   e. Exemption from licensure requirements in accordance with PUC statute at C.R.S. § 40-10.1-105.

5. Only provide NEMT services appropriate to their current licensure(s) and within the geographic limitations applicable to the licensure; and

6. Ensure that all vehicles and auxiliary equipment used to transport clients meet federal, state, and local safety inspection and maintenance requirements.

PUC statute at C.R.S. §§ 40-10.1-105, 40-10.1-107 and 40-10.1-302 (2019) and CDPHE rule at 6 CCR 1015-3, Chapters Four and Five (2019), are hereby incorporated by reference.

8.014.3.C. NEMT transportation providers must maintain a Trip report for each NEMT Trip provided and must, at a minimum, include:

1. The pick-up address;

2. The destination address;~~, which must be a covered place of service under Section 8.014.4;~~

3. Date and time of the Trip;

4. Client's name or identifier;

5. Confirmation that the driver verified the client's identity;

6. Confirmation by the client, Escort, or medical facility that the Trip occurred;

7. The actual pick-up and drop off time;

8. The driver's name; and

9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. NEMT providers may not transport more than one client at the same time, unless the additional passenger is an Escort.~~Except as otherwise specified at Section 8.014.3.D.2., NEMT providers may transport more than one client at the same time if:~~

~~a. Standard safety guidelines are followed;~~

~~b. Each client agrees to be transported with other clients;~~

~~c. No client is in the vehicle for more than thirty minutes longer than if the client were transported alone; and~~

~~d. Children traveling without an Escort are transported only with persons known by such Children including, but not limited to, other Children attending the same service, family members, or friends, at all times.~~

~~2. Taxicabs must comply with applicable PUC rules regarding multiple passengers at 4 CCR 723-6, § 6252 (2019), which is hereby incorporated by reference.~~

8.014.3.E. The Section 8.014.3 requirements do not apply to client reimbursement or bus or rail systems.

8.014.4. COVERED PLACES OF SERVICE

~~8.014.4.A. NEMT must be to service location(s) enrolled with the Colorado Medical Assistance Program to provide the medical services the client is receiving, regardless of whether the medical services will be paid for by the Colorado Medical Assistance Program or another entity.~~

8.014.4.~~B~~A. NEMT must be provided to the closest provider available qualified to provide the service the client is traveling to receive. The closest provider is defined as a provider within a 25-mile radius of the client's residence, or the nearest provider if one is not practicing within a 25-mile radius of the client's residence. Exceptions may be made by the SDE in the following circumstances:

1. If the closest provider is not willing to accept the client, the client may use NEMT to access the next closest qualified provider.

2. If the client has complex medical conditions that restrict the closest medical provider from accepting the patient, the SDE may authorize NEMT to be used to travel to the next closest qualified provider. The treating medical provider must send the SDE written documentation indicating why the client cannot be treated by the closest provider.

3. If a client has moved within the three (3) months preceding an NEMT transport, the client may use NEMT to their established medical provider seen in their previous locale. During

these three (3) months, the client and medical provider must transfer care to the closest provider as defined at Section 8.014.4.B. or determine transportation options other than NEMT.

8.014.5. COVERED SERVICES

8.014.5.A. Transportation Modes

1. Covered Modes of transportation include:

    a. Bus and public rail systems

        i. Transit passes may be issued by the SDE when the cumulative cost of bus tickets exceeds the cost of a pass.

    b. Personal vehicle mileage reimbursement

    c. Ambulatory Vehicles

    d. Wheelchair Vehicles

    e. Taxicab Service

    f. Stretcher Van

    g. Ground Ambulance

    h. Air Ambulance

    i. Commercial plane

    j. Train

8.014.5.B. NEMT Services

1. NEMT is a covered service when:

    a. The client does not have Access to other means of transportation, including free transportation;

    b. Transportation is required to obtain a non-emergency service(s) that is medically necessary, as defined in Section 8.076.1.8.; and

    c. The client is receiving a service covered by the Colorado Medical Assistance Program.

2. NEMT services may be covered for clients even if the medical procedure is paid for by an entity other than the Colorado Medical Assistance Program.

3. Non-emergent ambulance service (Ground and Air Ambulance), from the client's pickup point to the treating facility, is covered when:

    a. Transportation by any other means would endanger the client's life; or

b. The client requires basic life support (BLS) or advanced life support (ALS) to maintain life and to be transported safely.

i. BLS includes:

1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

2. Suctioning en route (not deep suctioning); and

3. Airway control/positioning.

ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference.

1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

2. ALS Level 2 includes:

a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

b. The provision of at least one of the following ALS procedures:

i. Manual defibrillation/cardioversion.

ii. Endotracheal intubation.

iii. Central venous line.

iv. Cardiac pacing.

v. Chest decompression.

vi. Surgical airway.

vii. Intraosseous line.

4. NEMT may be provided to an Urgent Care appointment under the following circumstances:

a. A provider is available;

b. The appointment is for a covered medical service with verification from an attending physician that the client must be seen within 48 hours; and

c. The client is transported to an Urgent Care facility, which may include a trauma center if it is the nearest and most appropriate facility.

8.014.5.C. Personal Vehicle Mileage Reimbursement

1. Personal vehicle mileage reimbursement is covered for a privately owned, non-commercial vehicle when used to provide NEMT services in accordance with Section 8.014.5.B and owned by:

    a. A client, a client's relative, or an acquaintance; or

    b. A volunteer or organization with no vested interest in the client.

2. Personal vehicle mileage reimbursement will only be made for the shortest Trip length in miles as determined by an internet-based map, Trip planner, or other Global Positioning System (GPS).

    a. Exceptions can be made by the SDE if the shortest distance is impassable due to:

        i. Severe weather;

        ii. Road closure; or

        iii. Other unforeseen circumstances outside of the client's control that severely limit using the shortest route.

    b. If an exception is made under Section 8.014.5.C.2.a., the SDE must document the reason and pay mileage for the actual route traveled.

3. To be reimbursed for personal vehicle mileage, the client must provide the following information to the SDE within forty-five (45) calendar days of the final leg of the Trip:

    a. Name and address of vehicle owner and driver (if different from owner);

    b. Name of the insurance company and policy number for the vehicle; and

    c. Driver's license number and expiration date.

8.014.5.D. Ancillary Services

1. Escort

    a. The Colorado Medical Assistance Program may cover the cost of transporting one Escort when the client is:

        i. A Child.

            1. An Escort is required to accompany a client if the client is under thirteen (13) years old, unless the Child:

                a. Is traveling to a Day Treatment program (Children are not eligible for NEMT travel to and from school-funded day treatment programs);

                b. The parent or guardian signs a written release;

                c. An adult will be present to receive the Child at the destination and return location; and

d. The Day Treatment program and the parents approve of the NEMT provider used.

2. Clients who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel without an Escort if:

a. The parent or guardian signs a written release; andAn adult will be present to receive the Child at the destination and return location.

ii. An At-Risk Adult unable to make personal or medical determinations, or to provide necessary self-care, as certified in writing by the client's attending Colorado Medical Assistance Program enrolled NEMT provider.

b. The Escort must be physically and cognitively capable of providing the needed services for the client.

i. If a client's primary caregiver has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay, a second Escort may be covered under Section 8.014.5.D.1.c.ii.

c. The Colorado Medical Assistance Program may cover the cost of transporting a second Escort for the client, if prior authorized under Section 8.014.7. A second Escort will only be approved if:

i. The client has a behavioral or medical condition which may cause the client to be a threat to self or to others if only one Escort is provided; or

ii. The client's primary caregiver Escort has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay.

2. Meals and Lodging

a. Meals and lodging for in-state treatment may be reimbursed when:

i. Travel cannot be completed in one calendar day; or

ii. The client requires ongoing, continuous treatment and:

1. The cost of meals and lodging is less than or equal to the cost of traveling to and from the treatment facility and the client's residence; or

2. The client's treating medical professional determines that traveling to and from the client's residence would put the client's health at risk.

b. Meals and lodging may be covered for the Escort(s) when the client is a Child or an At-Risk Adult who requires the Escort's continued stay under Section 8.014.5.D.1.

c. Reimbursement will only be made for meals and lodging for which clients and Escorts are actually charged, up to the per diem rate established by the Colorado Medical Assistance Program.

d. Meals and lodging will not be paid or reimbursed when those services are included as part of an inpatient stay.

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

8.014.6.A. The following services are not covered or reimbursable to NEMT providers as part of a NEMT service:

1. Services provided only as a convenience to the client.

2. Charges incurred while client is not in the vehicle, except for lodging and meals in accordance with Section 8.014.5.D.2.

3. Transportation to or from non-covered medical services, including services that do not qualify due to coverage limitations. ~~and services provided at locations not included in Section 8.014.4.~~

4. Waiting time.

5. Cancellations.

6. Transportation which is covered by another entity.

7. Metered taxi services.

8. Charges for additional passengers, including siblings or Children, not receiving a medical service, except when acting as an Escort under Section 8.014.5.D.1.

9. Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle.

10. Transportation to emergency departments to receive emergency services. See Section 8.018 for Emergency Medical Transportation services.

11. Providing Escorts or the Escort's wages.

12. Trips to receive Home and Community Based Services

a. Non-medical transportation should be utilized if other transportation options are not available to the client.

8.014.6.B. General Limitations

1. The SDE is responsible for ensuring that the client utilizes the least costly Mode of transportation available that is suitable to the client's condition.

8.014.7. AUTHORIZATION

8.014.7.A. All NEMT services must be authorized as required by the SDE.

1. Authorization requests submitted more than three months after an NEMT service is rendered will be denied.

2. NEMT services may be denied if proper documentation is not provided to the SDE.

8.014.7.B. If a client requests transportation via Wheelchair Vehicle, Stretcher Van, or ambulance, the SDE must verify the service is medically necessary with the client's medical provider

1. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

8.014.7.C. Out-of-State NEMT

1. NEMT to receive out of state treatment is permissible only if treatment is not available in the state of Colorado.

2. The following border towns are not considered out of state for the purposes of NEMT prior authorization:

a. Arizona: Flagstaff and Teec Nos Pos.

b. Kansas: Elkhart, Goodland, Johnson, Sharon Springs, St. Francis, Syracuse, Tribune.

c. Nebraska: Benkelman, Cambridge, Chappell, Grant, Imperial, Kimball, Ogallala, and Sidney.

d. New Mexico: Aztec, Chama, Farmington, Raton, and Shiprock.

e. Oklahoma: Boise City.

f. Utah: Monticello and Vernal.

g. Wyoming: Cheyenne and Laramie.

8.014.7.D. Prior Authorization

1. The following services require prior authorization by Colorado Medical Assistance Program:

a. Out-of-state travel, except to the border towns identified at section 8.014.7.C.2.

b. Air travel, both commercial air and Air Ambulance.

c. Train travel via commercial railway.

d. Second Escort.

2. Prior authorization requests require the following information:

a. NEMT prior authorization request form completed by SDE and member's physician and submitted to Colorado Medical Assistance Program according to form instructions.

i. The Colorado Medical Assistance Program will return requests completed by non-physicians and incomplete requests to the SDE.

ii. The Colorado Medical Assistance Program's determination will be communicated to the SDE. If additional information is requested, the SDE must obtain the information and submit to the Colorado Medical Assistance Program. If the request is denied, the SDE must send the client a denial notice.

8.014.8. INCORPORATIONS BY REFERENCE

The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), 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.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
Rule Number: MSB 22-02-29-E
Division / Contact / Phone: Health Program Office / Christina Winship/303-866-5578

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 22-02-29-E, Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443

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) 8.815, 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)?	Yes
If yes, state effective date:	03/11/2022
Is rule to be made permanent? (If yes, please attach notice of hearing).	No<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.815 with the proposed text beginning at 8.815.1 through the end of 8.815.1. Replace the current text at 8.815.3 with the proposed text beginning at 8.815.3.A through the end of 8.815.3.A. Replace the current text at 8.815.4 beginning at 8.815.4.A through the end of 8.815.4.C. Replace the current text at 8.815.6 with the proposed text beginning at 8.815.6 through the end of 8.815.6. Replace the current text at 8.443 with the proposed text beginning at 8.443.7.A.5 through the end of 8.443.7.A.5. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
Rule Number: MSB 22-02-29-E
Division / Contact / Phone: Health Program Office / Christina Winship/303-866-5578

STATEMENT OF BASIS AND PURPOSE

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

   This rule revision will allow the Department to reimburse pharmacies for administration of the COVID-19 vaccine in Long-term Care Facilities through the Centers for Disease Control and Prevention's (CDC's) Pharmacy Partnership for Long-term Care Program or other partnership between an LTC and a pharmacy.

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:

   These revisions are required to facilitate administration of the forthcoming COVID-19 vaccine to nursing home facility residents.

3. Federal authority for the Rule, if any:

   Section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
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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.

Health First Colorado members residing in nursing facilities and pharmacy providers licensed to administer vaccines will benefit from the flexibility provided by this rule revision. Current policy limits reimbursement to vaccines ordered by the resident's own physician and administration is either included in the facility's rate or part of a regularly scheduled home health service.

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

This revision will help expedite administration of the COVID-19 vaccine to Health First Colorado members residing in nursing facilities. The rule will also allow nursing facility providers to utilize existing partnerships with pharmacies to administer the vaccine.

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.

   The Department expects this change to cost approximately $60,000 in total funds, which will be incorporated through the regular budget process.

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

   The proposed rule will facilitate the expeditious administration of the COVID-19 vaccine to this population.

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 intrusive methods to achieve the purpose of the proposed rule.

DO NOT PUBLISH THIS PAGE

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.

8.815 IMMUNIZATION SERVICES

8.815.1 Definitions

8.815.1.A. Advisory Committee on Immunization Practices (ACIP) means the~~a~~ group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 2l7a).

8.815.1.B. Immunization means the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.

8.815.1.C. School District means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado S~~s~~chool for the ~~d~~Deaf and ~~b~~Blind, created in article 80 of title 22, C.R.S., and any public ~~s~~School ~~d~~District organized under the laws of Colorado except a junior college district.

8.815.1.D. Vaccine means a biological preparation that improves immunity to a particular disease.

8.815.1.E. Vaccine Administration Services means the provision of an injection, nasal absorption, or oral administration of a vaccine product.

8.815.1.F. Vaccines for Children (VFC) means the~~a~~ federally funded program administered through the Centers for Disease Control for the purchase and distribution of pediatric vaccines to program-registered providers for the Immunization of vaccine-eligible children 18 years of age and younger.

8.815.2 Client Eligibility

8.815.2.A. All Colorado Medicaid clients are eligible for Immunization and Vaccine Administration Services.

8.815.3 Provider Eligibility

8.815.3.A. Rendering Providers

1. Colorado Medicaid enrolled providers are eligible to administer Vaccines and Vaccine Administration Services as follows:

   a. If it is within the scope of the provider's practice;

   b. In accordance with the requirements at 10 CCR 2505-10, Section 8.200.2.; and

   c. If the provider is administering Vaccines and Vaccine Administration Services to a client 18 years of age or younger, the provider is using Vaccines provided free of cost by the federal government, including through the ~~must also be enrolled as a~~ VFC~~-~~ program~~provider~~.

8.815.3.B. Prescribing Providers

1. Colorado Medicaid enrolled providers are eligible to prescribe Vaccines and Vaccine Administration Services in accordance with Section 8.815.3.A.1.a.-b.

8.815.4 Covered Services

8.815.4.A. Vaccines identified in the ACIP Vaccine Recommendations and Guidelines are updated routinely and are covered as follows:

1. For clients 18 years of age and younger, Vaccines are either provided through the VFC program or are otherwise provided without cost by the federal government. ~~are covered by the VFC program.~~

2. For clients 19 years of age and older, Vaccines are covered by Colorado Medicaid.

8.815.4.B. Administration of Vaccines identified in the ACIP Vaccine Recommendations and Guidelines is a covered service for all clients.

8.815.4.C. Immunization and Vaccine Administration Services that are provided by home health agencies, physicians, or other non-physician practitioners to ~~groups of~~ clients at nursing facilities, group homes, or residential treatment centers ~~that are provided by home health agencies, physicians, or other non-physician practitioners~~ are covered only as follows:

1. Immunization services for ~~C~~clients who are residents of nursing facilities and clients receiving home health services ~~may receive Immunization services~~are covered only if ordered by their physician. The skilled nursing component for Immunization administration provided at a nursing facility is included in the facility's rate or part of a regularly scheduled home health service for clients receiving home health services.

2. Clients who are residents of an Alternative Care Facility, as defined at Section 8.495.1, may receive Immunization services from their own physician. They may also receive Immunization services as part of a home health service in accordance with Section 8.815.4.C.1.

8.815.5 Prior Authorization Requirements

8.815.5.A. Prior authorization is not required for this benefit.

8.815.6 Non-covered Services

8.815.6.A. The following services are not covered by Colorado Medicaid:

1. For clients 18 years of age and younger, Vaccines that have been obtained from a source other than ~~VFC~~the federal government;

2. Immunization and Vaccine Administration Services provided by a S~~s~~chool ~~d~~District provider; and

3. Travel-related Immunization and Vaccine Administration Services.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

   If a facility employee or a management company/home office employee or owner has dual health care and administrative duties, the provider must keep contemporaneous time records or perform time studies to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation. Time studies used must meet the following criteria:

   a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

   b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

   c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

   d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

   e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

   f. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

Social Workers: Includes social workers, life enhancement specialists and admissions coordinators.

Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as “activities” must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider’s chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum three year period. The provider cannot change methods until the three year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.

5. Non-prescription drugs ordered by a physician that are included in the per diem rate, including costs associated with vaccinations.

    a. Pharmacies are eligible for reimbursement for administration of the COVID-19 vaccine

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.

7. Purchases, rental, depreciation, interest and repair expenses of health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities. Purchases, lease expenses or fees associated with computers and software (including the associated training and upgrades) used in departments within the facility that provide direct or indirect health care services to residents. Dual purpose software that includes both a health care and administrative and general component will be considered a health care service.

8. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual purpose vehicle is one used for both resident transport and maintenance activities.

9. Copier lease expense.

10. Salaries, fees, or other expenses related to health care duties performed by a facility owner or manager who has a medical or nursing credential. Note that costs associated with the Nursing Home Administrator are an administrative and general cost.

11. Related Party Management Fees and Home Office Costs

    Related party management fees and home office costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the related party which are listed in this section, may be included in the health care cost center equal to the actual costs incurred by the related party. Documentation supporting the cost and health care licenses must be maintained. Only salaries, payroll taxes and employee benefits associated with health care personnel will be considered as allowable in the health care cost center. No overhead expenses will be included. The amount allowable in the health care cost category will be calculated in one of two ways:

    a. Keeping contemporaneous time logs in 15 minute increments supporting the number of hours worked at each facility.

    b. Distributing the cost evenly across all facilities as follows: the amount allowable in each health care facility's health care costs shall be equal to the total salary, payroll taxes and benefits of the health care personnel divided by the number of facilities where the health care personnel worked during the year. For example, if a nurse's total salary, payroll taxes, and benefits total $80,000, and the nurse worked on five facilities during the year, $16,000 is allowable in each of the facility's health care costs.

    Auditable documentation supporting the number of facilities worked on during the year must be maintained. Even if a related party exception is granted in accordance with 10 CCR 2505-10 section 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

    Non-Related Party Management Fees

    Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

12. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.

13. Medical director fees.

14. Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review
Dental care, when required by federal law
Audiology
Psychology and mental health services
Physical therapy
Recreational therapy
Occupational therapy
Speech therapy

15. Nursing licenses and permits, disposal costs associated with infectious material (medical or hazardous waste), background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

16. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

8.443.7.B CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.

3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:

   a. Exclude part, or all, of a provider's MED-13.

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.

4. The health care limit and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers; except that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

   a. In determining the median cost, the cost of direct health care shall be case-mix neutral.

b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.

c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

i). The percentage change shall be rounded at least to the fifth decimal point.

ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.7.C. CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year beginning July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent (8%) per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

8.443.7.D. CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE MIX INDEX (CMI):

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. This payment shall not exceed the health care limit described at 10 CCR 2505-10 section 8.443.7B. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:

    a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.

    b. The facility's Medicaid resident acuity case mix index shall be a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.

    c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.

    d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.

    e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.

    f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.

2. The annual facility specific direct health care maximum reimbursement rate shall be determined as follows:

    a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

    b. The statewide health care maximum allowable reimbursement rate (calculated at 10 CCR 2505-10 section 8.443.7B) shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

    c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

3. The annual facility specific indirect health care maximum allowable reimbursement shall be determined as follows:

    a. The percentage of the indirect health care per diem cost to total health care cost shall be determined by dividing the indirect health care per diem cost by the sum

of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The facility specific in direct health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

4. The case mix reimbursement rate component shall be determined as follows:

a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.

b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall the case mix reimbursement rate component.

5. The indirect health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

8.443.7.E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV FACILITIES

1. For class II facilities, one hundred twenty-five percent (125%) of the median actual costs of all class II facilities;

2. For non-state administered class IV facilities, one hundred twenty-five percent (125%) of the median actual costs of all class IV facilities.

3. State-administered class IV facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV facilities shall be included in the health care limit calculation for other class IV facilities.

4. The determination of the reasonable cost of services shall be made every 12 months.

5. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed in accordance with these regulations, by each facility on or before May 2.

6. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.

7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

a. Exclude part, or all, of a provider's MED-13; or

b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report.

8. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.

9. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 22-02-29-F
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

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

a

2. Title of Rule: MSB 22-02-29-F, Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6

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) 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6, 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)? Yes
If yes, state effective date: 03/11/2022
Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100 with the proposed text beginning at 8.100.3.D through the end of 8.100.3.D. Replace the current text at 8.100.3.F with the proposed text beginning at 8.100.3.F through the end of 8.100.3.F. Replace the current text at 8.100.3.I with the proposed text beginning at 8.100.3.I through the end of 8.100.3.I. Replace the current text at 8.100.3.K with the proposed text beginning at 8.100.3.K through the end of 8.100.3.K. Replace the current text at 8.100.3.L with the proposed text beginning at 8.100.3.L. Replace the current text at 8.100.3.P with the proposed text beginning at 8.100.3.P through the end of 8.100.3.P. Replace the current text at 8.100.4.B with the proposed beginning at 8.100.4.B through the end of 8.100.4.B.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Replace the current text at 8.100.4.C with the proposed text beginning at 8.100.4.C through the end of 8.100.4.C. Replace the current text at 8.100.4.G with the proposed text beginning at 8.100.4.G through the end of 8.100.4.G. Replace the current text at 8.100.5.A with the proposed text beginning at 8.100.5.A through the end of 8.100.5.A. Replace the current text at 8.100.5.B with the proposed text beginning at 8.100.5.B through the end of 8.100.5.B. Replace the current text at 8.100.6.P with the proposed text beginning at 8.100.6.P through the end of 8.100.6.P. Replace the current text at 8.100.6.Q with the proposed text beginning at 8.100.6.Q through the end of 8.100.6.Q. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 22-02-29-F
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

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 will amend 10 CCR 2505-10 sections 8.100.1,8.100.3, 8.100.4, 8.100.5 and 8.100.6 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during the federal Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories and these policy changes will stay in place until the end of the federal Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Self-attestation for most verifications will be acceptable to be in compliance with the Maintenance of Effort (MOE) provision to ensure the continuance of health coverage for all eligible members. When a member is not reasonable compatible based off income a member self-attests, documentation will not be required, and the member will remain eligible for Medical Assistance. Self-attestation of resources will be acceptable for Non-MAGI programs. Premiums for the Buy-In program will be waived. Required through the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program. Newly enrolled members will still need to meet the work requirements. For applicants who are not eligible for Medical Assistance but have been exposed or who are potentially infected by the COVID-19, will be eligible for Medical Assistance for related COVID testing. The economic stimulus relief package designed to provide direct assistance to individuals to help offset the financial impacts of the COVID-19 Public Health Emergency will be exempt for MAGI and Non-MAGI eligibility determinations. The economic stimulus will *not* be a countable resource for 12 months for any Non-MAGI financial eligibility determinations that include a resource test. Lastly, the Federal Pandemic Unemployment Compensation (FPUC) program which provides an extra $600.00 a week is not countable unearned income for Medical Assistance categories

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:

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Due to the Coronavirus (COVID-19) Public Health Emergency the state rules need to be updated to comply with federal regulations.

3. Federal authority for the Rule, if any:

   Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 and Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 and the Affordable Care Act (ACA), which includes the Maintenance of Effort (MOE) provision.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   25.5-4-205(3)(II)(b)(A), 25.5-5-105, 25.5-5-206(1)(II)(B), 25.5-6-1404(1)(b) and(3)(a)(b), 25.5-6-1405(1),25.5.-6-1405(2)

Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 22-02-29-F
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

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 rules will impact applicants and members who are applying or enrolled in a MAGI and Non-MAGI Medical Assistance program. The rule updates will benefit both an applicant and member who becomes eligible for Medical Assistance by remaining eligible during this Coronavirus (COVID-19) Public Health Emergency.

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

   The proposed rule will help to determine eligibility correctly by applying regulations based on the CARES Act to help applicants and members remain eligible for MAGI and Non-MAGI Medical Assistance programs during this Coronavirus (COVID-19) Public Health Emergency.

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.

   Self-attestation of all eligibility requirements, including resources, is likely to increase the number of individuals who will be eligible to enroll in Medicaid, therefore the Department expects its expenditures to increase as a result of this policy change. The Department expects that the waiving of premiums for the Disabled Buy-In program will reduce the revenues to the Department, which will result in an increase in expenditures from the Healthcare Affordability and Sustainability Fee (HAS) Cash Fund and federal funds, in order to fill the gap in revenue lost from the premiums.

   The Department expects that the provision of COVID testing to applicants will increase expenditures to the Department, but these expenditures will be covered with 100% federal funds and will not impact expenditures from state fund sources.

The exemptions to counting the economic relief provided to individuals from the federal government towards eligibility for Medical Assistance is likely to not affect eligibility, and therefore not impact costs to the Department.

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

   The allowance of self-attestation of eligibility criteria is mandated by the Families First Coronavirus Response Act in order for states to qualify for an enhanced FMAP of 6.2%. If the Department does not act in accordance with this policy, the costs to the Department will increase beyond what is necessary. The benefit of implementing this policy will allow the Department to secure a higher FMAP, which will allow the Department to operate with less administrative burden and serve more members during the emergency period. With respect to the proposal to waive the premiums for the Disabled Buy-In program, the Department expects that inaction will cause potential members to not qualify for buy-in because they will be unable to pay the premiums due to the severity of the economic shock. Therefore, the Department sees no benefit to inaction of the rule changes.

   In addition, the Families First Coronavirus Response Act allows state Medicaid and CHP+ programs to fund the cost of COVID-19 diagnostic testing for residents who do not qualify for Medical Assistance through 100% federal funds. Thus, inaction will lead to less testing of individual during the emergency and more uncertainty of the status of the emergency in Colorado. Again, the Department sees no benefit to inaction as the costs will be covered by federal funds.

   The exemptions to counting the economic relief provided to individuals from the federal government towards eligibility for Medical Assistance are mandated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. If the Department does not act it will be in violation of the law.

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 methods available to the Department to comply with the Families First Coronavirus Response Act and the CARES Act. The purposes of the proposed rule changes are to allow the Department to better serve Medicaid members and the people of Colorado during this emergency period and the Department sees no other method to accomplish this goal.

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 that were 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.

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

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

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

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

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

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

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

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

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

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

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive

Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community Spouse is the spouse of an institutionalized spouse.

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

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

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

Dependent Child is a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to graduate by age 19.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Long-Term Care Institution means class I nursing facilities, intermediate care facilities for 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 Verification is defined in this volume as the minimum amount of information needed to process an application for benefits. No other verification can be requested from clients unless the information provided is questionable or inconsistent.

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

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

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

MAGI-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 Insurance is the official term Social Security uses for Social Security Act Title II benefits including retirement, survivors, and disability. This does not include SSI payments.

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

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive

medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

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

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

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

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

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 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 Facility is a facility that is licensed as a residential care facility or hospital and that provides inpatient psychiatric services for individuals under the direction of a licensed physician.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TANF - Temporary Assistance to Needy Families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

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

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

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

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

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

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.

8.100.2 Legal Basis

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

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

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

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

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

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.A. Application Requirements

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

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

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

Medical Assistance eligibility programs, the application data and verifications shall be transferred to the state insurance marketplace.

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

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

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

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

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

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

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

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

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

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

11. The applicant has the right to withdraw his or her application at any time.

8.100.3.B. Residency Requirements

1. Individuals shall make application in the county in which they live. Individuals who reside in a county but who do not reside in a permanent dwelling nor have a fixed mailing address shall be considered eligible for the Medical Assistance Program, provided all other eligibility requirements are met. In no instance shall there be a durational residency requirement imposed upon the applicant, nor shall there be a requirement for the applicant to reside in a permanent dwelling or have a fixed mailing address. If an individual without a permanent dwelling or fixed mailing address is hospitalized, the county where the hospital is located shall be responsible for processing the application to completion. If the individual moves prior to completion of the

eligibility determination the origination eligibility site completes the determination and transfers the case as applicable.

a. For applicants in Long Term Care institutions - The county of domicile for all Long Term Care clients is the county in which they are physically located and receiving services.

2. A resident of Colorado is defined as a person that is living within the state of Colorado and considers Colorado to be their place of residence at the time of application. For institutionalized individuals who are incapable of indicating intent as to their state of residence, the state of residence shall be where the institution is located unless that state determines that the individual is a resident of another state, by applying the following criteria:

a. for any institutionalized individual who is under age 21 or who is age 21 or older and incapable of indicating intent before age 21, the state of residence is that of the individual's parent(s) or legally appointed guardian at the time of placement;

b. for any institutionalized individual who became incapable of indicating intent at or after age 21, (1) the state of residence is the state in which the person was living when he or she became incapable of indicating intent, or (2) if this cannot be determined, the state of residence is the state in which the person was living when he or she was first determined to be incapable of indicating intent;

c. upon placement in another state, the new state is the state of residence unless the current state of residence is involved in the placement. If a current state arranged for an individual to be placed in an institution located in another state, the current state shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent;

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

3. For purposes of this section on establishing an individual's state of residence, an individual is considered incapable of indicating intent if:

a. the person has an I.Q. of 49 or less or has a mental age of 7 or less, based on standardized tests as specified in the persons in medical facilities section of this volume;

b. the person is judged legally incompetent; or

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

4. Residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.

5. A non-resident shall mean a person who considers his/her place of residence to be other than Colorado. Any person who enters the state to receive Medical Assistance or for any other reason is a non-resident, so long as they consider their permanent place of residence to be outside of the state of Colorado.

8.100.3.C. Transferring Requirements

1. When a family or individual moves from one county to another within Colorado, the client shall report the change of address to the eligibility site responsible for the current active Medical

Assistance Program case(s). If a household applies in the county in which they live and then moves out of that county during the application determination process, the originating eligibility site shall complete the processing of that application before transferring the case. The originating eligibility site shall electronically transfer the case to the new county of residence in CBMS.

2. The originating eligibility site must notify the receiving eligibility site of the client's transfer of Medical Assistance. The originating eligibility site may notify the receiving eligibility site by telephone that a client has moved to the receiving county. If the family or individual wishes to apply for other types of assistance, they shall submit a new application to the receiving eligibility site.

3. If the household is transferring the current Medical Assistance case, the receiving eligibility site cannot mandate a new application, verification, or an office visit to authorize the transfer. The receiving eligibility site can request copies of specific case documents to be forwarded from the originating eligibility site to verify the data contained in CBMS.

4. If the originating eligibility site closes a case for the discontinuation reason of “unable to locate,” the applicant shall reapply at the receiving eligibility site for the Medical Assistance Program.

5. If a case is closed for any other discontinuation reason than “unable to locate” and the client provides appropriate information to overturn the discontinuation with the originating eligibility site, then, upon transfer, the receiving eligibility site shall reopen the case with case comments in CBMS. These actions shall be performed according to timeframes defined by the Department.

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

    a. the initiating eligibility site will transfer the case electronically in the eligibility system to the eligibility site in which the nursing facility is located when the individual is determined eligible; and

    b. The following items shall be furnished by the initiating eligibility site to the new eligibility site in hard copy format:

        i) 5615 that was sent to the nursing facility indicating the case transfer; and

        ii) Identification and citizenship documents; and

        iii) The ULTC 100.2.

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

8.100.3.D. Processing Requirements

1. The eligibility site shall process a Single Streamlined Application for Medical Assistance Program benefits within the following deadlines:

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

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

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

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

e. Due to the Coronavirus COVID-19 Public Health Emergency, required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories, regardless of changes made for a redetermination or additional documentation for current Medicaid enrollees. The Department will allow these individuals to continue eligibility through the period of the COVID-19 pandemic federal emergency declaration. Once the federal emergency declaration has concluded, the Department will process eligibility redeterminations and /or changes for all members whose eligibility was maintained during the emergency declaration.

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

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

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

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

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

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

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

b. The eligibility site shall not:

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

ii) Display any political preference or party allegiance;

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

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

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

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

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

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

8.100.3.E. Retroactive Medical Assistance Coverage

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

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

8.100.3.F. Groups Assisted Under the Program

1. The Medical Assistance Program provides benefits to the following persons who meet the federal definition of categorically needy at the time they apply for benefits:

a. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults as defined under the Modified Adjusted Gross Income (MAGI)Medical Assistance section 8.100.4.

b. Persons who meet legal immigrant requirements as outlined in this volume, who were or would have been eligible for SSI but for their alien status, if such persons meet the resource, income and disability requirements for SSI eligibility.

c. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B. See section 8.100.3.M for more information on SISC Codes.

d. Persons who are eligible for financial assistance under Old Age Pension (OAP) and SSI, but are not receiving the money payment.

e. Persons who would be eligible for financial assistance from OAP or SSI, except for the receipt of Social Security Cost of Living Adjustment (COLA) increases, or other retirement, survivors, or disability benefit increases to their own or a spouse's income. This group also includes persons who lost OAP or SSI due to the receipt of Social Security Benefits and who would still be eligible for the Medical Assistance Program except for the cost of living adjustments (COLA's) received. These populations are referenced as Pickle and Disabled Widow(er)s.

f. Persons who are blind, disabled, or aged individuals residing in the medical institution or Long Term Care Institution whose income does not exceed 300% of SSI.

g. Persons who are blind, disabled or aged receiving HCBS whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.

h. A disabled adult child who is at least 18 years of age and who was receiving SSI as a disabled child prior to the age of 22, and for whom SSI was discontinued on or after May 1, 1987, due to having received of OASDI drawn from a parent(s) Social Security Number, and who would continue to be eligible for SSI if the above OASDI and all subsequent cost of living adjustments were disregarded. This population is referenced as Disabled Adult Child (DAC).

i. Children age 18 and under who would otherwise require institutionalization in an Long Term Care Institution, Nursing Facility (NF), or a hospital but for which it is appropriate to provide care outside of an institution as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).

j. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility criteria but do meet the state eligibility criteria for the OAP State Only Medical Assistance Program. These persons qualify for a SISC Code C.

k. Persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergencies only.

l. Persons with a disability or limited disability who are at least 16 but less than 65 years of age, with income less than or equal to 450% of FPL after income disregards, regardless of resources, and who are employed.

m. Children with a disability who are age 18 and under, with household income less than or equal to 300% of FPL after income disregards, regardless of resources.

n. Due to the Coronavirus COVID-19 Public Health Emergency, an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection of COVID-19 may be eligible to receive services for COVID-19 testing, treatment, or care for complications related to COVID-19. To qualify for this limited benefit, the ~~a~~Applicant must satisfy residency and immigration or citizenship and not be enrolled in other health insurance. ~~and meet the criteria of citizenship~~

8.100.3.G. General and Citizenship Eligibility Requirements

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

a. Be a resident of Colorado;

b. Meet the following requirements while being an inmate, in-patient or resident of a public institution:

i). The following individuals, if eligible, may be enrolled for Medical Assistance

1. Patients in a public medical institution

2. Residents of a Long-Term Care Institution

3. Prior inmates who have been paroled

4. Resident of a publicly operated community residence which serves no more than 16 residents

5. Individuals participating in community corrections programs or residents in community corrections facilities ("halfway houses") who have freedom of movement and association which includes individuals who:

a) are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision;

b) can use community resources (e.g., libraries, grocery stores, recreation, and education) at will;

c) can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state; and/or

d) are residing at their home, such as house arrest, or another location

ii). Inmates who are incarcerated in a correctional institution such as a city, county, state or federal prison may be enrolled, if eligible, with benefits limited to an in-patient stay of 24 hours or longer in a medical institution.

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

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

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

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

g. Fall into one of the following categories:

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

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

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

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

2) paroled into the United States for at least one year under 8 U.S.C. § 1182(d)(5); or

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

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

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

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

2) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or

3) granted asylum under section 208 of the INA, or

4) refugee under section 207 of the INA, or

5) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA, or

6) Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, or

7) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 5304(e)(2016), or

8) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461), or

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

10) a victim of a severe form of trafficking in persons, as defined in section 103 of the Victims of Trafficking and Violence Protection Act of 2000, Pub. L.106-386, as amended (22 U.S.C. § 7105(b) (2016)), or

11) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA, or

12) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA.

v) The statutes listed at sections 8.100.3.G.1.g.iii.1-5 and at 8.100.3.G.1.g.iv.3-11 are incorporated herein by reference. No amendments or later editions are incorporated. These regulations are available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Pursuant to C.R.S. 24-4-103(12.5)(b)(2016), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

vi) Be a lawfully admitted non-citizen who is a pregnant women or a child under the age of 19 years in the United States who falls into one of the categories listed in 8.100.3.G.1.g.iii or into one of the following categories listed below. These individuals are exempt from the 5-year waiting period:

1) granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a,or

2) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C 1254a and pending applicants for TPS granted employment authorization,

3) granted employment authorization under 8 CFR 274a.12(c),or

4) Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.

5) Deferred Enforced Departure (DED), pursuant to a decision made by the President,

6) granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum,

7) granted an administrative stay of removal under 8 CFR 241.6(2016), or

8) Beneficiary of approved visa petition who has a pending application for adjustment of status.

9) Pending an application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who-

a) as been granted employment authorization; or

b) Is under the age of 14 and has had an application pending for at least 180 days.

10) granted withholding of removal under the Convention Against Torture,

11) A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C. 1101(a)(27)(J), or

12) Citizens of Micronesia, the Marshall Islands, and Palau, or

13) is lawfully present American Samoa under the immigration of laws of American Samoa.

14) A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or under 8 U.S.C. 1101(a)(17), or

15) A non-citizen who has been paroled into the United States for less than one year under 8 U.S.C. § 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.

vii) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but who are not citizens, and are not eligible non-citizens, according to the criteria set forth in 8.100.3.G.1.g, shall receive Medical Assistance benefits for emergency medical care only. 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) (iii) (iv) or (vi) and has declared that he or she has a legal immigration status.

a. The Verify Lawful Presence (VLP) interface will be used to verify immigration status. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) Program to verify legal immigration status.

i) If an automated response from VLP confirms that the information submitted is consistent with VLP data for immigration status verification requirements, no further action is required for the individual and no additional documentation of immigration status is required.

ii) If the VLP cannot automatically confirm the information submitted, the individual will be contacted with a request for additional documents and/or information needed to verify their legal immigration status through the VLP interface. If a response from the VLP interface confirms that the additional documents and/or information received from the individual verifies their legal immigration status, no further action is required for the individual and no additional documentation of immigration status is required.

3. Reasonable Opportunity Period

a. If the verification through the electronic interface is unsuccessful then the applicant will be provided a reasonable opportunity period, of 90 days, to submit documents indicating a legal immigration status, as listed in 8.100.3.G.1.g. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period.

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

c. The reasonable opportunity period applies to MAGI, Adult and Buy-In Programs.

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

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical	8.100.4.G.3

Assistance	
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Legal Immigrant Prenatal Medical Assistance	8.100.4.G.6
Transitional Medical Assistance	8.100.4.I.1-5

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

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

8.100.3.H. Citizenship and Identity Documentation Requirements

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

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

      i) SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.

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

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

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

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

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

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

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

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

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

2) Special Provisions for Retroactive Reversal of a Previous Denial

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

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

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

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

b) A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.P.1. Such

redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

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

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

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

a. Stand-alone documents for evidence of citizenship and identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:

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

1) includes the applicant or recipient, and

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

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

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

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

1) Special Provisions for Retroactive Reversal of a Previous Denial

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

(1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity documentation requirements as they existed during that period;

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

(3) The individual or a legally appointed guardian or conservator of the individual requests that the denial of

eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

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

b. Evidence of citizenship. If evidence from the list in 8.100.3.H.2.a. is not provided, an applicant or recipient shall provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H. 3. to establish identity. Evidence of citizenship includes:

i) A U.S. public birth certificate.

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

a) One of the 50 States,

b) The District of Columbia,

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

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

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

f) American Samoa,

g) Swain's Island, or

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

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

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

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

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

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

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

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

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

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

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

viii) A final adoption decree that:

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

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

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

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

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

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

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

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

2) The child is under the age of 18;

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

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

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

xiii) Extract of a hospital record on hospital letterhead.

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

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

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

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

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

xiv) Life, health, or other insurance record.

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

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

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

xv) Religious record.

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

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

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

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

xvi) Early school record that meets the following criteria:

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

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

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

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

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

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

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

1) Seneca Indian tribal census record;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Evidence of citizenship for collectively naturalized individuals. If a document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. A second document from 8.100.3.H.3. to establish identity shall also be presented.

i) Puerto Rico:

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

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

ii) US Virgin Islands:

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

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

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

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

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

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

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

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

d) Referrals for Colorado Birth Certificates

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

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

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

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

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

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

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

a) A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

b) School identification card with a photograph of the individual;

c) U.S. military card or draft record;

d) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses;

e) Military dependent's identification card;

f) U.S. Coast Guard Merchant Mariner card;

g) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. The document is acceptable if it carries a photograph of the individual or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color; or

h) Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted evidence of citizenship listed under 8.100.3.H.2.b. or 8.100.3.H.2.c. The following requirements must be met:

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

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

iii) All documents used must contain consistent identifying information.

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

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

i) Clinic, doctor, or hospital records; or

ii) School records.

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

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

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

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

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

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

d) The affidavit is not required to be notarized.

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

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

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

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

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

3) The affidavit is not required to be notarized.

k) Expired identity documents.

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

l) Referrals for Colorado Identification Cards

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

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

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

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

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

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

4. Documentation Requirements

a. Citizenship and identity documents may be submitted as originals, certified copies, photocopies, facsimiles, scans or other copies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Record Retention Requirements

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

6. Name Change Provisions

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

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

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

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

7. Reasonable Level of Assistance

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

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

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

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

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

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

8. Individuals Requiring Additional Assistance

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

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

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

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

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

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

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

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

9. Reasonable Opportunity Period

a. If a Medical Assistance applicant does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required ~~documentation.~~ documentation. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period. If the applicant does not provide the required documentation within

the reasonable opportunity period, then the applicant's Medical Assistance benefits shall not be terminated during the federal Coronavirus COVID-19 Public Health Emergency. Required documentation will be requested during the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable opportunity period will be given to request proper documentation from the member.

i) During the federal Coronavirus COVID-19 Public Health Emergency the Department will continue eligibility for all Medical Assistance categories, regardless of requested documentation and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.

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

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

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

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

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

10. Good Faith Effort

a. In some cases, a Medical Assistance client or applicant may not be able to obtain the required documentation within the applicable reasonable opportunity period. If the client

or applicant is making a good faith effort to obtain the required documentation, then the reasonable opportunity period should be extended. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

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

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

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

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

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

8.100.3.I. Additional General Eligibility Requirements

1. Each person for whom Medical Assistance is being requested shall furnish a Social Security Number (SSN); or, if one has not been issued or is unknown, shall apply for the number and submit verification of the application, unless an exception below applies. The application for an SSN shall be documented in the case record by the eligibility site. Upon receipt of the assigned SSN, the client shall provide the number to the eligibility site. This requirement does not apply to those individuals who are not requesting Medical Assistance yet appear on the application, nor does it apply to individuals applying for emergency medical services or eligible newborns born to a Medical Assistance eligible mother.

    a. An applicant's or client's refusal to furnish or apply for a Social Security Number affects the family's eligibility for assistance as follows:

        i) that person cannot be determined eligible for the Medical Assistance Program; and/or

        ii) if the person with no SSN or proof of application for SSN is the only dependent child on whose behalf assistance is requested or received, assistance shall be denied or terminated.

    b. Exception: An individual who qualifies for any of the following exceptions must not be required to provide an SSN:

        i.) The individual is not eligible to receive an SSN; or

        ii) The individual does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

        iii) The individual refuses to obtain an SSN because of a well-established religious objection.

c. Due to the -COVID-19 Public Health Emergency, the Department will accept self-attestations for SSN verification. At the end of the COVID-19 Public Health Emergency, verification for eligibility criteria will be required as specified prior to the public health emergency.

2. A person who is applying for or receiving Medical Assistance shall assign to the State all rights against any other person (including but not limited to the sponsor of an alien) for medical support or payments for medical expenses paid on the applicant's or client's behalf or on the behalf of any other person for whom application is made or assistance is received.

   All appropriate clients of the Medical Assistance Program shall have the option to be referred for child support enforcement services using the form as specified by the Department.

3. A person who is applying for or receiving Medical Assistance shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources are any health coverage or insurance other than the Medical Assistance Program. A client's refusal to supply information regarding third party resources may result in loss of Medical Assistance Program eligibility.

4. A person who is eligible for Medical Assistance shall be free to choose any qualified and approved participating institution, agency, or person offering care and services which are benefits of the program unless that person is enrolled in a managed care program operating under Federal waiver authority.

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

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

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

   b. may apply for a determination of eligibility under either or both programs;~~, 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; and

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

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

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

3. An individual receiving Aid to the Needy Disabled (AND) may also receive MAGI Medical Assistance, if the recipient meets the eligibility requirements for MAGI Medical Assistance. For

these individuals, eligibility sites shall not include the applicant's AND payment when calculating income to determine the household's financial eligibility for MAGI Medical Assistance.

8.100.3.K. Consideration of Income

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

    a. Exception: When the sponsored alien is a pregnant woman or a child the income or resources of an alien sponsor or an alien sponsor's spouse will not be countable to the sponsored alien.

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

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

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

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

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

7. An applicant or member who is a live-In home care provider to a care recipient receiving a Difficulty of Care Payment and who is being determined for a MAGI Medical Assistance program, must meet the following requirements for Difficulty of Care payments to be excluded as countable income:

    a. The care provider receiving payments for personal care or supportive services provided to a care recipient must live full-time in the same home with the care recipient; and

    b. The care recipient must either

        i) receiving personal care or supportive services must be enrolled in Long Term Service Supports (LTSS), with additional services through a Home-Based Services (HCBS) waiver program; or

        ii) The care recipient must be enrolled in the Buy-In Program for Working Adults with Disabilities, and receive additional services through the Home and Community Based Services (HCBS) waiver program.

c. Exception: Difficulty of Care Payments are not excluded if the payments are for more than 10 qualified foster individuals under the age of 19 or 5 qualified foster individuals who are over the age of 19

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

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

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

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

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

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

i) the rent of business premises,

ii) wholesale cost of merchandise,

iii) utilities,

iv) taxes,

v) labor, and

vi) upkeep of necessary equipment.

b. The following are not allowed as business expenses:

i) Depreciation of equipment;

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

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

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

c. Appropriate allowances for cost of doing business for Medical Assistance clients who are licensed, certified or approved day care providers are (1) $ 55 for the first child for whom day care is provided, and (2) $ 22 for each additional child. If the client can document a

cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.

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

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

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

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

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

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

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

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

a. Pensions and other period payments, such as:

i) Private pensions or disability benefits

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

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

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

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

vii) Alimony and support payments

viii) Interest, dividends and certain royalties on countable resources

12. For all Medical Assistance categories, the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan (ARP) Act Recovery Rebate, known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.

13. Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra $600.00 a week for qualifying individuals, is exempt as countable unearned income for all Medical Assistance categories.

8.100.3.L Consideration of Resources

Consideration of Resources

1. Resources are counted in determining eligibility for the Aged, Blind and Disabled, and Long-Term Care institutionalized and Home and Community Based Services categories of Medical Assistance. Resources are not counted in determining eligibility for the MAGI Medical Assistance programs, the Medicaid Buy-in Program for Working Adults with Disabilities, or the Medicaid Buy-In Program for Children with Disabilities, See section 8.100.5 for rules regarding consideration of resources.

2. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan (ARP) Act Recovery Rebate~~,~~ ~~known~~ as COVID-19 Economic Stimulus, shall be an exempt resource for the first 12 months following the receipt of the Recovery Rebate, after which the remaining balance will be considered a countable resource for all Medical Assistance categories which include an asset test.

8.100.3.M. Federal Financial Participation (FFP)

1. The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medical Assistance Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons.

2. The SISC codes are as follows:

    a. Code A - for institutionalized persons whose income is under 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; and non-institutionalized persons receiving Home and Community Based Services, whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; code A signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments;

    b. Code B - for persons eligible to receive financial assistance under SSI; persons eligible to receive financial assistance under OAP “A” who, except for the level of their income, would be eligible for an SSI payment; persons who are receiving mandatory State supplementary payments; and persons who continue to be eligible for Medical Assistance after disregarding certain Social Security increases; code B signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program and also for SMIB premium payments;

    c. Code C - for persons eligible to receive assistance under OAP “A”, OAP “B”, or OAP Refugee Assistance for financial assistance only; who do not receive SSI payment and do not otherwise qualify under SISC code B as described in item B. above; code C signifies that no FFP is available in Medical Assistance program expenditures.

d. Code D1 – for persons eligible to receive assistance under AwDC from program implementation through 12/31/2013; Code D1 signifies 50% FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program.

e. Code E1 - for persons eligible to receive assistance under the Medicaid Buy-In Program for Working Adults with Disabilities and whose annual adjusted gross income, as defined under IRS statute, is less than or equal to 450% of FPL – after SSI earned income deductions; as well as for children eligible to receive assistance under the Medicaid Buy-In Program for Children with Disabilities and whose household income is less than or equal to 300% of FPL after income disregards. Code E1 signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments.

3. Recipients of financial assistance under State AND, State AB, or OAP “C” are not automatically eligible for Medical Assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.3.N. Confidentiality

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

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

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

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

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

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

6. The eligibility site policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials. If a court issues a subpoena for a case record or for any eligibility site representative to testify concerning an

applicant or recipient, the eligibility site must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

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

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

   b. Medical services provided;

   c. Social and economic conditions or circumstances;

   d. Agency evaluation of personal information;

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

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

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

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

   i. Social Security Numbers.

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

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

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

   c. To individuals executing Income and Eligibility Verification System;

   d. Child Support enforcement officials;

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

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

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

8.100.3.O. Protection Against Discrimination

1. Eligibility sites are to administer the Medical Assistance Program in such a manner that no person will, on the basis of race, color, sex, age, religion, political belief, national origin, or handicap, be excluded from participation, be denied any aid, care, services, or other benefits of, or be otherwise subjected to discrimination in such program.

2. The eligibility site shall not, directly or through contractual or other arrangements, on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap:

    a. Provide aid, care, services, or other benefits to an individual which is different, or provided in a different manner, from that of others;

    b. Subject an individual to segregation barriers or separate treatment in any manner related to access to or receipt of assistance, care services, or other benefits;

    c. Restrict an individual in any way in the enjoyment or any advantage or privilege enjoyed by others receiving aid, care, services, or other benefits provided under the Medical Assistance Program;

    d. Treat an individual differently from others in determining whether he/she satisfies any eligibility or other requirements or conditions which individuals shall meet in order to receive aid, care, services, or other benefits provided under the Medical Assistance Programs;

    e. Deny an individual an opportunity to participate in programs of assistance through the provision of services or otherwise, or afford him/her an opportunity to do so which is different from that afforded others under the Medical Assistance Program.

3. No distinction on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap is permitted in relation to the use of physical facilities, intake and application procedures, caseload assignments, determination of eligibility, and the amount and type of benefits extended by the eligibility site to Medical Assistance recipients.

4. An individual who believes he/she is being discriminated against may file a complaint with the eligibility site, the Department, or directly with the Federal government. When a complaint is filed with the eligibility site, the county director is responsible for an immediate investigation of the matter and taking necessary corrective action to eliminate any discriminatory activities found. If such activities are not found, the individual is given an explanation. If the person is not satisfied, he/she is requested to direct his/her complaint, in writing, to the State Department, Complaint Section, which will be responsible for further investigation and other necessary action consistent with the provisions of Title VI of the 1963 Civil Rights Act, as amended 42 U.S.C. §2000e et seq. and section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. §791.

8.100.3.P. Redetermination of Eligibility

1. A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medical Assistance Program client continues to be eligible to receive Medical Assistance. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months for Title XIX Medical Assistance only cases. An eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

2. The eligibility site shall promptly redetermine eligibility when:

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

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

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

3. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program, verification system, and/or CBMS. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the findings of the review will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

4. A redetermination form, approved by the Department, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself cannot be required to be returned. The only verification that can be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

   The redetermination form shall direct clients to review current information and to take no action if there are no changes to report in the household. Eligibility sites and CBMS shall view the absence of reported changes from the client at this redetermination period as confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

   The following procedures relate to mail-out redetermination:

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

   b. Required verification shall be returned by the client to the eligibility site no later than ten working days after receipt of request;

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

   d. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the individual.

   e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the individual. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.

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

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

   b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance client shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department.

6. Due to the federal Coronavirus COVID-19 Public Health Emergency, the Department will continue eligibility for all Medical Assistance categories, regardless of a redetermination and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.

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

1. Continuous eligibility applies to children under age 19, who through an eligibility determination, reassessment or redetermination, are found eligible for a Medical Assistance program. The continuous eligibility period may last for up to 12 months.

   a. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

      i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, any changes to income or other factors made to the child's case during the 14-day no fault period may change his or her eligibility for Medical Assistance.

   b. Exception: A child's continuous eligibility period will end effective the earliest possible month if any of the following occur:

      i) Child is deceased

      ii) Becomes an inmate of a public institution

      iii) The child is no longer part of the Medical Assistance required household

      iv) Is no longer a Colorado resident

      v) Is unable to be located based on evidence or reasonable assumption

      vi) Requests to be withdrawn from continuous eligibility

      vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

      viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

2. The continuous eligibility period will begin on the first day of the month the application is received or from the date all criteria is met. Continuous eligibility is applicable to children enrolled in the following Medical Assistance programs:

    a. MAGI-Medical Assistance, program as specified in section 8.100.4.G.2

    b. SSI Mandatory, as specified in section 8.100.6.C

        i.) When a child is no longer eligible for SSI Mandatory they will be categorized as eligible within the MAGI-Child category for the remainder of the eligibility period.

    c. Long- Term Care services

        i.) When a child is no longer eligible for Long-Term Care services they will be categorized as eligible within the MAGI- Child category for the remainder of the eligibility period.

    d. Medicaid Buy-In program specified in section 8.100.6.Q

        i) Exception: Enrollment will be discontinued if there is a failure to pay premiums

    e. Pickle

    f. Disabled Adult Child DAC)

3. Children, under the age of 19, no longer enrolled in Foster Care Medicaid will be eligible for the MAGI-Medical Assistance program. The continuous eligibility period will begin the month the child is no longer enrolled in Foster Care Medicaid as long as they meet one of the following conditions:

    a. Begin living with other Relatives

    b. Are reunited with Parents

    c. Have received guardianship

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

8.100.4.A. MAGI Application Requirements

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

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

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

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

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

8.100.4.B. MAGI Category Verification Requirements

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

a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the COVID-19 Public Health Emergency, at the time of application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the federally -declared COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1) A-pplicants who meet the criteria for any categorical Medical Assistance programs, but do not meet federal and state citizenship and immigration status requirements, are only eligible to receive emergency medical services.

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

c. Earned Income: Income 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 self-attested, it 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.

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

d. Unearned income: Unearned income can be self-attested by an applicant. Certain types of unearned income, such as unemployment and survivor benefits may be verified through electronic data sources. Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify

that the individual's income has changed for all Medical Assistance programs- in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded, for all people whose eligibility was maintained during the emergency declaration, for these individuals to maintain eligibility.

e. Verification of Legal Immigrant Status: Immigration status can be self-declared by an applicant applying for Medical Assistance, to determine eligibility for full Medical Assistance benefits. This declaration of legal immigration status will be verified through the Verify Lawful Presence (VLP) interface. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) program to verify legal immigration status. See section 8.100.3.G for a description of the VLP interface. If status cannot be verified, or if the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

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

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

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

5. The criteria of age and relationship 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 criteria of:

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

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

8.100.4.C. MAGI Methodology for Income Calculation

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

purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:

a. Earned Income:

   i) Wages, salaries, tips;

   ii) Gross income derived from business;

   iii) Gains derived from dealings in property;

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

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

   vi) Taxable private disability income.

b. Unearned Income:

   i) Interest (includes tax exempt interest);

   ii) Rents;

   iii) Royalties;

   iv) Dividends;

   v) Alimony received counts as unearned income if the divorce or legal separation is executed on or before December 31, 2018. Alimony received will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019;

   vi) Pensions and annuities;

   vii) Income from life insurance and endowment contracts;

   viii) Income from discharge of indebtedness;

   ix) Income in respect of a decedent;

   x) Income from an interest in an estate or trust;

   xi) Social Security (SSA) income; and

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

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

   i) Any tax exempt interest income.

   ii) Untaxed foreign wages and salaries.

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

d. The following are Income exclusions:

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

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

iii) Child support received;

iv) Worker's Compensation;

v) Supplemental Security Income (SSI);

vi) Veteran's Benefits;

vii) The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan (ARP) Act Recovery Rebate, also known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.

viii) Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra $600.00 a week for qualified individuals, is exempt as countable unearned income.

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

e. Allowable Deductions: For an in-~~-~~depth treatment of allowable deductions from gross income, 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 can be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income (AGI) including (but not limited to):

i) Student loan interest deductions;

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

iii) Deductible part of self-employment tax;

iv) Health savings account deduction;

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

vi) Reimbursed expenses of employees;

vii) Moving expenses for active duty military who are moving due to a permanent change of station;

viii) IRA deduction: Regular Individual Retirement Account (IRA) contributions claimed on a federal income tax return and which does not exceed the IRA contributions limits;

ix) Penalty on early withdrawal of savings;

x) Domestic production activities deduction;

xi) Alimony paid can be deducted only if the divorce or legal separation is executed on or before December 31, 2018. It cannot be deducted if the divorce or separation is modified or executed on or after January 1, 20019. ;

xii) Certain educator expenses; and

xiii) Certain pre-tax contributions.

f. Income of children and tax dependents:

i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income above the tax filing threshold..

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

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

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

ii) The income of a child or tax dependent who does not live with their natural, adopted, or step parent will always count towards the determination of their own eligibility, even if the child's or tax dependent's income is below the tax filing threshold.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive 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 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 2~~1~~0%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall continue to be determined ~~in~~eligible during the federal Coronavirus COVID-19 Public Health Emergency.~~-~~

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

i) During the federal Coronavirus COVID-19 Public Health Emergency t~~T~~he Department ~~-~~may request paper documentation when ~~only if~~ the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.~~ 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 shall be sufficient verification of earnings, unless questionable.

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

a. Applicants who are found financially ineligible based on current or previous monthly household income and family size, and whose household has earned income from self-employment, seasonal employment, and/or commission-based employment, shall have their financial eligibility determined using annualized self-employment, seasonal employment, and commission-based employment income.

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

8.100.4.D. Income Disregard

1. An income disregard equivalent to five percentage points of the Federal Poverty Level for the applicable family size will be subtracted from MAGI-based income.

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

    b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be applied to determine eligibility.

8.100.4.E. Determining MAGI Household Composition.

1. MAGI household composition is similar to, but not necessarily the same as a tax household. To determine MAGI household composition, the individual's relationship to the tax filer must be established as declared on the Single Streamlined Application.

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

        i) The Tax-Filer;

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

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

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

        i) The Tax Dependent;

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

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

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

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

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

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

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

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

i) The applicant;

ii) The applicant's spouse who lives in the household;

iii) The applicant's natural, adopted, and step children under the age of 19, who live in the household; and

iv) In the case of applicants under the age of 19, the applicant's natural, adoptive, and step parents and natural, adoptive, and step siblings under age 19, who live in the household.

2. When a household includes a pregnant woman, regardless of the Medical Assistance category, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

3. 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.

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

5. 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 19may 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.

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

4. The presumptive eligibility site shall forward the application to the county within five business days.

5. The presumptive eligibility period begins on the date the applicant 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.

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

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

8.100.4.G. MAGI Covered Groups

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

2. Children applying for Medical Assistance whose total household income does not exceed 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. 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.

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

    a. A dependent child living in the household of a parent or caretaker relative shall have minimum essential coverage, in order for the parent or caretaker relative to be eligible for Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is considered a dependent child.

    b. Due to the COVID-19 Public Health Emergency an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection with COVID-19 may be eligible to receive services for COVID-19 testing only. To qualify for this limited benefit,- the a~~A~~pplicant must satisfy residency and immigration or citizenship status and not be enrolled in other health insurance. ~~and meet the criteria of citizenship~~

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 will be provided regardless of changes in the woman's financial circumstances once the income verification requirements are met.

    a. A pregnant women's eligibility period will end effective the earliest possible month, if the following occurs:

        i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90 day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

6. A lawfully admitted non-citizen who is pregnant and who has been in the United States for less than five years is eligible for Medical Assistance if she meets all of the other eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-5 and 8.100.3.G.1.g.vi.1-15. This population is referenced as Legal Immigrant Prenatal.

7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as "Eligible Needy Newborn". This coverage also applies in instances where the mother received Medical Assistance to cover the child's birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

    a. To receive Medical Assistance under this category, the birth must be reported verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn

8.100.4.H. Needy Persons

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

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

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

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

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

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

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

    g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the date the individual attained 18 years of age or was emancipated. Eligibility shall be extended until the individual's 21st birthday for these individuals with the exception of those receiving subsidized adoption payments.

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

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

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

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

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

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

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

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

   The extension shall be applied to individuals who:

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

   b. Are no longer eligible for coverage under the Parent/Caretaker Relative category because of new or increased income from employment or hours of employment

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

2. Any dependent child or Parent/Caretaker Relative who was or becomes part of the Medical Assistance household after the individual has begun receiving Transitional Medical Assistance is eligible for the remaining months of Transitional Medical Assistance.

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

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

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

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

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

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

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

    a. Alimony received will be countable income only if the divorce or legal separation is executed on or before December 31, 2018. Alimony will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019.

8.100.4.J. Express Lane Eligibility

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

1. Free/Reduced Lunch Program

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

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

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

        iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity shall receive 90days of eligibility while awaiting this verification.

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

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

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

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

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

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

2. Direct Certification

a. Individuals who have submitted a Food Assistance or Colorado Works application

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

ii) Children who meet all necessary eligibility requirements as outlined throughout 8.100.4 shall be automatically enrolled

iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.

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

v) Eligibility is based on income declared on the Food Assistance or Colorado Works application as well as eligibility requirements outlined throughout this volume.

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

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

8.100.5. Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan Medical Assistance General Eligibility

8.100.5.A. Application Requirements

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

a. Applicants who apply for Long-Term Care Medical Assistance on the basis of disability or blindness, or who apply for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities without a current disability determination, shall complete a Medical Assistance disability determination application in addition to the required Single Streamlined Application. The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.

b. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded to the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated eligibility site representative.

c. For the Medicaid Buy-In Program for Working Adults with Disabilities, if an individual does not meet the Social Security Administration definition of disability, the state disability determination contractor can review the individual's circumstances to determine if the individual meets limited disability.

d. Due to the ~~-~~Coronavirus ~~-~~COVID~~--~~19 Public Health Emergency~~-~~, if a person's ~~-~~existing disability determination has~~is~~ expired, the person shall remain enrolled in Medical Assistance until the emergency has ended and the state has processed the verification of eligibility, unless the individual requests a voluntary termination of eligibility.~~. . A disability determination will be verified by the state disability determination contractor as soon as possible after the Emergency has ended.~~

2. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the Single Streamlined Application.

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals applying for Medical Assistance:

a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the Coronavirus COVID-19 Public Health Emergency, at application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end ~~-~~of the COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1) Applicants who ~~-~~meet~~s~~ the criteria for any categorical Medical Assistance programs, but do not meet the federal and state criteria of citizenship and immigration status are~~-~~ ~~-~~only eligible to receive emergency medical services.

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

c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

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 section 8.100.3.H.9.

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 2~~1~~0%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall continue to be determined ~~in~~eligible during the federal Coronavirus COVID-19 Public Health Emergency~~due to income~~.

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

iv) During the federal Coronavirus COVID-19 Public Health Emergency t~~T~~he Department may request paper documentation when ~~only if~~ the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period. ~~and if the applicant does not provide a reasonable explanation or if electronic data are not available.~~

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

As of CBMS implementation, estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

v) During the federal -COVID-19 Public Health Emergency, all earned income and self-employment may be reported by self-attestation~~ed~~. At the end of the federal

COVID-19 Public Health Emergency, proof of any unverified income shall be provided.

d. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.

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

e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

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

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

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

g. Additional verification-If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.

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

8.100.5.C. Effective Date of Eligibility

1. Eligibility for the Aged, Blind and Disabled categories shall be approved effective on the later of:

   a. The first day of the month of the Single Streamlined Application for Medical Assistance; or

   b. The first day of the month the person becomes eligible for Medical Assistance.

2. The date that eligibility begins for Long-Term Care Medical Assistance is defined in section 8.100.7.A and B.

3. For the Medicaid Buy-In Program for Children with Disabilities, any child who is determined to be eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits during the entire month.

4. Clients applying for Medical Assistance under the Aged, Blind and Disabled category shall be reviewed for retroactive eligibility as described at 8.100.3.E. When reviewing for retroactive eligibility for an individual who is SSI eligible or applied and became SSI eligible in each of the retroactive months, the applicant must:

a. Be aged at least 65 years; or

b. Meet the Social Security Administration definition of disability by:

i) Being approved as eligible to receive either SSI or SSDI, on or prior to the date of a medical service; or

ii) Having a disability onset date determined on or prior to the date of a medical service; and

c. Meet the financial requirements as described at 8.100.5.E.

8.100.5.D. Medical Assistance Estate Recovery Program

1. The eligibility site shall provide written information from the Department to the following people explaining the provisions of the Medical Assistance Estate Recovery Program and how those provisions may pertain to the applicant/client:

a. Applicants age 55 and older who are institutionalized.

b. Applicants/clients who will turn age 55 before their next eligibility re-determination who are institutionalized.

c. Clients age 55 and older who are approved for admittance to an institution

8.100.5.E. Availability of Resources and Income

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

1. Income, which includes earned and unearned income, shall be calculated on a monthly basis regardless of whether it is received annually, semi-annually, quarterly or weekly.

2. For married couples, the income and resources of both spouses are counted in determining eligibility for either or both spouses. Refer to section 8.100.7.C for exceptions.

3. Resources and income shall be considered available when actually available; or, shall be deemed available when all of the following apply to the resources or income of the individual or individual's spouse:

a. has any ownership interest in income or resources or equity value of a resource;

b. has the right, authority, or power to convert the resource or income to cash or to cause the resource or income to be converted to cash; and

c. is not legally restricted from using the resource or income for his or her support and maintenance.

4. Resources and income shall not be considered unavailable merely because the individual or individual's spouse may need to initiate legal proceedings to access the resources or income.

5. If the applicant or client demonstrates with clear and convincing evidence that appropriate steps are being taken to secure the resources, Medical Assistance shall not be delayed or terminated.

Verification of efforts to secure the resources must be provided at regular intervals as requested by the Eligibility Site.

6. Resources will be considered available and Medical Assistance shall be denied or terminated if the applicant or client refuses or fails to make a reasonable effort to secure potential resources or income.

7. Timely and adequate notice must be given regarding a proposed action to deny, reduce, or terminate assistance due to failure to make reasonable efforts to secure resources or income. If upon receipt of the prior notice, the individual acts to secure the potential resource, the proposed action to deny, reduce, or terminate assistance must be withdrawn, and assistance must be approved or continued until the resource or income is, in fact, available.

8. If the resources or income has been transferred to a trust, the trust shall be submitted for review to the Department to determine the effect of the trust on eligibility in accordance with section 8.100.7.E.

9. A resource may not necessarily be unavailable by virtue that an individual may be unaware of his or her ownership of an asset. The Department will not treat the unknown asset as a resource during the period in which the individual was unaware of his/her ownership. However, the value of the previously unknown asset, including any monies such as interest that have accumulated on the asset through the month of discovery, is evaluated under regular income-counting rules in the month of discovery, and the asset is a resource subject to the resource-counting rules following the month of discovery.

    a. The burden is on the individual to prove by clear and convincing evidence that the asset was unavailable by virtue of being unknown by the recipient.

    b. Unknown assets shall not be deemed an overpayment pursuant to Section 8.065 of the Department's regulations where the asset was unknown through no fault of the individual.

    c. If the previously unknown asset causes the individual to be ineligible, the individual may repay the Department from the excess resources to retain Medicaid eligibility.

8.100.5.F. Income Requirements

1. This section reviews how income is looked at for the ABD and Long Term Care Medical Programs and determining premiums for the Medicaid Buy-In Program for Working Adults with Disabilities. For more general income information and income types refer to the Medical Assistance General Eligibility Requirements section 8.100.3.

2. Income for the ABD Medical Programs eligibility is income which is received by an individual or family in the month in which they are applying for or receiving Medical Assistance, or the previous month if income for the current month is not yet available to determine eligibility.

3. A self-declared common law spouse retains the same financial responsibility as a legally married spouse. Once self-declared as married under the common law, financial responsibility remains unless legal separation or divorce occurs. If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other. This is not changed by the fact that the unmarried individuals may share a common child.

4. Earned income is countable as income in the month received and a countable resource the following month. Earned Income includes the following:

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

    b. Net earnings from self-employment

    c. Payments for services performed in a sheltered workshop or work activities center

    d. Certain Royalties and honoraria

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

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

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

    b. Prizes and awards

    c. Gifts and inheritances

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

    e. Interest or dividend payments received from any resources

    f. Lump sum payments from workers' compensation, insurance settlements, etc.

    g. Dividends, royalties or other payments from mineral rights or other resources listed for sale within the resource limits

    h. Income from annuities that meet requirements for exclusion as a resource

    i. Pensions and other period payments, such as:

        i) Private pensions or disability benefits

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

        iii) Workers' Compensation payments

        iv) Railroad retirement annuities

        v) Unemployment insurance payments

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

        vii) Alimony and support payments

    j. Support and maintenance in kind - The support and maintenance in kind amount should not be greater than one third of the Federal Benefit Rate (FBR). Use the Presumed

Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the support and maintenance in kind amount. Use one third of the FBR if an amount is not declared by the client.

6. For the purpose of determining eligibility for the Long Term Care and Aged, Blind, and Disabled Medical Assistance categories the following shall be exempt from consideration as either income or resources:

   a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification.

   b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act.

   c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive payments (lump sum) for nine months following receipt and the remainder countable as a resource thereafter.

   d. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC).

   e. Home produce utilized for personal consumption.

   f. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner toward the purchase of a replacement dwelling are considered exempt for up to 6 months.

   g. The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

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

      ii) The United States Housing Act of 1937 (§ 1437 et seq. of 42 U.S.C.)

      iii) The National Housing Act (§ 1701 et seq. of 12 U.S.C.)

      iv) Section 101 of the Housing and Urban Development Act of 1965 (§ 1701s of 12 U.S.C., § 1451 of 42 U.S.C.);

      v) Title V of the Housing Act of 1949 (§ 1471 et seq. of 42 U.S.C.); or

      vi) Section 202(h) of the Housing Act of 1959.

   h. Payments made from Indian judgment funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458).

   i. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed $ 2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to $ 2000, received by a client in one

calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to $ 2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s).

j. Assistance from other agencies and organizations.

k. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for Medical Assistance.

l. Payments received for providing foster care.

m. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act.

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

o. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program

p. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act.

q. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended.

r. Monies received pursuant to the “Civil Liberties Act of 1988” P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts).

s. Payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y).

t. A child receiving subsidized adoption funds shall be excluded from the Medical Assistance budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household.

u. The Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.

v. Any money received from the Radiation Exposure Compensation Trust Fund, Including the Energy Employees Occupational Illness Compensation Program Act, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.

w. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are actual expenses for food, housing, medical items, clothing, transportation, or personal needs items.

x. Payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.

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

z. All wages paid by the United States Census Bureau for temporary employment related to the decennial Census.

aa. Any grant or loan to an undergraduate student for educational purposes made or insured under any programs administered by the Commissioner of Education (Basic Education Opportunity Grants, Supplementary Education Opportunity Grants, National Direct Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program, the BYRD Honor Scholarship programs and the College Work Study Program.

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

cc. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.

dd. The additional unemployment compensation of $25 a week enacted through the American Recovery and Reinvestment Act of 2009.

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

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

8.100.5.H. Income Allocations and Disregards

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

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

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

a. Income of spouses living together is considered mutually available for SSI related, OAP, and Medicare Savings Programs (MSP).

b. For a person living in the household of another and not paying shelter costs, one third of the Federal Benefit Rate (FBR) is counted as in-kind income and is added to the countable income. This does not apply to unemancipated children.

2. For the purposes of this rule, the following definitions apply:

a. unemancipated child is:

i) a child under age 18 who is living in the same household with a parent or spouse of a parent, or

ii) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment.

b. Ineligible child is a child who is not applying or eligible for SSI.

c. Ineligible parent/spouse is a parent or spouse who is not applying or eligible for SSI.

3. Countable income is calculated by reducing the gross income by the following allocations and disregards.

a. Income allocations are the part of the gross income that is allocated to individuals in the home who are not eligible for Supplemental Security Income or Old Age Pension. The allocation reduces the gross income that is deemed available to the applicant/client. The allocation is deducted from the gross income prior to applying the other disregards.

The allocations are:

i) An Ineligible Child Allocation is an amount equal to one half the current year's SSI FBR that is disregarded from the ineligible parents' gross income. This allocation is used to meet the needs of ineligible children in the household. This allocation is available for each ineligible child in the home. The amount of the allocation is reduced by any of the ineligible child's own income.

ii) An Ineligible Parent(s) Allocation is an amount equal to the current year's SSI FBR for a single individual or a couple, as applicable. This amount is used to meet the needs of the ineligible parent(s) in the home with an applicant/client child.

iii) No allocations are allowed for applicant/recipient spouses who do not have children in the home.

b. Allocations are applied to the income in the following manner:

i) Allocation disregards are deducted from unearned income before earned income.

ii) Ineligible child allocation disregards are deducted from parents' income before any standard disregards are applied.

iii) Ineligible parent(s) allocation disregards are deducted after any ineligible child allocation disregards and after the standard income disregards.

4. Income disregards

a. $20 General Income Disregard

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

i) The first $20 of total available unearned income (except for SSI income) must be disregarded. The remaining amount of unearned income is countable.

ii) If the client has less than $20 of unearned income, the difference between the gross unearned income and the $20 deduction shall be applied as an earned income disregard, if applicable.

iii) Only one $20 general income disregard is allowed per couple and is divided between the two spouses. If one of the spouses has no income the other spouse shall get the full $20 disregard.

b. $65 Plus One Half Remainder Earned Income Disregard

i) If there is earned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied:

1) Deduct the first $65 of all earned income.

2) Divide the remaining income in half.

3) The result is the amount of earned income used for determining eligibility.

c. Child support received by an applicant/recipient child is reduced by one third of the total child support payment. This reduction does not apply to ineligible children when calculating the ineligible child allocation disregard.

d. The first $400 of the gross monthly earned income is exempt for a blind or disabled child who is a student that is regularly attending school. The exemption cannot exceed $1,620 in a calendar year.

e. Title 20 of the Code of Federal Regulations, § 416.1112 (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.5.I. Determining Ownership of Income

1. If payment is made solely to one individual, the income shall be considered available income to that individual.

2. If payment is made to more than one individual, the income shall be considered available to each individual in proportion to their interests.

3. In case of a married couple in which there is no document establishing specific ownership interests, one-half of the income shall be considered available to each spouse.

4. Income from the Community Spouse's Monthly Income Allowance, as defined in the spousal protection rules in this volume at 8.100.7.R, is income to the community spouse.

8.100.5.J. Income-Producing Property

1. Net rental income from an exempt home or a life estate interest in an exempt home is countable after the following allowable deductions:

    a. Property taxes and insurance

    b. Necessary reasonable routine maintenance expenses

    c. Reasonable management fee for a professional property manager.

2. Non-business property that is necessary to produce goods or services essential to self- support is excluded up to $6,000.

3. Property used in a trade or business which is essential to self-support is excluded up to a limit of $6,000 if it produces 6% return of the $6,000 excluded value.

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

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

1. The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall not be used as patient payment to the medical facility:

    a. for a veteran or surviving spouse of a veteran in a medical facility other than State Veterans Home; or

    b. for a veteran or surviving spouse of a veteran in a State Veterans Home with dependents.

2. For a veteran or surviving spouse of a veteran in a State Veterans Home with no dependents the portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall be used as patient payment to the medical facility.

8.100.5.L. Reverse Mortgages

1. In accordance with C.R.S. § 11-38-110, reverse mortgages payments made to a borrower shall not be treated as income for eligibility purposes.

2. Funds remaining the following month after the payment is made will be countable as a resource.

3. Any payments from a reverse mortgage that are transferred to another individual without fair consideration shall be analyzed in accordance with the rules on transfers without fair consideration in the Long-Term Care section and may result in a penalty period of ineligibility.

8.100.5.M. Resource Requirements

1. Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is $2,000. For a married couple, the resource limit is $3,000. If one spouse is institutionalized, refer

to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses. Effective January 1, 2011, the resource limits for the Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), and Qualified Individuals 1 (QI-1) programs are $8,180 for a single individual and $13,020 for a married individual living with a spouse and no other dependents. The resource limits for the QMB, SLMB, and QI programs shall be adjusted annually by the Centers for Medicare and Medicaid Services on January 1 of each year. These resource limits are based upon the change in the annual consumer price index (CPI) as of September of the previous year. Resources are not counted for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities.

2. The following resources are exempt in determining eligibility:

   a. A home, which is any property in which an individual or spouse of an individual has an ownership interest and which serves as the individual's principal place of residence. The property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

      i) Only one principal place of residence is excluded for a single individual or a married couple.

      ii) The individual's ownership interest in the home must have an equity value that:

         1) From January 1, 2006 thru December 31, 2010 is $500,000 or less, or;

         2) Is less than the amount that results from the year to year percentage increase to the $500,000 limit. The increase is based upon the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

      iii) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual intends to return to that home, then the individual does not meet the residency requirement for Colorado Medicaid eligibility.

      iv) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless the individual's spouse or dependent relative lives in the home.

      v) If an individual or spouse of an individual owns a home located inside Colorado with an equity value lower than the limit in subparagraph (1), above, and if the individual intends to return to that home, then the home is considered an exempt resource if:

         1) The individual is institutionalized; and

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

      vi) If an individual or spouse of an individual owns a home with an equity value greater than the limit that is located inside Colorado, and if the individual intends to return to that home, then the home is considered to be a countable resource unless spouse or dependent relative lives in the home.

vii) If an individual or spouse of an individual owns a home of any value located inside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless spouse or dependent relative lives in the home.

viii) If an individual or spouse moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence.

ix) If an individual leaves his or her home to live in an institution, the home shall still be considered the principal place of residence, irrespective of the individual's intent to return as long as the individual's spouse or dependent relative continues to live there.

x) The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

xi) The intent to return home applies to the home in which the individual or spouse of the individual was living prior to being institutionalized or to a replacement home as long as the individual's spouse or dependent relative continues to live in the home.

xii) The intent to return home also applies if the individual is living in an assisted living facility or alternative care facility and receives HCBS while in that facility or transfers into a Long-Term Care institution to receive services.

xiii) For an individual in a Long-Term Care institution, receiving HCBS, or enrolled in PACE, the exemption for the principal place of residence does not apply to a residence which has been transferred to a trust or other entity, such as a partnership or corporation.

1) The exemption shall be regained if the residence is transferred back into the name of the individual.

xiv) The principal place of residence, which is subject to estate recovery, becomes a countable resource upon the execution and recording of a beneficiary deed.

The exemption can be regained if a revocation of the beneficiary deed is executed and recorded.

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

i.) The property is listed with a professional such as a real estate agent, broker, dealer, auction house, etc., at current market value.

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

iii) Any reasonable offer must be accepted.

iv) If an offer is received that is at least two-thirds of the current market value, that offer is presumed reasonable.

v) The client must continue reasonable efforts to sell and must submit verification of these efforts to the Eligibility Site on a quarterly basis. Reasonable effort is at Eligibility Site discretion.

vi) If the exemption is used to become eligible under the Spousal Protection rules, the property shall continue to be viewed according to 8.100.7.L while efforts to sell it are being made.

vii) Eligibility under this exemption is conditional. Once the property sells, the client shall be ineligible until the resources are below the prescribed limit.

c. One automobile is totally excluded regardless of its value if it is used for transportation for the individual or a member of the individual's household. An automobile includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

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

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

ii) Items needed by the household for maintenance, use and occupancy of the premises as a home.

iii) Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.

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

i) Items of personal property ordinarily worn or carried by the individual; or

ii) Articles otherwise having an intimate relation to the individual.

iii) Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments.

iv) Items of cultural or religious significance to the individual and items required because of an individual’s impairment are also not counted as a resource.

f. The cash surrender value of all life insurance policies owned by an individual and spouse, if any, is exempt if the total face value of all life insurance policies does not exceed $1,500 on any person. If the total face value of all the life insurance policies exceeds $1,500 on one person, the cash surrender value of those policies will be counted.

g. Term life insurance having no cash surrender value, and burial insurance, the proceeds of which can be used only for burial expenses, are not countable toward the resource limit.

h. The total value of burial spaces for the applicant/recipient, his/her spouse and any other members of his/her immediate family is exempt as a resource. If any interest is earned on

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

i. An applicant or recipient may own burial funds through an irrevocable trust or other irrevocable arrangement which are available for burial and are held in an irrevocable burial contract, an irrevocable burial trust, or in an irrevocable trust which is specifically identified as available for burial expenses without such funds affecting the person's eligibility for assistance.

j. An applicant or recipient may also own up to $1,500 in burial funds through a revocable account, trust, or other arrangement for burial expenses, without such funds affecting the person's eligibility for assistance. This exclusion only applies if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual or spouse's burial expenses. Interest on the burial funds is also excluded if left to accumulate in the burial fund. For a married couple, a separate $1,500 exemption applies to each spouse.

The $1,500 exemption is reduced by:

i) the amount of any irrevocable burial funds such as are described in the preceding subparagraph, and

ii) the face value of any life insurance policy whose cash surrender value is exempt.

k. Achieving a Better Life Experience (ABLE) Accounts.

3. Countable resources include the following:

a. Cash;

b. Funds held by a financial institution in a checking or savings account, certificate of deposit or money market account;

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

d. All funds in a joint account are presumed to be a resource of the applicant or client. If there is more than one applicant or client account holder, it is presumed that the funds in the account belong to those individuals in equal shares. To rebut this presumption, evidence must be furnished that proves that some or all of the funds in a jointly held account do not belong to him or her. To rebut the sole ownership presumption, the following procedure must be followed:

i) Submit statements from all of the account holders regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent.

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

iii) Correct the account title and submit revised account records showing that the applicant or client is no longer an account holder or separate the funds to show they are solely owned by the individual within 45 days.

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

f. For applications filed on or after January 1, 2006, an individual's home if the individual's equity interest in the home exceeds the equity value limit described at 8.100.5.M.2.a.i)1).

g. Real property not exempt as the principal place of residence and not exempt as income producing property with a value of $6,000 or less, as described at 8.100.5.J.

h. When the applicant alleges that the sale of real property would cause undue hardship to the co-owner due to loss of housing, all of the following information must be obtained:

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

    ii) Verification of joint ownership.

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

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

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

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

        4) There is no other readily available residence because there is no other affordable housing available or no other housing with the necessary modifications for the co-owner if he is a person with disabilities.

i. Personal property such as a mobile home or trailer or the like, that is not exempt as a principal place of residence or that is not income producing.

j. Personal effects acquired or held for their value or as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.

k. The equity value of all automobiles that are in addition to one exempt vehicle.

l. The cash surrender value of all life insurance policies owned by an individual and spouse is counted if the total face value of all the policies combined exceeds $1,500 on any person.

m. Promissory notes established before April 1, 2006 are treated as follows:

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

    ii) In order to determine the fair market value, the applicant shall obtain three estimates of fair market value from a private note broker, who is engaged in the business of purchasing such notes. In order to obtain the estimates and locate willing buyers, the note shall be advertised in a newspaper with state wide circulation under business or investment opportunities.

    iii) A note or similar instrument which transferred funds or assets for less than fair consideration shall be considered as a transfer for less than fair consideration and a period of ineligibility shall be imposed.

n. Promissory notes established on or after April 1, 2006 and before March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is an available countable resource unless the note, loan or mortgage:

1) Has a repayment term that is actuarially sound based on the individual's life expectancy, found in the tables at 8.100.7.J, for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

ii) The value of a promissory note, loan or mortgage which does not meet the criteria in outlined in 8.100.5.M.3.n.i)1)-3) is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is subject to the transfer of assets without fair consideration provisions as outlined in section 8.100.7.F.

o. Promissory notes established on or after March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is an available countable resource, and

ii) A promissory note, loan or mortgage which does not meet the following criteria shall be considered to be a transfer without fair consideration and shall be subject to the provisions outlined at 8.100.7.F.

1) Has a repayment term that is actuarially sound based on the individual's life expectancy as found in the tables in section 8.100.7.J for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

p. Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

i) Ownership of land and mineral rights. If the individual owns the land to which the mineral rights pertain, the current market value of the land generally includes the value of the mineral rights.

ii) If the individual does not own the land to which the mineral rights pertain, the individual should obtain a current market value estimate from a knowledgeable source. Such sources may include:

1) any mining company that holds leases;

2) the Bureau of Land Management;

3) the U.S. Geological Survey.

8.100.5.N. Treatment of Self-Funded Retirement Accounts

1. The following regulations apply to self-funded retirement accounts such as an Individual Retirement Account (IRA), Keogh Plan, 401(k), 403(b) and any other self-funded retirement account.

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

3. Self-funded retirement accounts in the name of the applicant's spouse who is living with the applicant are exempt in determining eligibility for the applicant, except as set forth in 4. below.

4. Self-funded retirement accounts in the name of a community spouse who is married to an applicant who is applying for Long Term Care in a Long Term Care institution, HCBS or PACE, are countable as a resource to the applicant and may be included in the Community Spouse Resource Allowance (CSRA) up to the maximum amount allowable. The terms community spouse and CSRA are further defined in the regulations on Spousal Protection in this volume.

5. The value of a self-funded retirement account is determined as follows:

    a. The gross value of the account, less any taxes due, is the amount that is countable as a resource, regardless of whether any monthly income is being received from the account.

    b. If the applicant is not able to provide the amount of taxes that are due, the value shall be determined by deducting 20% from the gross value of the account.

8.100.5.O. Treatment of Inheritances

1. An inheritance is cash, other liquid resources, non-cash items, or any right in real or personal property received at the death of another.

2. If an Individual or individual’s spouse is the beneficiary of a will, the inheritance is presumed to be available at the conclusion of the probate process or within 6 months if the estate is not in probate.

3. If an individual or individual’s spouse is eligible for a family allowance in a probate proceeding, that allowance will be considered available three months after death or when actually available, whichever is sooner.

4. Evidence demonstrating that the inheritance is not available due to probate or other legal restrictions must be provided to rebut the presumption.

8.100.5.P. Treatment of Proceeds from Disposition of Resources

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

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

2. The net proceeds are the selling price less any valid encumbrances and costs of sale.

3. After deducting any amount necessary to raise the individual's and spouse's resources to the applicable limits, the balance of the net proceeds, in excess of the resource limits, shall be

considered available resources. In lieu of terminating eligibility due to excess resources, the client may request that the proceeds be used to reimburse the Medical Assistance Program for previous payments for Medical Assistance.

4. The proceeds from the sale of an exempt home will be excluded to the extent they are intended to be used and are, in fact, used to purchase another home in which the individual, a spouse or dependent child resides, within three months of the date of the sale of the home.

8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility

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

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

8.100.6.B. Disability Determinations

1. Beginning on July 1, 2001, the Department or its contractor shall determine whether the client is disabled or blind in accordance with the requirements and procedures set forth elsewhere in this volume and according to Federal regulations regarding disability determinations.

2. A client who disagrees with the decision on disability or blindness shall have the right to appeal that decision to a state-level fair hearing in accordance with the procedures at 8.057.

8.100.6.C. SSI Eligibles

1. Benefits of the Colorado Medical Assistance Program must be provided to the following:

    a. persons receiving financial assistance under SSI;

    b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

    c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

2. The Department has entered into an agreement with SSA in which SSA shall determine Medical Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving SSI benefits as determined by SSA to be eligible for Medical Assistance.

3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the eligibility site to authorize Medical Assistance.

4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical Assistance.

6. The SISC Code for this type of assistance is B.

7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later overturned, must be approved from the original SSI eligibility date.

8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive Medical Assistance benefits. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income.

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

10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.

    a. Special Provisions for Infants

        i) For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:

            1) the infant was born in a hospital;

            2) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and

            3) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI

8.100.6.D. Pickle Amendment

1. Beginning July 1977, Medical Assistance must be provided to an individual if their countable income is below the current years SSI standard after a cost of living adjustment (COLA) disregard is applied to their OASDI (excluding Railroad Retirement Benefits) and they meet all other eligibility criteria. This is referred to as Pickle Disregard.

2. The Pickle Disregard applies to an individual who:

    a. lost SSI and/or OAP because of a cost of living adjustment to his/her own OASDI benefits.

    b. lost SSI and/or OAP because a cost of living adjustment to OASDI income deemed from a parent or spouse.

    c. lost OAP and/or SSI due to the receipt of, or increase to, OASDI, and would be eligible for OAP and/or SSI if all COLA'S on the amount that caused them to lose eligibility is disregarded from their current OASDI amount.

8.100.6.E. Pickle Determination

1. To determine eligibility of Medical Assistance recipients to whom the Pickle disregards apply, the eligibility site must:

a. establish whether the person was eligible for SSI or OAP and, for the same month, was entitled to OASDI;

b. determine the previous amount of the OASDI that caused them to lose SSI and/or OAP;

c. determine the current OASDI income;

d. subtract the previous OASDI income from the current OASDI income to find the cumulative OASDI COLAs since SSI and/or OAP was lost. This is the Pickle Disregard amount;

e. subtract the Pickle Disregard amount from the current OASDI income to get the countable OASDI income.

2. If the countable OASDI income and all other countable income is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria then medical eligibility must continue or be reinstated.

3. This disregard must also be applied to any OASDI cost of living increases paid to any financially responsible individual such as a parent or spouse whose income is considered in determining the person's continued eligibility for Medical Assistance.

4. The cost of living increase disregard specified in the preceding action must continue to be applied at each eligibility redetermination.

5. An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be contacted by the eligibility site to determine if the individual would continue to remain eligible for Medical Assistance under the provisions for SSI related cases. The individual must complete an application for assistance to continue receiving benefits.

8.100.6.F. 1972 Disregard Individuals

1. Medical Assistance must be provided to a person who was receiving financial assistance under AND or Aid to the Blind (AB) for August 1972 and who – except for the October 1972 Social Security (includes RRB) 20% increase amount would currently be eligible for financial assistance. This disregard must also be applied to a person receiving Medical Assistance in August 1972 who was eligible for financial assistance but was not receiving the money payment and to a person receiving Medical Assistance as a resident in a medical institution in August 1972.

2. To redetermine the eligibility of Medical Assistance recipients to whom the 1972 disregard applies, the eligibility site must:

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

b. apply the resource and income criteria specified in section 8.100.5;

c. subtract the 1972 disregard amount from the income;

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

8.100.6.G. Individuals Eligible in 1973

1. Medical Assistance must be provided to ABD persons who are receiving mandatory state supplementary payments (SSP). Such persons are those with income below their December 1973 minimum income level (MIL).

2. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an inpatient of a medical facility, who continues to meet the December 1973 eligibility criteria for institutionalized persons and who remains institutionalized.

3. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an "essential spouse" of an AND or AB financial assistance recipient, and who continues to be in the grant and continues to meet the December 1973 eligibility criteria. Except for such persons who were grandfathered-in for continued assistance, essential spouses included in assistance grants after December 1973 are not eligible for Medical Assistance.

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

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

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

   a. have been continuously entitled to Title II benefits since December 1983;

   b. have been disabled widow(er)s in January 1984;

   c. have established entitlement to Title II benefits prior to age 60;

   d. have been eligible for SSI/SSP benefits prior to application of the revised actuarial reduction formula;

   e. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial table; and

   f. reapply for assistance prior to July 1, 1987.

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

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

   To qualify these individuals must:

   a. be a widow(er);

   b. have received SSI in the past;

   c. be at least 50 years old but not 65 years old;

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

   e. not have hospital insurance under Medicare; and,

   f. meet all other Medical Assistance requirements.

8.100.6.J. Disabled Adult Children

1. Medical Assistance shall be provided to an individual aged 18 or older who loses SSI due to the receipt of OASDI drawn from his/her parents' Social Security Number; and:

    a. who was determined disabled prior to the age of 22; and

    b. who is currently receiving OASDI income as a Disabled Adult Child; and

    c. who would continue to be eligible for SSI if:

        i) the current OASDI income of the applicant is disregarded; and

        ii) the resources are below the applicable limit as listed at 8.100.5.M; and

        iii) other countable income is below the current years SSI FBR.

2. Disabled Adult Children are identified by the OASDI Beneficiary Identification Code (BIC) of “C”.

8.100.6.K. Old Age Pension (OAP) Eligibles

1. Individuals that are 65 and over are defined as the OAP-A category. Individuals who attain the age of 60 but not yet 65 are defined as the OAP-B category.

2. Medical Assistance must be provided to persons receiving OAP-A or OAP-B and SSI (SISC B).

3. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria but are not receiving a money payment (SISC-B).

4. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria except for the level of their income (SISC-B).

5. Medical Assistance must be provided to persons in a facility eligible for Medical Assistance reimbursement whose income is under 300% of the SSI benefit level and who, but for the level of their income, would be eligible for OAP “A” or OAP “B” and SSI financial assistance. This group includes persons 65 years of age or older receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement (SISC A). This population is referenced as Psych >65.

6. The OAP B individual included in AFDC assistance unit shall receive Medical Assistance as a member of the AFDC household (SISC B).

7. The OAP State Only Medical Assistance Program provides Medical Assistance to OAP-A, OAP-B or OAP Refugees who lost their OAP financial assistance because of a cost of living adjustment other than OASDI. Examples of other sources of income are VA, RRB, PERA, etc. (SISC C).

8. For the purpose of identifying the proper SISC code for persons receiving assistance under OAP “A” or OAP “B”, if the person:

    a. receives an SSI payment (SISC B);

    b. does not receive an SSI payment but is receiving assistance under OAP “A”, a second evaluation of resources must be made using the same resource criteria as specified in section 8.100.5.M for those who meet this criteria the SISC code is B for money payment and “disregard” case, A for institutional cases;

c. does not receive an SSI payment and does not otherwise qualify under SISC code B or A as described in item b. above (SISC C).

8.100.6.L. Qualified Medicare Beneficiaries (QMB)

1. Medical Assistance coverage for QMB clients is payment of Medicare part B premiums, co-insurance and deductibles.

2. Effective July 1, 1989, a Qualified Medicare Beneficiary is an individual who:

   a. is entitled to Part A Medicare; and

   b. resources may not exceed the standard for an individual or couple who have resources, as described in section 8.100.5.M; and

   c. has income at or below the percentage of the federal poverty level for the size family as mandated for QMB by federal regulations. Poverty level is established by the Executive Office of Management and Budget.

3. For QMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for QMB.

4. For QMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

5. Medicare cost sharing expenses must be provided to qualified Medicare beneficiaries. This limited Medical Assistance package of Medicare cost sharing expenses only includes:

   a. payment of Part A Medicare premiums where applicable;

   b. payment of Part B Medicare premiums; and

   c. payment of coinsurance and deductibles for Medicare services whether or not a benefit of Medical Assistance up to the full Medicare rate or reasonable rates as established in the State Plan.

6. Individuals may be QMB recipients only or the individual may be classified as a dual eligible. A dual eligible is a Medicare recipient who is otherwise eligible for Medical Assistance.

7. A QMB-only recipient is an individual who is not eligible for other categorical assistance program due to their income and/or resources but who meets the eligibility criteria for QMB described above.

8. Individuals who apply for QMB assistance have the right to have their eligibility determined under all categories of assistance for which they may qualify.

9. All other general non-financial requirements or conditions of eligibility must also be met such as age, citizenship, residency requirements as well as reporting and redetermination requirements. These criteria are defined in section 8.100.3 of this volume.

10. Eligibility for QMB benefits shall be effective the month following the month of determination. Beneficiaries who submit and complete an application within the 45-day standard shall be eligible

for benefits no later than the first of the month following the 45th day of application. Administrative delays shall not postpone the effective date of eligibility.

11. QMB benefits are not retroactive and the three month retroactive Medical Assistance rule does not apply to QMB benefits.

12. Clients who would lose their QMB entitlement due to annual social security COLA will remain eligible for QMB coverage under Medical Assistance, as income disregard cases, until the next year's federal poverty guidelines are published.

8.100.6.M. Specified Low Income Medicare Beneficiaries

1. Medical Assistance coverage for SLMB clients is limited to payment of monthly Medicare Part B (Supplemental Medical Insurance Benefits) premiums.

2. Effective January 1, 1993, a Specified Low Income Medicare Beneficiary (SLMB) is an individual who:

   a. is entitled to Medicare Part A;

   b. resources may not exceed the standard for an individual or couple who has resources as described in section 8.100.5.M of this volume.

   c. has income at or below a percentage of the federal poverty level for the family size as mandated by federal regulations for SLMB. Income limits have been defined through CY 1995, as follows: CY 1993 and 1994 100-110% of FPL, CY 1995 100-120% of FPL.

3. For SLMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for SLMB.

4. For SLMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

5. SLMB eligibility starts on the date of application or up to three month prior to the application date for retroactive Medical Assistance.

6. Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.

7. Clients who would lose their SLMB entitlement due to annual SSA COLA will remain eligible for SLMB coverage, as income disregard cases, through the month following the month in which the annual federal poverty levels (FPL) update is published.

8.100.6.N. Medicare Qualifying Individuals 1 (QI1)

1. Medical Assistance coverage is limited to monthly payment of Medicare Part B premiums. Payment of the premium shall be made by the Department on behalf of the individual.

2. Eligibility for this benefit is limited by the availability of the allocation set by CMS. Once the state allocation is met, no further benefits under this category shall be paid and a waiting list of eligible individuals shall be maintained.

3. Eligibility for QI1 benefits shall be effective the month in which application is made and the individual is eligible for benefits. Eligibility may be retroactive up to three months from the date of application, but not prior to January 1, 1998.

4. In order to qualify as a Medicare Qualifying Individual 1, the individual must meet the following:

    a. be entitled to Part A of Medicare,

    b. income of at least 120%, but less than 135% of the FPL.

    c. resources may not exceed the standard as described in section 8.100.5.M, and

    d. he/she cannot otherwise be eligible for Medical Assistance.

5. For QI1 purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

6. Clients who would lose QI-1 entitlement due to annual social security COLA will remain eligible for QI-1 coverage under Medical Assistance, as an income disregard case, until the next year's federal poverty guidelines are published.

8.100.6.O. Qualified Disabled And Working Individuals

1. Medical Assistance coverage is limited to monthly payment of Medicare Part A premiums, and any other Medicare cost sharing expenses determined necessary by CMS.

2. Effective July 1, 1990, a Qualified Disabled and Working Individual (QDWI) is an individual who:

    a. was a recipient of federal Social Security Disability Insurance (SSDI) benefits, who continues to be disabled but lost SSDI entitlement due to earned income in excess of the Social Security Administration's Substantial Gainful Activity (SGA) threshold, and;

    b. has exhausted SSA's allowed extension of "premium free" Medicare Part A coverage under SSDI, and;

    c. has resources at or below twice the SSI resource limit as described in section 8.100.5., and;

    d. has income less than 200% of FPL.

3. For QDWI purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

4. An individual may be eligible under this section only if he/she is not otherwise eligible under another Medical Assistance category of eligibility.

5. Eligibility for QDWI benefits shall be effective the month of determination of entitlement.

6. Eligibility may be retroactive only to the date as of which SSA approves an individual's application for coverage as a "Qualified Disabled and Working Individual". However, eligibility may not begin prior to 07/01/90.

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

1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:

   a. Applicants must be at least age 16 but less than 65 years of age.

   b. Income must be less than or equal to 450% of FPL after income allocations and disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income allocations and disregards. Only the applicant's income will be considered.

   c. Resources are not counted in determining eligibility.

   d. Individuals must have a disability as defined by Social Security Administration medical listing or a limited disability as determined by a state contractor.

   e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.

      i) Due to the federal COVID-19 Public Health Emergency, and required by the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss —of employment will remain in the Buy-In program until the end of the federal Public Health Emergency.~~.~~ At the end of the federal Public Health Emergency, members will be redetermined based on their current - employment status-. New applicants enrolled will still need to meet the work requirement.

   ~~g~~

   f. Individuals will be required to pay monthly premiums on a sliding scale based on income.

      i) The amount of premiums cannot exceed 7.5% of the individual's income.

      ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.

      iii) Premium amounts are as follows:

         1) There is no monthly premium for individuals with income at or below 40% FPL.

         2) A monthly premium of $25 is applied to individuals with income above 40% of FPL but at or below 133% of FPL.

         3) A monthly premium of $90 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.

         4) A monthly premium of $130 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.

         5) A monthly premium of $200 is applied to individuals with income above 300% of FPL but at or below 450% of FPL./

      iv) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

v) A change in client net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

vi) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Medicaid Buy-In for Working Adults with Disability Program during the federal COVID-19 emergency declaration. -Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume. -

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation

3. Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Working Adults with Disabilities. This is also called "opt out."

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

1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:

a. Applicants must be age 18 or younger.

b. Household income will be considered and must be less than or equal to 300% of FPL after income disregards. The following rules apply:

i) 8.100.4.E - MAGI Household Requirements

ii) 8.100.5.F - Income Requirements

iii) 8.100.5.F.6 - Income Exemptions

iv) An earned income of $90 shall be disregarded from the gross wages of each individual who is employed

v) A disregard of a 33% (.3333) reduction will be applied to the household's net income.

c. Resources are not counted in determining eligibility.

d. Individuals must have a disability as defined by Social Security Administration medical listing.

e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18 shall be determined for eligibility through the Medicaid Buy-In Program for Working Adults with Disabilities.

f. Families will be required to pay monthly premiums on a sliding scale based on household size and income.

i) For families whose income does not exceed 200% of FPL, the amount of premiums and cost-sharing charges cannot exceed 5% of the family's adjusted gross income. For families whose income exceeds 200% of FPL but does not

exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot exceed 7.5% of the family's adjusted gross income.

ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.

iii) For households with two or more children eligible for the Medicaid Buy-In Program for Children with Disabilities, the total premium shall be the amount due for one eligible child.

iv) Premium amounts are as follows:

1) There is no monthly premium for households with income at or below 133% of FPL.

2) A monthly premium of $70 is applied to households with income above 133% of FPL but at or below 185% of FPL.

3) A monthly premium of $90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL.

4) A monthly premium of $120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.

v) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

vi) A change in household net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

vii) Due to the federal COVID-19 ——Public Health Emergency, the Department will waive premiums for the Department's Children with Disabilities Program during the federal emergency declaration. Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.

3. Verification requirements will follow the MAGI Category Verification Requirements found at 8.100.4.B.

4, Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Children with Disabilities. This is also called "opt out."

8.100.7 Long-Term Care Medical Assistance Eligibility

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

1. For Long-Term Care services to be covered in a Long-Term Care institution, a client must be determined eligible under the 300% Institutionalized Special Income category. If the client is

already Medicaid eligible, a new application is not required but the client must be determined to meet the eligibility criteria.

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

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

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

2. Eligibility under the 300% Institutionalized Special Income category will be provided to applicants who:

   a. Have attained the age of 65 years or;

   b. Have met the requirements according to the definition of disability or blindness applicable to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)

   c. Have been institutionalized for at least 30 consecutive full days in a Long-Term Care institution. The 30 consecutive full day stay may be a combination of days in a hospital, Long-Term Care institution, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE).

      Supporting documentation must be provided which verifies the 30 consecutive full days. This documentation shall include the ULTC 100.2 and/or medical records which must be verified by a physician or case manager.

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

      i) There is a statement from a physician, or case manager that declares if the client had not died, he/she would have been institutionalized for 30 consecutive full days, and;

      ii) The statement is verified by supporting documentation from the beginning of the institutionalized period, which is the first 15 days, or prior to the death of the client, whichever is earliest.

      iii) Once the 30 consecutive days of institutionalization requirement has been met, Medical Assistance benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date.

   d. Are in a facility eligible for Medical Assistance Program reimbursement if the individual is in a hospital or Long-Term Care institution; and

   e. Have gross income that does not exceed 300% of the current individual SSI benefit level or;

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

i) This special income standard must be applied for:

1) A person 65 years of age or older, or disabled or blind receiving care in a hospital, nursing facility; or

2) A person who is not SSI eligible needing Long-Term Care from HCBS or PACE; or

3) A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement; and

f. Have resources that conform with the regulations regarding resource limits and exemptions set forth in section 8.100.5 of this volume; and

g. If married, Income and resources conform to rules set forth at 8.100.7.C and 8.100.7.K; and

h. Have not transferred assets without fair consideration on or after the look-back date defined in section 8.100.7.F.2.d. which would incur a penalty period of ineligibility in accordance with the regulations on transfers without fair consideration in section 8.100.7 of this volume; and

i. Have submitted trust documents to the Department if the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of trust. The Department shall determine the effect of the trust on Medical Assistance Program eligibility.

j. Have submitted documents verifying that an annuity conforms to the regulations regarding Annuities at 8.100.7.I.

3. An appeal process is available to children identified by C.R.S. 27-10.3-101 to 108, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Department of Human Services (9 CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to Medical Assistance eligibility

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

1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry Point/Case Management Agency to have met the functional level of care and will remain in the community by receiving HCBS or PACE; and

a. are SSI (including 1619b) or OAP Medicaid eligible; or

b. are eligible under the Institutionalized 300% Special Income category described at 8.100.7.A; or

c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P. For this group, access to HCBS:

i) Is limited to the Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI) and Supported Living Services (SLS) waivers; and

ii) Is contingent on the Department receiving all necessary federal approval for the waiver amendments that extend access to HCBS to the Working Adults with Disabilities population described at 8.100.6.P.

2. A client who is already Medicaid eligible does not need to submit a new application. The client must request the need for Long-Term Care services and the Eligibility Site must redetermine the client's eligibility.

   a. All individuals applying for or requesting Long-Term Care services must disclose and provide documentation of:

      i) any transfer of assets without fair consideration as described at 8.100.7.F; and

      ii) any interest in an annuity as described at 8.100.7.I; and

      iii) any interest in a trust as described at 8.100.7.E.

   b. Failure to disclose and provide documentation of the assets described at 8.100.7.B.2.a may result in the denial of Long-Term Care services.

   c. The requirements at 8.100.7.B.2.a and 8.100.7.B.2.b do not apply to individuals who have been determined eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P.

3. For individuals served in Alternative Care Facilities (ACF), income in excess of the personal needs allowance and room and board amount for the ACF shall be applied to the Medical Assistance charges for ACF services. The total amount allowed for personal need and room and board cannot exceed the State's Old Age Pension Standard.

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

1. The income of a community spouse is not deemed to the institutionalized spouse in determining eligibility. If both spouses are institutionalized, their individual income is counted in determining their own eligibility. The income of one institutionalized spouse is not deemed to the other institutionalized spouse when determining eligibility.

2. The income and resources of both spouses are counted in determining eligibility for either or both spouses with the following exceptions:

   a. If spouses share the same room in an institution, the income of the individual spouse is counted in determining his or her eligibility, and each spouse is allowed the $2000 limit for resources.

   b. Beginning the first month following the month the couple ceases to live together, only the income of the individual spouse is counted in determining his or her eligibility.

   c. If one spouse is applying for Long-Term Care in a Long-Term Care institution or Home and Community Based Services (HCBS), refer to the rules on Treatment of Income and Resources for Institutionalized Spouses.

3. Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the Long-Term Care institution.

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

Long-Term Care

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

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

8.100.7.E Consideration of Trusts in Determining Medical Assistance Eligibility

1. Trusts established before August 11, 1993:

    a. Medical Assistance Qualifying Trust (MQT)

        i) In the case of a Medical Assistance qualifying trust, as defined in 42 U.S.C. Sec. 1396a(k), the amount of the trust property that is considered available to the applicant/recipient who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual assuming the full exercise of discretion by the trustee(s) for the distribution of the maximum amount to the applicant/recipient. This amount of property is deemed available resources to the individual, whether or not is actually received.

        ii) 42 U.S.C. Sec. 1396a(k) was repealed in 1993 and is reprinted here exclusively for purposes of trusts established before August 11, 1993. 42 U.S.C. Sec. 1396a(k) defines a Medical Assistance qualifying trust as “a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.”

    b. This provision does not apply to any trust or initial decrees established before April 7, 1986, solely for the benefit of a developmentally disabled individual who resides in an Long Term Care Institution for the developmentally disabled.

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

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

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

    a. The individual or the individual's spouse,

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

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

3. In determining an individual's eligibility for Medical Assistance, the following regulations apply to a trust established by an individual:

a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust, other than by will:

i) The individual or the individual's spouse

ii) A person, including a court or administrative body, with legal authority to act in place of, or on the behalf of, the individual or the individual's spouse;

iii) A person, including a court or administrative body acting at the direction or upon the request of the individual or the individual's spouse.

b. In the case of a trust, the corpus of which includes assets of an individual and the assets of any other person(s), this regulation shall apply to the portion of the trust attributable to the assets of the individual.

c. These regulations apply without regard to the following:

i) The purposes for which a trust is established;

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

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

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

4. Revocable Trusts are considered as follows:

a. The corpus of the trust shall be considered resources available to the individual.

b. Payments from the trust to or for the benefit of the individual shall be considered income to the individual, and

c. Any other payments from the trust shall be considered assets transferred by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.

5. Irrevocable Trusts

If there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the following shall apply:

a) The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.

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

c) Payments from that portion of the corpus or income for any other purpose shall be considered as a transfer of assets by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.

d) Any portion of the trust from which, or any income on the corpus from which no payment could be made to the individual under any circumstances, shall be considered as a transfer of assets for less than fair market value and shall be subject to a 60 month look back period and penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume. The transfer will be effective as of the date of the establishment of the trust, or the date on which payment to the individual from the trust was foreclosed, if later. The value of the trust shall be determined by including the amount of any payments made from such portion of the trust after such date.

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

a. Income Trusts

i) A trust consisting only of the individual's pension income, social security income and other monthly income that is established for the purpose of establishing income eligibility for Long Term Care institution care or Home and Community Based Services (HCBS). To be valid, the trust must meet the following criteria:

a) The individual's gross monthly income must be above the 300%-SSI limit but below the average cost of private Long Term Care institution care in the geographic region in which the individual resides and intends to remain. The Colorado Department of Health Care Policy and Financing shall calculate the average rates for such regions on an annual, calendar-year basis. The geographic regions which are used for calculating the average private pay rate for Long Term Care institution care shall be based on the Bureau of Economic Analysis Regions and consist of the following counties:

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

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

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

REGION IV: (Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison, Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel)

b) For Long Term Care institution clients, each month the trustee shall distribute the entire amount of income which is transferred into the trust. An amount not to exceed $20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust.

c) The only deductions from the monthly trust distribution to the Long Term Care institution are the allowable deductions which are permitted for Medical Assistance-eligible persons who do not have income trusts. Allowable deductions include only the following:

i) Personal need allowance

ii) Spousal income payments

iii) Approved PETI payments

d) Any funds remaining after the allowable deductions shall be paid solely to the cost of the Long Term Care institution care in an amount not to exceed the Medical Assistance reimbursement rate. Any excess income which is not distributed shall accumulate in the trust.

e) No other deductions or expenses may be paid from the trust. Expenses which cannot be paid from the trust include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past-due medical bills and other debts. Trustee fees which were ordered prior to April 1, 1996 may continue until the trust terminates.

f) For HCBS clients, the amount distributed each month shall be limited to the 300% of the SSI limit. Any monthly income above that amount shall remain in the trust. An amount not to exceed $20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust. No other trust expenses or deductions may be paid from the trust. For the purpose of calculating Individual Cost Containment or client payment (PETI), the client's monthly income will be 300% of the SSI limit. Upon termination, the funds which have accumulated in the trust shall be paid to the Department up to the total amount of Medical Assistance paid on behalf of the individual.

g) For a court-approved trust, notice of the time and place of the hearing, with the petition and trust attached, shall be given to the eligibility site and the Department in the manner prescribed by law.

h) The sole beneficiaries of the trust are the individual for whose benefit the trust is established and the Department. The trust terminates upon the death of the individual or if the trust is not required for Medical Assistance eligibility in Colorado.

i) The trust must provide that upon the death of the individual or termination of the trust, whichever occurs sooner, the Department shall receive all amounts remaining in the trust up to the total amount of Medical Assistance paid on behalf of the individual.

j) The trust must include the name and mailing address of the trustee. The trustee must notify the Department of any trustee address changes or change of trustee(s) within 30 calendar days.

k) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the eligibility site or to the Department upon reasonable request or upon any change of trustee.

l) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.

m) The regulations in this section for income trusts shall also apply to income trusts established after January 1, 1992, under the undue hardship provisions in 26-4-506.3(3),C.R.S. and 15-14-412.5,C.R.S.

b. Disability Trusts

i) A trust that is established solely for the benefit of a disabled individual under the age of 65, which consists of the assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the individual's resource eligibility for Medical Assistance and which meets the following criteria:

a) The individual for whom the trust is established must meet the disability criteria of Social Security.

b) The only assets used to fund the trust are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zebley. (This provision is applicable to disability trusts established from July 1, 1994 to December 31, 2000.)

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

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

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

f) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the trust and approval of the trust.

g) If the trust is funded with an annuity or other periodic payments, the Department shall be named on the contract or settlement as the remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual.

h) The trust shall provide that, upon the death of the beneficiary or termination of the trust, the Department shall receive all amounts remaining in the trust up to the amount of total Medical Assistance paid on behalf of the individual.

i) No expenditures may be made after the death of the beneficiary, except for federal and state taxes. However, prior to the death of the individual beneficiary, trust funds may be used to purchase a burial fund for the beneficiary.

j) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.

k) The trust fund shall not be considered as a countable resource in determining eligibility for Medical Assistance.

l) [Rule 8.110.52 B 5. b. 1) l), adopted or amended on or after November 1, 2000 and before November 1, 2001 was not extended by HB 02-1203, and therefore expired May 15, 2002.]

m) Distributions from the trust may be made only to or for the benefit of the individual beneficiary. Cash distributions from the trust shall be considered income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

n) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward eligibility.

o) The trust must include the name and mailing address of the trustee. The Department must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.

p) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the eligibility site or to the Department upon reasonable request or upon any change of trustee.

q) Prior to the establishment or funding of a disability trust, the trust shall be submitted for review to the Department, along with proof that the individual beneficiary is disabled according to Social Security criteria. No disability trust shall be valid unless the Department has reviewed the trust and determined that the trust conforms to the requirements of 15-14-412.8,C.R.S., as amended, and any rules adopted by the Medical Services Board.

c. Pooled Trusts

i) A trust consisting of individual accounts established for disabled individuals for the purpose of establishing resource eligibility for Medical Assistance. A valid pooled trust shall meet the following criteria:

a) The individual for whom the trust is established must meet the disability criteria of Social Security.

b) The trust is established and managed by a non-profit association which has been approved by the Internal Revenue Service.

c) A separate account is maintained for each beneficiary; however, the trust pools the accounts for the purposes of investment and management of the funds.

d) The sole lifetime beneficiaries of each trust account are the individual for whom the trust is established and the Department.

e) If the trust is funded with an annuity or other periodic payments, the Department or the pooled trust shall be named as remainder beneficiary.

f) The trust account shall be established by the disabled individual, parent, grandparent, legal guardian, or the court.

g) The only assets used to fund each trust account are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zeblev . (This provision is applicable to pooled trusts established from July 1, 1994 to December 31, 2000.)

h) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the individual's trust account and approval of the joinder agreement.

i) Following the disabled individual's death or termination of the trust account, whichever occurs sooner, to the extent that the remaining funds in the trust account are not retained by the pooled trust, the Department shall receive any amount remaining in the individual's trust account up to the total amount of Medical Assistance paid on behalf of the individual.

j) The pooled trust account shall not be considered as a countable resource in determining Medical Assistance eligibility.

k) Distributions from the trust account may be made only to or for the benefit of the individual. Cash distributions to the individual from the trust shall be considered as income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

l) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward resource eligibility.

ii) If an institutionalized individual for whom a pooled trust is established is 65 years of age or older, the transfer of assets into the pooled trust creates a rebuttable resumption that the assets were transferred without fair consideration and shall be analyzed in accordance with the rules on transfers without fair consideration in this volume. This regulation is effective for transfers to pooled trusts after January 1, 2001.

iii) When the individual beneficiary of an income, disability or pooled trust dies or the trust is terminated, the trustee shall promptly notify the eligibility site and the Department. To the extent required by these rules the trustee shall promptly forward the remainder of the trust property to the Department, up to the amount of Medical Assistance paid on behalf of the individual beneficiary.

d. Third Party Trusts

i) Third party trusts are trusts which are established with assets which are contributed by individuals other than the applicant or the applicant's spouse for the benefit of an applicant or client

ii) The terms of the trust will determine whether the trust fund is countable as a resource or income for Medical Assistance eligibility.

iii) Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource. If distributions are made for income or resources, such distributions are countable as such for eligibility.

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

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

vi) If the trustee may exercise discretion in distributing income or resources, the income or resources are not countable in determining eligibility. If distributions are made for income or resources, such distributions are countable as such for eligibility.

e. Federally Approved Trusts

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

ii) If the eligibility site has a copy of a federally approved trust, the eligibility site must send a copy to the Department.

7. Submission of Trust Documents and Records

a. The trustee of a trust which was established by or which benefits a Medical Assistance Applicant or client shall submit trust documents and records to the eligibility site and to the Department.

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

c. The eligibility site shall submit any trust which is submitted with an application or at redetermination to The Department. The eligibility site shall determine Medical Assistance eligibility based on the determination of The Department as to the effect of the trust on eligibility.

8.100.7.F. Transfers of Assets Without Fair Consideration

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

   a. “Assets” include all income and resources of the individual and such individual's spouse, including any interest in income or a resource as well as all income or resources which the individual or such individual's spouse is entitled to but does not receive because of action by any of the following:

      i) The individual or such individual's spouse,

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

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

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

   c. “Fair consideration” is the amount the individual receives in exchange for the asset that is transferred, which is equal to or greater than the value of the transferred asset.

   d. “Look-back period” means the number of months prior to the month of application for long-term care services that the Department will consider for transfer of assets.

   e. “Penalty period” means a period of time for which an applicant or client will not be eligible to receive long-term care services.

   f. “Uncompensated value” shall mean the fair market value of an asset at the time of the transfer minus the value of compensation the individual receives in exchange for the asset.

   g. “Valuable consideration” shall mean what an individual receives in exchange for his or her right or interest in an asset which has a tangible and/or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset.

2. General Provisions

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

   a. For transfers made before February 8, 2006, the look-back period is 36 months prior to the date of application. For transfers made on or after February 8, 2006, the look-back date is 60 months prior to the date of application.

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

   c. If an institutionalized individual or such individual's spouse transfers assets without fair consideration on or after the look-back period, the transfer shall be evaluated as follows:

i) The fair market value of the transferred asset, less the actual amount received, if any, shall be divided by the average of the regions, defined at 8.100.7.E, monthly private pay cost for Long-Term Care institution care in the state of Colorado at the time of application.

ii) The resulting number is the number of months that the individual shall be ineligible for Medical Assistance. For transfers made before February 8, 2006, the period of ineligibility shall begin with the first day of the month following the month in which the transfer occurred. For transfers made on or after February 8, 2006, the period of ineligibility shall begin on the later of the following dates:

a) The first day of the month following the month in which the transfer occurred or is discovered. For transfers discovered after the date the transfer occurred, the date of transfer shall be the discovery date.

Or;

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

And;

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

d. The period of ineligibility shall also include partial months, which shall be calculated by multiplying 30 days by the decimal fractional share of the partial month. The result is the number of days of ineligibility. For transfers occurring on or after April 1, 2006, the result shall be rounded up to the nearest whole number.

e. There is no maximum period of ineligibility.

f. For transfers prior to February 8, 2006, the total amount of all of the transfers are added together and the period of ineligibility begins the first day of the month following the month in which the resources are transferred.

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

ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.

g. For transfers on or after February 8, 2006, the total amounts of all of the transfers are added together and the penalty period is assessed as outlined in section 8.100.7.F.2.c-dabove.

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

ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior

penalty period, the new penalty period begins the first day after the prior penalty period expires.

h. The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and basic Medical Assistance services, but shall not be eligible for Medical Assistance for Long-Term Care institution services, Home and Community Based Services or the Program of All Inclusive Care for the Elderly due to the transfer without fair consideration.

i. If a transfer without fair consideration is made during a period of eligibility, a period of ineligibility shall be assessed in the same manner as stated above.

j. Actions that prevent income or resources from being received, or reduce an individual's ownership, right or interest in an asset such that the individual does not receive valuable consideration as set forth on the following list, which is not exclusive, shall create a rebuttable presumption that the transfer was without fair consideration:

i) Waiving pension income.

ii) Waiving a right to receive an inheritance.

iii) Preventing access to assets to which an individual is entitled by diverting them to a trust or similar device. This is not applicable to valid income trusts, disability trusts and pooled trusts for individuals under the age of 65 years.

iv) Failure of a surviving spouse to elect a share of a spouse's estate or failure to open an estate within 6 months after a spouse's death.

v) Failure to obtain a family allowance or exempt property allowance from an estate of a deceased spouse or parent. Such allowances are presumed to be available 3 months after death.

vi) Not accepting or accessing a personal injury settlement.

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

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

ix) Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony, if the benefit outweighs the cost.

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

xi) Purchasing a single-premium life insurance policy, endowment policy or similar instrument within the look-back period, which has no cash value, and for which the individual receives no valuable consideration shall be considered an uncompensated transfer. The total amount of the purchase price shall be considered a transfer without fair consideration.

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

1. Promissory notes established before April 1, 2006:

a. The fair market value of promissory notes is a countable resource and must be evaluated in accordance with the regulations on consideration of resources in this volume.

b. Promissory notes with one or more of the following provisions, indicating they have little or no market value, shall create a rebuttable presumption of a transfer without fair consideration:

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

ii) A term for repayment longer than the life expectancy of the holder of the note, as determined by the tables at 8.100.7.J.for annuities purchased on or after February 8, 2006.

iii) Low payments.

iv) Cancellation at the death of the note holder.

c. Promissory notes which have been appraised by a note broker as having little or no value shall create a rebuttable presumption of a transfer without fair consideration.

2. Promissory notes established on or after April 1, 2006 but before March 1, 2007

a. Subject to the look-back date described in section 8.100.7.F.2.b for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.n. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c.

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

a. Subject to the look-back date described in section 8.100.7.F.2.b, for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.o. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c..

4. Personal care services

a. Effective for agreements that were signed and notarized prior to March 1, 2007, family members who provide assistance or services are presumed to do so for love and affection, and compensation for past assistance or services shall create a rebuttable presumption of a transfer without fair consideration unless the compensation is in accordance with the following:

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

ii) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement.

iii) The agreement must be dated and the signature must be notarized; and

iv) Compensation for services rendered must be comparable to what is received in the open market.

b. Effective for agreements that are signed and notarized on or after March 1, 2007, compensation under personal service agreements will be deemed to be a transfer without fair consideration unless the following requirements are met:

i) A written agreement was executed prior to the delivery of services; and

a) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement; and

b) The legally authorized representative, agent, guardian, conservator, or other representative of the applicant's estate may not be a beneficiary of a care agreement; and

c) The agreement specifies the type, frequency and time to be spent providing the services agreed to in exchange for the payment or transferred item; and

d) The agreement provides for payment of services on a regular basis, no less frequently than monthly, while the services are being provided; and

ii) Compensation for services rendered must be comparable to what is received in the open market. The burden is on the applicant to prove that the compensation is reasonable and comparable; and

iii) A record or log is provided which details the actual services rendered. The services cannot be services that duplicate services that another party is being paid to provide or which another party is responsible to provide.

c. Payment for services, which were rendered previously and for which no compensation was made, shall be considered as a transfer without fair consideration.

d. Assets transferred in exchange for a contract for personal services for future assistance after the date of application are considered available resources.

e. A care agreement must be entered into, signed, and notarized prior to providing any services for which a beneficiary will be compensated.

5. Transfers of real property into joint tenancy without fair consideration

a. If real property is transferred into joint tenancy with right of survivorship with one or more joint tenants, the amount transferred depends on the number of joint tenants to whom the property is transferred. The following are examples:

i) If the transfer is to one joint tenant, the amount transferred is equal to one-half of the value of the property at the time of the transfer.

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

iii) If the transfer is to three joint tenants, the amount transferred is equal to three-fourths of the value of the property at the time of the transfer.

b. If the transfer is completed with two deeds or transactions, the first of which transfers a fractional share of the property into tenancy in common, and the second into joint tenancy, the amount transferred shall be determined in the same manner as set forth above.

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

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

i) The spouse of such individual;

ii) A child of such individual who is either

1) Under the age of 21 years, or

2) Is blind or totally and permanently disabled as determined by the Social Security Administration.

iii) A brother or sister

1) Who has an equity interest in the home and

2) Who was residing in such individual's home for at least one year immediately before the date that the individual becomes institutionalized.

iv) A son or a daughter of such individual

1) Who was residing in the home for a period of at least two years immediately before the date the individual becomes institutionalized and

2) Who provided care to such individual by objective evidence, that permitted such individual to reside at home rather than in an institution.

3) Documentation shall be submitted proving that the son or daughter's sole residence was the home of the parent. The parent's attending physician(s) or professional health provider(s) during the past two years must substantiate in writing that the care was provided, and that the care prevented the parent from requiring placement in a Long-Term Care institution.

b. The assets were transferred:

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

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

iii) To a trust which is established solely for benefit of the individual's child who is determined to be blind or totally disabled by the Social Security Administration or to that child directly for the sole benefit of the child.

iv) To a trust established solely for the benefit of an individual under 65 years of age who is determined to be blind or totally disabled by the Social Security Administration.

c. Definition of the term “for the sole benefit of,” as used in the preceding exceptions to the transfer penalty rules:

i). A transfer or a trust is considered to be for the sole benefit of the spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

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

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

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

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

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

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

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

7. There is a rebuttable presumption the transfer without fair consideration was made for purposes of Medical Assistance eligibility or avoiding the medical assistance estate recovery program.

a. The presumption that an asset was transferred to establish or maintain Medicaid eligibility or to avoid the medical assistance estate recovery program is rebutted only if the individual or individual’s spouse demonstrates by providing convincing evidence that the asset was transferred exclusively for some other purpose and the reason for the transfer did not include Medical Assistance eligibility or avoidance of medical assistance estate recovery..

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

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

i) In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer total an amount insufficient to meet all living expenses and medical expenses reasonably expected to be incurred by the individual or the individual's spouse in the sixty (60) months following the transfer. Medical expenses include the cost of Long-Term Care unless the future necessity of such care could have been absolutely precluded because of the particular circumstances.

ii) In any case where:

1) the transfer was made on behalf of the individual or the individual's spouse;

2) the transfer was made by:

a) the individual or individual’s spouse

b) a guardian,

c) a conservator, or

d) agent under a power of attorney; and

3) the transfer was made to:

a) anyone related to the individual or individual’s spouse by birth, adoption or marriage, other than between the individual and the individual’s spouse; or to

b) anyone related to the guardian, conservator, or agent under a power of attorney by birth, adoption or marriage.

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

i) That at the time of the transfer the individual could not have anticipated needing long term Medical Assistance due to the existence of other circumstances which would have precluded the need.

ii) Other assets were available at the time of the transfer to meet current and future needs of the individual, including the cost of Long-Term Care institution or other institutionalized care for a period of sixty (60) months.

iii) The specific purpose for which the assets were transferred and the reason the transfer was necessary and the reason there was no alternative but to transfer the assets without fair consideration.

8. Apportionment of penalty period between spouses

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

b. If one spouse dies or is no longer institutionalized, any months remaining in the period of ineligibility shall be assigned to the spouse who remains institutionalized.

9. If the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of a trust, the trust document shall be submitted to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on Medical Assistance eligibility.

10. Notice

a. The Colorado Department of Health Care Policy and Financing is an interested person according to 15-14-406, C.R.S. or a successor statute.

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

11. Undue Hardship

a. The period of ineligibility resulting from the imposition of the transfer or the trust provisions may be waived if denial of eligibility would create an undue hardship for an individual who is otherwise eligible. Undue hardship can be established if application of the transfer penalty would:

i) deprive the individual of medical care such that the individual’s health or life would be endangered; or

ii) deprive the individual of food, clothing, shelter or other necessities of life.

b. Undue hardship shall not exist when the application of the trust or transfer rules merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

c. Notice of an undue hardship exception shall be given to the applicant or client. The Eligibility Site shall make a determination on the request within 15 working days from when the request is received. The Eligibility Site shall issue a notice of action on the determination of hardship. An adverse determination may be appealed in accordance with the appeal process as described at Section 8.057 of this volume.

d. The facility in which an institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual with the individual's or his or her personal representative's consent. Where the individual is unable to give consent and where the personal representative of the individual has a conflict of interest concerning the particular circumstance giving rise to the period of ineligibility, the facility may request an undue hardship on behalf of the individual. An example of such a conflict of interest would be a situation where the personal representative who is also an agent under a power of attorney transfers property to himself or herself. The facility shall submit the undue hardship request to the Eligibility Site and give sufficient detail of the circumstance surrounding the conflict of interest and the information required below to the Eligibility Site. These provisions are not intended to change the Department’s requirements under Section 8.057 of the Department’s regulations as to who has standing to file an appeal.

e. An individual or representative may request that the Eligibility Site waive a transfer penalty on the basis of undue hardship. The request shall be made in writing to the applicant's or client's Eligibility Site case worker. The individual making the request has the burden of proof and must provide clear and convincing evidence to substantiate the circumstances surrounding the transfer, attempts to recover the assets, and the impact of the denial of Medicaid payments for Long-Term Care services. The request and documentation shall include all of the following:

i) the reason(s) for the transfer including the individual's participation in the transfer or grant of legal authority to another that gave rise to the transfer, and the relationship between the transferor and transferee;

ii) evidence to prove that the assets have been irretrievably lost and that all reasonable attempts made to recover the asset(s), including any legal actions and the results of the attempts, including but not limited to a request for an adult protection investigation (such as in a case of financial exploitation), filing a police report, or filing a civil action have been exhausted or have been or are being pursued; and,

iii) documentation such as a notice of discharge or pending discharge from the facility and a physician's statement detailing how the inability to receive nursing facility or community based services would result in the individual's inability to obtain life-sustaining medical care or that the individual would not be able to obtain food, clothing or shelter.

f. To the extent that the transferred assets are recovered pursuant to the attempts in (e)(ii) above, the individual shall reimburse Medicaid for the funds expended as a result of an approved undue hardship request.

g. If the transferee and the transferor of the assets for which the transfer penalty is being imposed are related parties there shall be a rebuttable presumption that the transferred assets are not irretrievably lost as required under (e)(ii) above. Related parties are described in Section 8.100.7.G.7.c.ii of these regulations.

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

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

b. Convincing and objective evidence is presented proving that the resources were transferred exclusively for a purpose other than to qualify or remain eligible for Medical Assistance.

c. All of the resources transferred without fair consideration have been returned to the individual.

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

e. For assets transferred before February 8, 2006, the penalty period has expired based on the following formula: The fair market value of the transferred asset is divided by the average cost of Long Term Care institution care in the state at the time of application and the resulting number of months of ineligibility has ended prior to the date of application.

8.100.7.H. Life Estates

1. Definitions

   a. “Fair Market Value” means the amount for which a property or interest in a property could reasonably be expected to sell on the open market.

   b. “Life Estate.” A life estate conveys upon a grantee certain rights in property measured by the life of the life estate holder or of some other person. The owner of a life estate has the right to possess the property, the right to use the property, the right to obtain profits from the property, and the right to sell the life estate interest in the property. The establishment of a life estate on a property results in the creation of two interests: a life estate interest and a remainder interest.

   c. “Remainder Interest” means an interest in property created at the time a life estate is established which gives the holder of the interest the right to ownership of the property upon the death of the life estate holder. An individual holding a remainder interest is free to sell his or her interest in the property unless the sale is restricted by the terms of the instrument which established the remainder interest.

2. General Provisions

   a. Life Estates Established before July 1, 1995

      i) Transfer without fair consideration Treatment

         1) The establishment of a life estate before July 1, 1995 by an individual or individual’s spouse shall not be considered a transfer without fair consideration.

      ii) Resource Treatment

         1) A life estate owned by an individual or individual’s spouse that was established on exempt property shall be considered to be an exempt resource.

         2) A life estate owned by an individual or individual’s spouse that was established on countable property shall be considered a countable resource.

            i) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.

         3) A remainder interest held by an individual or individual’s spouse on exempt property shall be considered an exempt resource.

         4) A remainder interest held by an individual or individual’s spouse on countable property shall be considered a countable resource

            i) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.a.

   b. Life Estates Established on or after July 1, 1995

      i) Transfer without fair consideration Treatment

1) The establishment of a life estate on or after July 1, 1995 on property owned by an individual or individual's spouse shall be considered a transfer without fair consideration if the life estate was established within the look-back period described at 8.100.7.F.2.b.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be based on the value of the remainder interest, as calculated using the methodology described at 8.100.7.H.4.a.

2) The purchase of a life estate interest in a home not owned by an individual or individual's spouse on or after April 1, 2006 within the look-back period described at 8.100.7.F.2.b. shall be considered a transfer without fair consideration unless the purchaser lives in the home for a period of at least twelve (12) consecutive months after the date of the purchase.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be the entire amount used to purchase the life estate.

b) If the payment for the life estate exceeds the value of the life estate, as calculated using the methodology described at 8.100.7.H.3, then the difference between the amount paid and the value of the life estate shall be considered to be a transfer without fair consideration.

ii) Resource Treatment

1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered an exempt resource.

2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.

a) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.a.

3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.

5) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource

a) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.

3. Determining the Value of a Life Estate

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

i) Determine the fair market value of the property on which the life estate was established. The fair market value shall be obtained by using the most recent

actual value reported by the county assessor or from the most recent property assessment notice. If the actual value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Life Estate" factor in Column 1 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the life estate interest.

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

4. Determining the Value of a Remainder Interest

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

i) Determine the fair market value of the property on which the remainder interest was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the market value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Remainder" factor in Column 2 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the remainder interest.

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

5. Life Estate Table

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

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

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

8.100.7.I. Annuities

1. DEFINITIONS

a. "Annuity" means a contract between an individual and a commercial company in which the individual invests funds and in return receives installments for life or for a specified number of years.

b. "Annuitant" means an individual who is entitled to receive payments from an annuity.

c. “Annuitization Period” means the period of time during which an annuity makes payments to an annuitant.

d. “Annuitized” means an annuity that has become irrevocable and is making payments to an annuitant.

e. “Assignable” means an annuity that can have its owner and/or annuitant changed.

f. “Balloon Payment” means a lump sum equal to the initial annuity premium less any distributions paid out before the end of an annuitization period.

g. “Beneficiary” means an individual or individuals entitled to receive any remaining payments from an annuity upon the death of the annuitant.

h. “Department” means the Department of Health Care Policy and Financing, its successor(s), or its designee(s).

i. “Irrevocable” means an annuity that cannot be canceled, revoked, terminated, or surrendered under any circumstances.

j. “Non-assignable” means an annuity that cannot have its owner and/or annuitant changed under any circumstances.

k. “Owner” means the person who may exercise the rights provided in an annuity contract during the life of the annuitant. An owner can generally name himself or herself or another person as the annuitant.

l. “Revocable” means an annuity that can be canceled, revoked, terminated, or surrendered.

m. “Transaction” means:

i) The purchase of an annuity;

ii) The addition of principal to an annuity;

iii) Elective withdrawals from an annuity;

iv) Requests to change the distributions from an annuity;

v) Elections to annuitize an annuity contract; or

vi) Any other action taken by an individual that changes the course of payments made by an annuity or the treatment of income or principal of an annuity.

2. Annuities purchased on or before June 30, 1995

a. A revocable or irrevocable annuity established on or before June 30, 1995 is not a countable resource if it is annuitized and regular returns are being received by the annuitant.

i) Payments from the annuity to the individual or individual’s spouse are income in the month received.

b. A revocable or irrevocable annuity established on or before June 30, 1995 is a countable resource if it has not been annuitized.

3. Annuities Established on or after July 1, 1995 but before February 8, 2006

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

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

ii) The annuity is annuitized for the individual or individual's spouse;

iii) The annuity is purchased on the life of the individual or individual's spouse; and

iv) The annuity provides payments for a period not exceeding the annuitant's projected life expectancy based on life expectancy tables described at 8.100.7.J.

b. To determine if a transfer without fair consideration has occurred in the purchase of an annuity, the Eligibility Site shall:

i) Determine the date on which the annuity was purchased;

ii) Determine the amount of money used to purchase the annuity and the length of the annuitization period;

iii) Determine the age of the annuitant at the time the annuity was purchased; and

iv) Determine the life expectancy of the annuitant at the time the annuity was purchased using the appropriate life expectancy table described at 8.100.7.J.

1) If the length of the annuitization period exceeds the annuitant's life expectancy, then a transfer without fair consideration exists for the portion of the annuitization period that exceeds the annuitant's life expectancy.

2) If the total value of the annuity's payments during the annuitization period is less than the original purchase price of the annuity, then the difference shall be considered to be a transfer without fair consideration.

3) If the total value of the annuity's payments during the annuitization period is equal to or greater than the original purchase price of the annuity, then the purchase of the annuity shall not be considered to be a transfer without fair consideration. However, any payments made by the annuity shall be considered to be countable income in the month received.

4) If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period. However, any payments made by the annuity shall be considered to be countable income in the month received.

4. Annuities Established on or after April 1, 1998 but before February 8, 2006

a. The Eligibility Site shall determine the Minimum Monthly Maintenance Needs Allowance (MMMNA) of the community spouse, if applicable.

i) If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, then the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered to be a transfer without fair consideration in determining the institutionalized spouse's eligibility. This applies only to the extent that the transferred amount causes the Community Spouse Resource Allowance to exceed the maximum.

b. The Eligibility Site shall determine if the Individual is receiving substantially equal installments from the annuity for the annuitization period of the annuity.

i) If the annuity is not paid in substantially equal installments, then the original purchase price of the annuity shall be considered to be a transfer without fair consideration.

c. If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period.

i) Any payments made by the annuity shall be considered to be countable income in the month received.

5. Annuities Purchased on or after February 8, 2006

a. As a condition of Medicaid eligibility, at the time of application or redetermination, an applicant or his or her spouse for Medicaid Long-Term Care services shall disclose any interest that the Medicaid applicant or his or her spouse has in an annuity.

i) A complete copy of the annuity contract, including the most recent beneficiary designation, shall be provided to the eligibility site.

b. By providing Medicaid Long-Term Care services, the Department shall be a remainder beneficiary of any annuity in which an individual or individual's spouse has an interest. The purchase of the annuity shall not be considered to be a transfer without fair consideration if:

i) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or

ii) The Department is named as the remainder beneficiary in the next position after the community spouse or minor or disabled child.

iii) This provision shall not apply to annuities that are revocable and/or assignable.

c. The Eligibility Site shall notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity for medical assistance provided to the institutionalized individual. This notice shall include a statement requiring the issuer to notify the Eligibility Site of any changes in the amount of income or principal that is being withdrawn from the annuity or any other transactions, as defined at 8.100.7.I.1., regardless of when the annuity was purchased.

d. If the Department is not named on the annuity as a remainder beneficiary, then the value of funds used to purchase the annuity shall be deemed a transfer without fair

consideration and shall be subject to the penalty period provisions described at 8.100.7.F.

i) This provision shall not apply to annuities that are revocable and/or assignable.

e. Revocable Annuities

i) A revocable annuity is a countable resource. The value of the annuity is the total value of the annuity principal plus any accumulated interest.

a) If the annuity includes a surrender charge or other financial penalty (other than tax withholding or a tax penalty) for withdrawing funds from the annuity, then the value of the annuity is the net amount the individual would receive upon full surrender of the annuity.

ii) Payments from a revocable annuity are not countable as income.

f. Irrevocable Assignable Annuities

i) An irrevocable assignable annuity is a countable resource. The value of the annuity is presumed to be the total value of the annuity principal plus any accumulated interest.

a) An individual or individual's spouse can rebut the presumption by providing documented offers from at least three companies who are active in the market for buying and selling annuities an annuity income streams. The value of the annuity shall then be the highest of the offers.

b) Any payments from an irrevocable assignable annuity that is considered to be a countable resource are not considered to be countable income.

ii) An individual or individual's spouse can rebut the presumption that an irrevocable assignable annuity is not a countable resource by providing documented offers from at least three companies who are active in the market for buying and selling annuities and annuity income streams stating their unwillingness or inability to purchase the annuity or annuity income stream.

a) Any payments from an irrevocable assignable annuity that is not considered to be a countable resource are considered to be countable income in the month received.

g. Irrevocable Non-Assignable Annuities

i) An irrevocable non-assignable annuity is not considered to be a countable resource.

ii) Payments from an irrevocable non-assignable annuity are considered countable income in the month received.

iii) An irrevocable non-assignable annuity purchased by or for the benefit of a community spouse shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

iv) An irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

v) In addition to the requirements listed at 8.100.7.I.5.g.iv) for naming the Department as remainder beneficiary, an irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if the annuity meets any one of the following conditions:

1) The annuity is considered either:

a) An Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or

b) A deemed Individual Retirement Account under a qualified employer plan described in Section 408(q) of the Internal Revenue Code of 1986; or

2) The annuity is purchased with proceeds from one of the following:

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

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

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

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

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

3) The annuity meets all of the following requirements:

a) The annuity is irrevocable and non-assignable; and

b) The annuity is actuarially sound based on the life expectancy tables described at 8.100.7.J.; and

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

vi) If an irrevocable non-assignable annuity is considered to be a transfer without fair consideration, then, for the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount of funds used to purchase the annuity.

h. Annuity Transactions

i) If an Individual or individual's spouse undertakes any transaction, as defined at 8.100.7.I.1. which has the effect of changing the course of payments to be made by an annuity or the treatment of income or principal of the annuity, such a transaction shall be deemed to be a transfer without fair consideration, regardless of when the annuity was originally purchased. For the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount used to purchase the annuity.

a) Routine changes such as a notification of an address change or death or divorce of a remainder beneficiary are excluded from treatment as a transfer without fair consideration.

b) Changes which occur based on the terms of the annuity which existed before February 8, 2006 and which do not require a decision, election, or action to take effect are excluded from treatment as a transfer without fair consideration.

c) Changes which are beyond the control of the individual, such as a change in law, a change in the policies of the annuity issuer, or a change in terms based on other factors, such as the annuity issuer's financial condition, are excluded from treatment as a transfer without fair consideration.

8.100.7.J. Life Expectancy Tables

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

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

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

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

1. The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community. Being a community spouse does not prohibit Medicaid eligibility if all criteria are met. The community spouse resource allowance does not supersede the Medicaid eligibility criteria.

2. For purposes of spousal protection, an institutionalized spouse is an individual who:

    a. Begins a stay in a medical institution or nursing facility on or after September 30, 1989, or

    b. Is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or

    c. Receives Home and Community Based Services on or after July 1, 1999; and

    d. Is married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraphs 8.100.7.K.2.a thru c for at least 30 consecutive days.

3. A community spouse is defined as the spouse of an institutionalized spouse.

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

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

8.100.7.M. Calculation of the Community Spouse Resource Allowance

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

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

    a. The total resources of the couple but no more than the current maximum allowance which, changes each year beginning January 1st.; or

    b. The increased CSRA calculated pursuant to section 8.100.7.S; or

c. The amount a court has ordered the institutionalized spouse to transfer to the community spouse for monthly support of the community spouse or a dependent family member.

2. The resources allotted to the community spouse as the CSRA shall be transferred into the name of the community spouse and shall not be considered available to the institutionalized spouse. After the transfer of the CSRA to the community spouse, the income from these resources shall be attributed to the community spouse.

3. The transfer of the CSRA shall be completed as soon as possible, but no later than the next redetermination when the community spouse becomes institutionalizes; whichever is earlier. If the transfer is not completed within this time period, the resources shall be attributed to the institutionalized spouse and shall affect his/her Medical Assistance eligibility. Verification of the transfer of assets to the community spouse shall be provided to the eligibility site.

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

4. If the community spouse is in control of resources attributed to the institutionalized spouse, but fails to make such resources available for his/her cost of care, this fact shall not make the institutionalized spouse ineligible for Medical Assistance, where:

   a. The institutionalized spouse has assigned The Department any rights to support from the community spouse; or

   b. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but The Department has the right to bring a support proceeding against the community spouse without such assignment; or

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

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

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

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

1. The institutionalized spouse is resource eligible for Medical Assistance when the total resources owned by the couple are at or below the amount of the Community Spouse Resource Allowance plus the Medical Assistance resource allowance for an individual of $2,000.

2. The eligibility site shall determine whether the institutionalized spouse is income eligible for Medical Assistance. The institutionalized spouse shall be income eligible if his/her gross income is at or below the Medical Assistance income limit for recipients of long-term care. If an income trust is used the trust must be established before the MIA is calculated.

8.100.7.P. Attribution of Income

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

1. If payment of income from resources is made solely in the name of either the institutionalized spouse or the community spouse, the income shall be considered available only to the named spouse.

2. If payment of income from resources is made in the names of both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each spouse.

3. If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.

4. The above regulations of attribution of income are superseded if the institutionalized spouse can establish by a preponderance of the evidence that the ownership interests in the income are other than that provided in the regulations.

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

1. The community spouse's total minimum monthly needs shall be determined as follows:

    a. The current minimum monthly maintenance needs allowance (MMMNA), which is equal to 150% of the federal poverty level for a family of two and is adjusted in July of each year;

    b. An excess shelter allowance, in cases where the community spouse's expenses for shelter exceed 30% of the MMMNA. The excess shelter allowance is computed by adding (a) and (b) together:

        i) The community spouse's expenses for rent or mortgage payment including principal and interest, taxes and insurance, and, in the case of a condominium or cooperative, any required maintenance fee, for the community spouse's principal residence; and

        ii) The larger of the following amounts: the standard utility allowance used by Colorado under U.S.C. 2014(e) of Title 7; or the community spouse's actual, verified, utility expenses. A utility allowance shall not be allowed if the utility expenses are included in the rent or maintenance charge, which is paid by the community spouse.

        iii) The excess shelter allowance is the amount, if any, that exceeds 30% of the MMMNA.

2. An additional amount may be approved for the following expenses:

    a. Medical expenses of the community spouse or dependent family member for necessary medical or remedial care. Each medical or remedial care expense claimed for deduction must be documented in a manner that describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider. An expense may be deducted only if it is:

        i) Provided by a medical practitioner licensed to furnish the care;

ii) Not subject to payment by any third party, including Medical Assistance and Medicare;

b. The cost of Medicare, Long Term Care insurance, and health insurance premiums. A health insurance premium may be allowed in the month the premium is paid or may be prorated and allowed for the months the premium covers. This allowance does not include payments made for coverage which is:

i) Limited to disability or income protection coverage;

ii) Automobile medical payment coverage;

iii) Supplemental to liability insurance;

iv) Designed solely to provide payments on a per diem basis, daily indemnity or non-expense-incurred basis; or

v) Credit life and/or accident and health insurance.

3. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

4. The total that results from adding the current MMMNA and the excess shelter allowance shall not exceed the current maximum MMMNA which is $2,175.00 for the year 2001 and is adjusted by the Health Care Financing Administration in January of each year.

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

1. The Monthly Income Allowance (MIA) is the amount of money necessary to raise the community spouse's income to the level of his/her monthly needs, and shall be obtained from the monthly income of the institutionalized spouse. For individuals who become institutionalized on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse must be considered to have been made available to the community spouse before an MIA is allocated to the community spouse.

2. The MIA shall be the amount by which the community spouse's minimum monthly needs, which is the MMMNA, exceed his/her income from sources other than the institutionalized spouse. The community spouse’s income shall be calculated by using the gross income less mandatory deduct ions for FICA and Medicare tax.

3. If a court has entered an order against the institutionalized spouse for monthly support of the community spouse, the MIA shall not be less than the monthly amount ordered by the court.

4. The eligibility site shall make adjustments to the MMMNA and/or the MIA on a monthly basis for any continuing change in circumstances that exceeds $50 a month. Continuing changes of less than $50 in a month, and any infrequent or irregular changes, shall be considered at redetermination.

8.100.7.S. Increasing the Community Spouse Resource Allowance

1. The CSRA shall be increased above the maximum amount if additional resources are needed to raise the community spouse's monthly income to the level of the Minimum Monthly Maintenance Needs Allowance (MMMNA). In making this determination the items listed below are calculated in the following order:

    a. The community spouse's MMMNA;

    b. The community spouse's own income; and

    c. The Monthly Income Allowance (MIA) contribution that the community spouse is eligible to receive from the institutionalized spouse.

    d. If the community spouse's own income, and the Monthly Income Allowance contribution from the institutionalized spouse's income is less than the Minimum Monthly Maintenance Needs Allowance, additional available resources shall be shifted to the community spouse to bring his/her income up to the level of the MMMNA. The additional resources necessary to raise the community spouse's monthly income to the level of the MMMNA shall be based upon the cost of a single-premium lifetime annuity with monthly payments equal to the difference between the MMMNA and the community spouse's income. The following steps shall be followed to determine the amount of resources to be shifted:

        i) The applicant shall obtain three estimates of the cost of an annuity that would generate enough income to make up the difference between the MMMNA and the combined community spouse's income as described above.

        ii) The amount of the lowest estimate shall be used as the amount of resources to increase the CSRA.

        iii) The applicant shall not be required to purchase the annuity in order to have the CSRA increased.

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

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

1. During each month after the institutionalized spouse becomes Medical Assistance eligible, deductions shall be made from the institutionalized spouse's monthly income in the following order.

    a. A personal needs allowance or the client maintenance allowance as allowed by program eligibility.

    b. A Monthly Income Allowance (MIA) for the community spouse, but only to the extent that income of the institutionalized spouse is actually made available to, or for the benefit of, the community spouse;

    c. A family allowance for each dependent family member who lives with the community spouse.

        i) The allowance for each dependent family member shall be equal to one third of the amount of the MMMNA and shall be reduced by the monthly income of that family member.

ii) Family member means dependent children (minor or adult), dependent parents or dependent siblings of either spouse that are residing with the community spouse and can be claimed by either the institutionalized or community spouse as a dependent for federal income tax purposes.

d. Allowable deductions identified in section 8.100.7.V.

e. If the institutionalized spouse fails to make his/her income available to the community spouse or eligible dependent family members in accordance with these regulations, that income shall be applied to the cost of care for the institutionalized spouse.

f. No other deductions shall be allowed.

8.100.7.U. Right to Appeal

1. Both spouses shall be informed of the following:

   a. The amount and method by which the eligibility site calculated the community spouse resource allowance (CSRA), community spouse monthly income allowance (MIA), and any family allowance;

   b. The spouses' right to a fair hearing concerning these calculations;

   c. The eligibility site conclusions with respect to the spouses' ownership and availability of income and resources, and the spouses' right to a fair hearing concerning these conclusions.

2. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

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

8.100.7.V. Long-Term Care Institution Recipient Income

1. Determination of Income and Communication between the Long-Term Care institution and the Eligibility Site Using the AP-5615 Form for Patient Payment

   a. Sections I, II and IV of the AP-5615 form are to be completed by the Long-Term Care institution for all admissions, readmissions, transfers to and from another payer source, including private pay and Medicare, discharges, deaths, changes in income and/or patient payment, medical leaves of absence and non-medical/programmatic leave in excess of 42 days combined per calendar year.

   b. The initial determination of resident income for patient payment shall be made by the Eligibility Site. The Eligibility Site shall notify the Long-Term Care institution of current resident income.

   c. On receipt of AP-5615 form, the Eligibility Site will, within five working days:

      i) For an admission, a readmission or a transfer from/to private pay, Medicare, or another payer source:

1) Verify and correct, if necessary, data entered by the Long-Term Care institution.

2) List and/or verify the resident's monthly income adjustments and/or Long-Term Care Insurance benefit payments; and compute patient payment. Provide the completed AP-5615 to the Long-Term Care institution.

3) Correct the automated system to indicate the Long-Term Care institution name and provider number and to reflect the current distribution of income. Submit the AP-5615 form to the Department.

d. For change in patient payment with respect to changes in resident income:

i) Verify changes in resident income, and correct if necessary. All such corrections must be initialed,

ii) Compute patient payment and provide the completed AP-5615 to the Long-Term Care institution.

e. For change in patient payment with respect to the post-eligibility treatment of income, the Eligibility Site shall:

i) Review the AP-5615 form for Medicare part B premium deduction allowances for the first two months of admission.

ii) If client is already on the Medicare Buy-In program for Medicare part B, do not adjust patient payment on AP-5615 form for the Medicare premium deduction. If client is not on the Buy-In program, adjust AP-5615 form for the Medicare premium deduction for the first two months of Long-Term Care institution eligibility.

iii) If the client has a Medicare D premium, the Eligibility Site shall use the amount as an income adjustment/deduction in the patient payment calculation and complete the AP-5615 form.

f. For resident leave of absence:

i) Non-Medical/Programmatic Leave. When combined non-medical/programmatic days in excess of 42 days are reported, verify adherence to the restrictions and conditions of section 8.482.44.

ii) Medical Leave/Hospitalization. Verify that the patient payment is apportioned correctly between the nursing facility and the hospital so that no Medicaid payment is requested for the period. See also section 8.482.43.

iii) The nursing facility may wait until the end of the month to complete the AP-5615 form for an ongoing hospitalization.

g. For change in payer status:

i) If Medicare or insurance is a primary payer during the month, verify the nursing facility’s calculation of the patient payment.

ii) Complete and provide the AP-5615 to the nursing facility.

h. For discharge or death of resident:

i) Verify the date of death or discharge, and verify the correct patient payment including the resident's monthly income for the discharged month, and the amount calculated by per diem. All corrections must be initialed.

ii) Note if the resident entered another Long-Term Care institution and, if so, enter the name of the new Long-Term Care institution in the system.

iii) In the event the resident may return to the same facility, the AP-5615 form may be completed at the end of the month for discharges due to hospitalization.

i. For discontinuation of Long-Term Care eligibility:

i) Initiate and send an AP-5615 form to the Long-Term Care institution within 5 working days of the date of determination that the client’s eligibility will be discontinued. Indicate the date the discontinuation will be effective.

j. Failure to provide a correct and timely AP-5615 to the Long-Term Care institution may result in the refusal of the Department to reimburse such Long-Term Care institution care. The AP-5615 form is required in order for a Prior Authorization Request (PAR) to be issued for Long-Term Care institution claim reimbursement.

k. General Instructions:

i) The AP-5615 form must be verified and a signed AP-5615 form returned to the Long-Term Care institution.

ii) The AP-5615 form must be signed and dated by the director of the Eligibility Site or by his/her designee.

iii) AP-5615 forms may be initiated by either the Long-Term Care institution or Eligibility Site. If the Eligibility Site is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the Long-Term Care institution, the Eligibility Site may initiate the revision to the AP-5615 form. In such case, one copy of the AP-5615 form showing the changes will be sent to the Long-Term Care institution.

l. The Department may deduct excess payments from the Eligibility Site administrative reimbursement as stated in the Colorado Department of Human Services Finance Staff Manual, Volume 5 if the Eligibility Site fails to:

i) Perform the duties as detailed in this section; or

ii) Adhere to the limitations on a reduced patient payment; as detailed in section 8.100.7.V.4; or

iii) Notify the Long-Term Care institution within 5 working days of any changes in resident income, provided the Long-Term Care institution is not authorized to receive the resident's income; and excessive Medicaid funds are paid to the Long-Term Care institution as a result of this negligence.

2. Collection of Patient Payment

a. It shall be the responsibility of the Long-Term Care institution to collect from the client, or from the client's family, conservator or administrator, the patient payment, which is to be applied to the cost of client care. The Department is not responsible for any deficiency in patient payment accounts, due to failure of the Long-Term Care institution to collect such income.

b. If, however, the Long-Term Care institution is unable to collect such funds, through refusal of the resident or the resident's family, conservator, administrator or responsible party to release such income, the Long-Term Care institution shall immediately notify the Eligibility Site.

c. When notified by the Long-Term Care institution of the refusal of the client or the client's family, conservator administrator or responsible party to pay the patient payment due, the Eligibility Site shall immediately contact the refusing party. If, after such contact, the party still refuses to release such income, the action shall be deemed a failure to cooperate, and the Eligibility Site shall proceed to discontinue Medicaid benefits for the resident.

3. Calculation of Patient Payment

a. Specific instructions for computing the patient payment amount are contained in this volume under The “Status of Long-Term Care institution Care” Form, AP-5615

b. Once an applicant for Nursing Facility Medical Assistance has been determined eligible for Medical Assistance, the Eligibility Site shall determine the patient payment due to the Nursing Facility which is to be applied to the Medicaid reimbursement for the cost of care. That patient payment is calculated by:

i) Determining all applicable income of the recipient

ii) Deducting all applicable allowable monthly income adjustments, which include:

1) Personal Needs Allowance

2) If applicable, Monthly Income Allowance for the community spouse.

3) If applicable, Family Dependent Allowance

4) If applicable, Home Maintenance Allowance

5) If applicable, Trustee/Maintenance Fees: actual fees, with a maximum of $20 per month

6) If applicable, Mandatory Income Tax Withheld

7) Mandatory garnishments repaying Federal assistance overpayment

8) Medical or remedial care expenses that are not subject to payment by a third party:

a) Medicare Part B Premium expenses, if applicable, are deductible only for the first and second month in the Nursing Facility.

b) Medicare Part D Premium expenses, if applicable, are ongoing deductions.

c) Other medical and remedial expenses covered under the Nursing Facility PETI (NF PETI) program are not deductible. NF PETI-approved expenses are allowed only for residents with a patient payment, but do not change the patient payment amount. For NF PETI, see the Section 8.482.33 in this volume “Post Eligibility Treatment of Income”.

c. Long-Term Care Insurance

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

i) If Long-Term Care insurance is received for the month, and:

1) If, after all deductions, the client has income available for a patient payment, add this to the amount of the Long-Term Care insurance to determine the total patient payment.

a) If the total amount is greater that the allowable cost of care, the Long-Term Care insurance is applied before the client’s income, or;

b If after all deductions, the client does not have income available for the patient payment, only the Long-Term Care insurance payment is used.

d. Personal Needs Allowances

i) Non-Veteran related personal needs allowance

1) Prior to January 1, 2015 the personal needs allowance base amount is $50 per month.

2) Effective January 1, 2015 the personal needs allowance base amount is $75 per month and will be adjusted annually at the same rate as the statewide average of the nursing facility per diem rate net of patient payment pursuant to C.R.S. § 25.5-6-202(9)(b)(I). Each yearly adjustment will set a new base amount.

a) The first annual rate adjustment to the new $75 base amount will occur on January 1, 2015.

ii) Veterans-related personal needs allowance

Effective 07/01/91, the personal needs allowance shall be $90 per month for a veteran in a Long-Term Care institution who has no spouse or dependent child and who receives a non-service connected disability pension from the U.S. Veterans Administration. The personal needs allowance shall also be $90 per month for the widow(er) of a veteran with no dependent children.

1) Public Law requires that a veteran, without a spouse or dependent child, who enters a Long-Term Care institution have their veteran's pension reduced to $90 which is to be reserved for their personal needs. This reduction in pension is not applicable to veteran's who reside in a State Veteran's Nursing facility. If a veteran, who does not reside in a State Veteran's Nursing facility, receives a pension reduction of $90 he/she is allowed to apply this $90 to his/her personal needs allowance. It is not considered income toward the patient payment. The same regulation applies to a widow of a veteran without any dependent children.

2) To verify if those veterans residing in State Veteran's Nursing facilities are receiving a non-service connected pension you may request their award letter from the Department of Veterans Affairs or call the Department of Veterans Affairs and verify through contact. If they are receiving any amount in a non-service connected pension they are entitled to a $90 personal needs allowance so long as they do not have a spouse or dependent child. The same regulation applies to a widow of a veteran without any dependent children.

iii) For aged, disabled, or blind Long-Term Care institution recipients engaged in income-producing activities, an additional amount of $65 per month plus one-half of the remaining gross income may be retained by the individual.

iv) Effective September 15, 1994, aged, disabled, or blind Long-Term Care institution residents, HCBS or PACE recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included as a deduction from the patient payment. The patient payment deduction must be for a specific accounting period when the taxes are owed and expected to be withheld from income or paid by the individual in the accounting period. The Eligibility Site must verify that the taxes were withheld. If the taxes are not paid, the Eligibility Site must establish a recovery. The deduction is also applicable for any Federal pensions with mandated tax withholdings from unearned income despite the individual earner being institutionalized. All other pensions will discontinue the tax withholding once notified that the recipient is receiving institutionalized care through Medicaid, thus signifying that the withholding was not mandatory. This deduction does not apply to individuals who have elected to have taxes withheld from their earnings as a means to receiving a greater tax refund.

e. The reserve specified in section 8.100.7.V.3.d.iii. of this volume shall apply to Long-Term Care institution residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:

i) work in a sheltered workshop or work activity center;

ii) "protected employment" which means the employer gives special privileges to the individual;

iii) an activity that produced income in connection with a course of vocational rehabilitation;

iv) employment training sessions;

v) activities within the facility such as crafts products and facility employment.

f. In determining the personal needs reserve amount for Long-Term Care institution residents engaged in income-producing activities:

i) The personal needs allowance is reserved from earned income only when the person has insufficient unearned income to meet this need;

ii) In determining countable earned income of a Long-Term Care institution resident, the following rules shall apply:

1) $65 shall be subtracted from the gross earned income.

2) The result shall be divided in half.

3) The remaining income is the countable earned income and shall be considered in determining the patient payment.

iii) When the personal needs allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.

g. Other Deductions Reserved from Recipient's Income:

i) In the case of a married, long-term care recipient who is institutionalized in a Long-Term Care institution and who has a spouse (and, in some cases, other dependent family members) living in the community, there are “spousal protection” rules which permit the contribution of the institutionalized spouse's income toward their living expenses. See section 8.100.7.K.

ii) For a Long-Term Care institution recipient with no family at home, an amount in addition to the personal needs allowance may be reserved for maintenance of the recipient's home for a temporary period, not to exceed 6 months, if a physician has certified that the person is likely to return to his/her home within that period.

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

The Home Maintenance Allowance:

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

2) Beginning July 1, 2018

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

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

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

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

Or;

The individual’s actual, verified, utility expenses.

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

(1) The Department will calculate the Individual Needs Standard by dividing the Federal Minimum Monthly Maintenance Needs Allowance maximum by the Federal Minimum Monthly Maintenance Needs Allowance (MMMNA), described at 8.100.7.Q, which is in place on January 1st of each calendar year. The result of this division will be multiplied by 150% of FPL for a household of 1.

(2) The Home Maintenance Maximum is determined by subtracting 150% FPL for a household of 1 from the Individual Needs Standard and adding 30% of 150% FPL for a household of 1. The result will be rounded to the nearest whole dollar.

h. The necessity for the deduction from a recipient's income specified in section 8.100.7.V.3 shall be fully explained in the case record. Such additional reserve amount must be entered on the eligibility reporting form.

i. As of July 1, 1988, an SSI cash recipient may continue to receive SSI benefits when he/she is expected to be institutionalized for three months or less. This provision is intended to allow temporarily institutionalized recipients to pay the necessary expenses to maintain the principal place of residence.

i) Payments made under this continued benefit provision are not considered over-payments of SSI benefits if the recipient's stay is more than 90 days.

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

j. When a nursing facility resident's SSI is reduced due to institutionalization, the difference between the reduced SSI payment and the personal needs allowance amount shall be provided through the Adult Financial program so that the resident receives the full personal needs allowance.

4. Reduction of the Patient Payment

a. Patient payment may be reduced only under the following conditions:

i) A resident's income is equal to or less than the personal needs allowance and there is no long term care insurance payment, in which case the patient payment is zero; or

ii) A resident's income is equal to or less than the sum of all allowable and appropriate deductions, and there is no long term care insurance payment; or

iii) A resident is admitted to the Long Term Care institution from his/her home and the resident's funds are committed elsewhere for that month; or

iv) The resident is admitted from his/her home, where his/her funds were previously committed, to the hospital, and subsequently to the Long Term Care institution, in the same calendar month; or

v) The resident is discharged to his/her home, and the Eligibility Site determines that the income is necessary for living expenses; or

vi) The resident is admitted from another Long Term Care institution or from private pay within the facility and has committed the entire patient payment for the month for payment of care already provided in the month of admission.

vii) Medicare assesses a co-insurance payment for a QMB recipient; the recipient's patient payment cannot be used for payment of Medicare co-insurance.

b. Patient payment may not be waived in the following instances:

i) Transfers between nursing facilities, except that the patient payment for the receiving facility may be waived if the patient payment has already been committed to the former nursing facility; or

ii) Discharges from nursing facility to a hospital or other medical institution when Medicaid is paying for services in the medical institution; or

iii) Changes from private pay within the facility and the patient payment is not already committed for care provided under private pay status; or

iv) The death of the resident.

c. The Eligibility Site shall verify and approve partial month patient payments due to transfers, discharges or death when calculated by the nursing facility based upon the nursing facility's per diem rate.

d. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.

5. Responsibilities of the Eligibility Site Regarding the Personal Needs Fund

a. It shall be the responsibility of the Eligibility Site to explain to the resident the various options for handling the personal needs monies, as well as the resident's rights to such funds. The resident has the option to allow the Long Term Care institution to hold such funds in trust.

b. It shall be the responsibility of the Eligibility Site to assure that the Long Term Care institution properly transfers or disposes of the resident's personal needs funds within 30 days of discharge from the Long Term Care institution, or transfer to another Long Term Care institution.

c. The Eligibility Site shall notify the State Department if they become aware that a Long Term Care institution has retained personal needs funds more than 30 days after the death of a resident.

6. For rules regarding post eligibility treatment of income, see the section in this volume titled “Post Eligibility Treatment of Income”

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization
Rule Number: MSB 22-03-08-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 22-03-08-A, Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization

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) 8.520.8, 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)? Yes
   If yes, state effective date: 3/11/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Remove the current text at 8.520.8.C. This rule is effective March 11, 2022.

*to be completed by MSB Board Coordinator

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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 removes prior authorization reinstatement requirements for long-term home health (LTHH) originally established by rule number MSB 21-11-17-B, which was adopted at the December 2021 Medical Services Board meeting.

   The Department of Health Care Policy & Financing (the Department) recently met with Health First Colorado (Colorado's Medicaid program) members and families, providers, and other stakeholders about concerns related to the pediatric long-term home health (LTHH) benefit prior authorization request (PAR) reinstatement process. Based on these conversations, the Department has made the decision to temporarily pause the PAR process effective November 1, 2021 until at least March 2024.

   The pause allows the Department and partners time to robustly engage with stakeholders, train providers on operational changes, evaluate benefit policy, and notify Health First Colorado members before the pause is lifted. This also gives the Department time to ensure full compliance with federal and state policy while keeping Health First Colorado members and their needs front and center.

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:

   The proposed rule is imperatively necessary to address concerns raised by stakeholders concerning the tiered prior authorization reinstatement for long-term home health. The suspension of prior authorization requirements for said services is imperatively necessary for the preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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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.

   Members receiving pediatric long-term home health services, and the providers of such services, are impacted by this rule.

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

   The proposed rule will remove the requirement that pediatric long-term home health services be prior authorized in accordance with the tiered reinstatement of long-term home health prior authorizations established in Sections 8.520.8.C.1.

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.

   The Department anticipates that expenditure for pediatric long-term home health services would remain in line with spending for the last two years when all prior authorizations for such services were suspended.

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

   The benefit of the proposed rule is providing the Department and stakeholders time to discuss long-term solutions concerning prior authorization of pediatric long-term home health services. The cost of the proposed rule is suspension of prior authorization requirements for such services. The cost of inaction would be continuing the tiered reinstatement of prior authorization of such services while the Department is actively working with stakeholders to discuss the long-term solutions. There are no benefits to inaction.

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 pausing the prior authorization of the services at issue in order to provide the Department and stakeholders time to discuss long-term solutions.

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 pausing the prior authorization of the services at issue in order to provide the Department and stakeholders time to discuss long-term solutions

8.520 HOME HEALTH SERVICES

~~**8.520.8.C. Long-Term Home Health**~~

~~1. Beginning November 1, 2021, providers must submit a prior authorization request (PAR) for all new long-term pediatric Home Health Services under Section 8.017.E, except for Certified Nurse Assistant services, physical therapy services, occupational therapy services, and speech-language pathology services. For members currently receiving long-term pediatric Home Health Services initiated prior to November 1, 2021, providers must submit a PAR in accordance with the following schedule:~~

~~a. Ten percent (10%) of PARs must be submitted by November 30, 2021;~~

~~b. An additional 10% of PARs must be submitted by December 31, 2021;~~

~~c. An additional 10% of PARs must be submitted by January 31, 2022;~~

~~d. An additional 10% of PARs must be submitted by February 28, 2022;~~

~~e. An additional 10% of PARs must be submitted by March 31, 2022;~~

~~f. An additional 10% of PARs must be submitted by April 30, 2022;~~

~~g. An additional 10% of PARs must be submitted by May 31, 2022;~~

~~h. An additional 10% of PARs must be submitted by June 30, 2022;~~

~~i. An additional 10% of PARs must be submitted by July 31, 2022;~~

~~j. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.~~