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 20-04-29-A
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:

   Due to the Coronavirus (COVID-19) Public Health Emergency the state rules need to be updated to comply with federal regulations.

Initial Review
Proposed Effective Date **9/4/2020**
Final Adoption
Emergency Adoption **8/14/2020**

DOCUMENT #10

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
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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. (2019);
   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)

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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.

   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.

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

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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.

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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.

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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.

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

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

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

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

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

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

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

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

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

21 Face Value of a Life Insurance Policy is the basic death benefit of the policy exclusive of dividend
22 additions or additional amounts payable because of accidental death or other special provisions.

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

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

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

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

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

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

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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.

DRAFT

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

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

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

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

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

18 MAGI - Modified Adjusted Gross Income refers to the methodology by which income and household
19 composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act.
20 These MAGI groups include Parents and Caretaker Relatives, Pregnant Women, Children, and Adults.
21 For a more complete description of the MAGI categories and pursuant rules, please refer to section
22 8.100.4.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Secondary School is a school or educational program that provides instruction or training towards a high
8 school diploma or an equivalent degree such as a High School Equivalency Diploma (HSED).

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

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

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

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

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

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

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

33 TANF - Temporary Assistance to Needy Families is the Federal assistance program which provides
34 supportive services and federal benefits to families with little or no income or resources. It is the Block
35 Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in
36 Title IV of the Social Security Act.

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

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

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

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

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

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

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

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

14 **8.100.2 Legal Basis**

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

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

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

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

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

32 **8.100.3. Medical Assistance General Eligibility Requirements**

33 **8.100.3.A. Application Requirements**

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 11. The applicant has the right to withdraw his or her application at any time.

2

3 **8.100.3.B. Residency Requirements**

4 1. Individuals shall make application in the county in which they live.. Individuals who reside in a
5 county but who do not reside in a permanent dwelling nor have a fixed mailing address shall be
6 considered eligible for the Medical Assistance Program, provided all other eligibility requirements
7 are met. In no instance shall there be a durational residency requirement imposed upon the
8 applicant, nor shall there be a requirement for the applicant to reside in a permanent dwelling or
9 have a fixed mailing address. If an individual without a permanent dwelling or fixed mailing
10 address is hospitalized, the county where the hospital is located shall be responsible for
11 processing the application to completion. If the individual moves prior to completion of the
12 eligibility determination the origination eligibility site completes the determination and transfers the
13 case as applicable.

14 a. For applicants in Long Term Care institutions - The county of domicile for all Long Term
15 Care clients is the county in which they are physically located and receiving services.

16 2. A resident of Colorado is defined as a person that is living within the state of Colorado and
17 considers Colorado to be their place of residence at the time of application. For institutionalized
18 individuals who are incapable of indicating intent as to their state of residence, the state of
19 residence shall be where the institution is located unless that state determines that the individual
20 is a resident of another state, by applying the following criteria:

21 a. for any institutionalized individual who is under age 21 or who is age 21 or older and
22 incapable of indicating intent before age 21, the state of residence is that of the
23 individual's parent(s) or legally appointed guardian at the time of placement;

24 b. for any institutionalized individual who became incapable of indicating intent at or after
25 age 21, (1) the state of residence is the state in which the person was living when he or
26 she became incapable of indicating intent, or (2) if this cannot be determined, the state of
27 residence is the state in which the person was living when he or she was first determined
28 to be incapable of indicating intent;

29 c. upon placement in another state, the new state is the state of residence unless the
30 current state of residence is involved in the placement. If a current state arranged for an
31 individual to be placed in an institution located in another state, the current state shall be
32 the individual's state of residence, irrespective of the individual's indicated intent or ability
33 to indicate intent;

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

36 3. For purposes of this section on establishing an individual's state of residence, an individual is
37 considered incapable of indicating intent if:

38 a. the person has an I.Q. of 49 or less or has a mental age of 7 or less, based on
39 standardized tests as specified in the persons in medical facilities section of this volume;

40 b. the person is judged legally incompetent; or

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1 c. medical documentation, or other documentation acceptable to the eligibility site, supports
2 a finding that the person is incapable of indicating intent.

3 4. Residence shall be retained until abandoned. A person temporarily absent from the state, inside
4 or outside the United States, retains Colorado residence. Temporarily absent means that at the
5 time he/she leaves, the person intends to return.

6 5. A non-resident shall mean a person who considers his/her place of residence to be other than
7 Colorado. Any person who enters the state to receive Medical Assistance or for any other reason
8 is a non-resident, so long as they consider their permanent place of residence to be outside of the
9 state of Colorado.

10 **8.100.3.C. Transferring Requirements**

11 1. When a family or individual moves from one county to another within Colorado, the client shall
12 report the change of address to the eligibility site responsible for the current active Medical
13 Assistance Program case(s). If a household applies in the county in which they live and then
14 moves out of that county during the application determination process, the originating eligibility
15 site shall complete the processing of that application before transferring the case. The originating
16 eligibility site shall electronically transfer the case to the new county of residence in CBMS.

17 2. The originating eligibility site must notify the receiving eligibility site of the client's transfer of
18 Medical Assistance. The originating eligibility site may notify the receiving eligibility site by
19 telephone that a client has moved to the receiving county. If the family or individual wishes to
20 apply for other types of assistance, they shall submit a new application to the receiving eligibility
21 site.

22 3. If the household is transferring the current Medical Assistance case, the receiving eligibility site
23 cannot mandate a new application, verification, or an office visit to authorize the transfer. The
24 receiving eligibility site can request copies of specific case documents to be forwarded from the
25 originating eligibility site to verify the data contained in CBMS.

26 4. If the originating eligibility site closes a case for the discontinuation reason of “unable to locate,”
27 the applicant shall reapply at the receiving eligibility site for the Medical Assistance Program.

28 5. If a case is closed for any other discontinuation reason than “unable to locate” and the client
29 provides appropriate information to overturn the discontinuation with the originating eligibility site,
30 then, upon transfer, the receiving eligibility site shall reopen the case with case comments in
31 CBMS. These actions shall be performed according to timeframes defined by the Department.

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

34 a. the initiating eligibility site will transfer the case electronically in the eligibility system to
35 the eligibility site in which the nursing facility is located when the individual is determined
36 eligible; and

37 b. The following items shall be furnished by the initiating eligibility site to the new eligibility
38 site in hard copy format:

39 i) 5615 that was sent to the nursing facility indicating the case transfer; and

40 ii) Identification and citizenship documents; and

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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 by ~~through~~ the Federal Families First Coronavirus Response ~~CARES~~ Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories for any individual enrolled in Health First Colorado prior to the Public Health Emergency or who is enrolled in Health First Colorado during the Public Health Emergency but before the last day of the month in which the Public Health Emergency period ends, unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the state. ~~,regardless of changes made forcurrent Medicaid enrollees.~~ The Department will allow these individuals to continue eligibility through the last day of the month in which the Public Health Emergency period ends. ~~period of the COVID-19 pandemic federal emergency declaration.Once the federal emergency declaration has concluded, the Department will process eligibility s 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

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1 beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay.
2 The eligibility site shall send this notice no later than 91 days following the application for the
3 Medical Assistance Program.

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

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

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

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

17 b. The eligibility site shall not:

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

19 ii) Display any political preference or party allegiance;

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

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

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

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

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

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

40 **8.100.3.E. Retroactive Medical Assistance Coverage**

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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

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1 subsequent cost of living adjustments were disregarded. This population is referenced as
2 Disabled Adult Child (DAC).

3 i. Children age 18 and under who would otherwise require institutionalization in an Long
4 Term Care Institution, Nursing Facility (NF), or a hospital but for which it is appropriate to
5 provide care outside of an institution as described in 1902(e)(3) of the Act Public Law No.
6 97-248 (Section 134).

7 j. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility
8 criteria but do meet the state eligibility criteria for the OAP State Only Medical Assistance
9 Program. These persons qualify for a SISC Code C.

10 k. Persons who apply for and meet the criteria for one of the categorical Medical Assistance
11 programs, but do not meet the criteria of citizenship shall receive Medical Assistance
12 benefits for emergencies only.

13 l. Persons with a disability or limited disability who are at least 16 but less than 65 years of
14 age, with income less than or equal to 450% of FPL after income disregards, regardless
15 of resources, and who are employed.

16 m. Children with a disability who are age 18 and under, with household income less than or
17 equal to 300% of FPL after income disregards, regardless of resources.

18 n. Due to the Coronavirus COVID-19 Public Health Emergency, an applicant who is not
19 eligible for Medical Assistance but has been impacted through exposure to or potential
20 infection of COVID-19 may be eligible to receive services for COVID-19 testing only. To
21 qualify for this limited benefit, the Applicant must not be enrolled in other health insurance
22 and meet the criteria of citizenship.

23 **8.100.3.G. General and Citizenship Eligibility Requirements**

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

25 a. Be a resident of Colorado;

26 b. Meet the following requirements while being an inmate, in-patient or resident of a public
27 institution:

28 i). The following individuals, if eligible, may be enrolled for Medical Assistance

29 1. Patients in a public medical institution

30 2. Residents of a Long-Term Care Institution

31 3. Prior inmates who have been paroled

32 4. Resident of a publicly operated community residence which serves no
33 more than 16 residents

34 5. Individuals participating in community corrections programs or residents
35 in community corrections facilities (“halfway houses”) who have freedom
36 of movement and association which includes individuals who:

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1 2 3 a) are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision;

4 5 b) can use community resources (e.g., libraries, grocery stores, recreation, and education) at will;

6 7 8 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

9 10 d) are residing at their home, such as house arrest, or another location

11 12 13 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.

14 15 16 17 18 19 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;

20 21 d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;

22 23 e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;

24 25 f. Meet all other requirements of the Medical Assistance Program for which application is being made; and

26 g. Fall into one of the following categories:

27 28 29 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

30 31 ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

32 33 34 35 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:

36 37 1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");

38 39 2) paroled into the United States for at least one year under 8 U.S.C. § 1182(d)(5); or

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

3 4) determined by the eligibility site, in accordance with guidelines issued by
4 the U.S. Attorney General, to be a spouse, child, parent of a child, or
5 child of a parent who, in circumstances specifically described in 8 U.S.C.
6 §1641(c), has been battered or subjected to extreme cruelty which
7 necessitates the provision of Medical Assistance (Medicaid); or

8 iv) Be a non-citizen who arrived in the United States on any date, who falls into one
9 of the following categories:

10 1) lawfully residing in Colorado and is an honorably discharged military
11 veteran (also includes spouse, unremarried surviving spouse and
12 unmarried, dependent children), or

13 2) lawfully residing in Colorado and is on active duty (excluding training) in
14 the U.S. Armed Forces (also includes spouse, unremarried surviving
15 spouse and unmarried, dependent children), or

16 3) granted asylum under section 208 of the INA, or

17 4) refugee under section 207 of the INA, or

18 5) deportation withheld under section 243(h) (as in effect prior to
19 September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208)
20 of the INA, or

21 6) Cuban or Haitian entrant, as defined in section 501(e) of the Refugee
22 Education Assistance Act of 1980, or

23 7) an individual who (1) was born in Canada and possesses at least 50
24 percent American Indian blood, or is a member of an Indian tribe as
25 defined in 25 U.S.C. sec. 5304(e)(2016), or

26 8) admitted to the U.S. as an Amerasian immigrant pursuant to section 584
27 of the Foreign Operations, Export Financing, and Related Programs
28 Appropriations Act of 1988 (as amended by P.L. 100-461), or

29 9) lawfully admitted permanent resident who is a Hmong or Highland Lao
30 veteran of the Vietnam conflict, or

31 10) a victim of a severe form of trafficking in persons, as defined in section
32 103 of the Victims of Trafficking and Violence Protection Act of 2000,
33 Pub. L.106-386, as amended (22 U.S.C. § 7105(b) (2016)), or

34 11) An alien who arrived in the United States on or after December 26, 2007
35 who is an Iraqi special immigrant under section 101(a)(27) of the INA, or

36 12) An alien who arrived in the United States on or after December 26, 2007
37 who is an Afghan Special Immigrant under section 101(a)(27) of the INA.

38 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
39 are incorporated herein by reference. No amendments or later editions are

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1 incorporated. These regulations are available for public inspection at the
2 Colorado Department of Health Care Policy and Financing, 1570 Grant Street,
3 Denver, Colorado 80203-1714. Pursuant to C.R.S. 24-4-103(12.5)(b)(2016), the
4 agency shall provide certified copies of the material incorporated at cost upon
5 request or shall provide the requestor with information on how to obtain a
6 certified copy of the material incorporated by reference from the agency of the
7 United States, this state, another state, or the organization or association
8 originally issuing the code, standard, guideline or rule.

9 vi) Be a lawfully admitted non-citizen who is a pregnant women or a child under the
10 age of 19 years in the United States who falls into one of the categories listed in
11 8.100.3.G.1.g.iii or into one of the following categories listed below. These
12 individuals are exempt from the 5-year waiting period:

13 1) granted temporary resident status in accordance with 8 U.S.C. 1160 or
14 1255a,or

15 2) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C
16 1254a and pending applicants for TPS granted employment
17 authorization,

18 3) granted employment authorization under 8 CFR 274a.12(c),or

19 4) Family Unity beneficiary in accordance with section 301 of Pub. L. 101-
20 649, as amended.

21 5) Deferred Enforced Departure (DED), pursuant to a decision made by the
22 President,

23 6) granted Deferred Action status (excluding Deferred Action for Childhood
24 Arrivals (DACA)) as described in the Secretary of Homeland Security's
25 June 15,2012 memorandum,

26 7) granted an administrative stay of removal under 8 CFR 241.6(2016), or

27 8) Beneficiary of approved visa petition who has a pending application for
28 adjustment of status.

29 9) Pending an application for asylum under 8 U.S.C. 1158, or for
30 withholding of removal under 8 U.S.C. 1231, or under the Convention
31 Against Torture who-

32 a) as been granted employment authorization; or

33 b) Is under the age of 14 and has had an application pending for at
34 least 180 days.

35 10) granted withholding of removal under the Convention Against Torture,

36 11) A child who has a pending application for Special Immigrant Juvenile
37 status under 8 U.S.C. 1101(a)(27)(J), or

38 12) Citizens of Micronesia, the Marshall Islands, and Palau, or

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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.

1 ii) If the VLP cannot automatically confirm the information submitted, the individual
2 will be contacted with a request for additional documents and/or information
3 needed to verify their legal immigration status through the VLP interface. If a
4 response from the VLP interface confirms that the additional documents and/or
5 information received from the individual verifies their legal immigration status, no
6 further action is required for the individual and no additional documentation of
7 immigration status is required.

8 3. Reasonable Opportunity Period

9 a. If the verification through the electronic interface is unsuccessful then the applicant will be
10 provided a reasonable opportunity period, of 90 days, to submit documents indicating a
11 legal immigration status, as listed in 8.100.3.G.1.g. The reasonable opportunity period will
12 begin as of the date of the Notice of Action. The required documentation must be
13 received within the reasonable opportunity period.

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

17 c. The reasonable opportunity period applies to MAGI, Adult and Buy-In Programs.

18 i) For the purpose of this section only, MAGI Programs for persons covered
19 pursuant to 8.100.4.G or 8.100.4.I. include the following:
20

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

21

22 ii) For the purpose of this section only, Adult and Buy-In Programs for persons
23 covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715. include the
24 following:
25

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

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27 **8.100.3.H. Citizenship and Identity Documentation Requirements**

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

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

9 i) SSA Interface is an acceptable interface to verify citizenship and identity. An
10 automated response from SSA that confirms that the data submitted is consistent
11 with SSA data, including citizenship or nationality, meets citizenship and identity
12 verification requirements. No further action is required for the individual and no
13 additional documentation of either citizenship or identity is required.

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

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

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

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

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

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

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

27

28 vi) Children born to a woman who has applied for, has been determined eligible, and
29 is receiving Medical Assistance on the date of the child's birth, as described in
30 8.100.4.G.5. This includes instances where the labor and delivery services were
31 provided before the date of application and were covered by the Medical
32 Assistance Program as an emergency service based on retroactive eligibility.

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

38 2) Special Provisions for Retroactive Reversal of a Previous Denial

39 a) If a child described at 8.100.3.H.1.b.vi was previously
40 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.

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

4 1) Special Provisions for Retroactive Reversal of a Previous Denial

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

12 (1) The individual was determined to be ineligible for
13 Medical Assistance on or after July 1, 2006 solely on the
14 basis of not meeting the citizenship and identity
15 documentation requirements as they existed during that
16 period;

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

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

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

31

32

33 b. Evidence of citizenship. If evidence from the list in 8.100.3.H.2.a. is not provided, an
34 applicant or recipient shall provide satisfactory documentary evidence of citizenship from
35 the list specified in this section to establish citizenship AND satisfactory documentary
36 evidence from the documents listed in section 8.100.3.H. 3. to establish identity.
37 Evidence of citizenship includes:

38 i) A U.S. public birth certificate.

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

40 a) One of the 50 States,

41 b) The District of Columbia,

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

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

3 e) The Virgin Islands of the U.S. (if born on or after January 17,
4 1917),

5 f) American Samoa,

6 g) Swain's Island, or

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

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

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

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

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

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

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

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

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

28 vi) A Northern Mariana Identification Card (I-873) issued by INS to a collectively
29 naturalized citizen of the U.S. who was born in the NMI before November 4,
30 1986.

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

33 viii) A final adoption decree that:

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

35 2) a statement from a State approved adoption agency that shows the
36 child's name and U.S. place of birth. The adoption agency must state in

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1 the certification that the source of the place of birth information is an
2 original birth certificate.

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

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

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

9 xii) Child Citizenship Act. Adopted or biological children born outside the United
10 States may establish citizenship obtained automatically under section 320 of the
11 Immigration and Nationality Act (8 USC § 1431), as amended by the Child
12 Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). section
13 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the
14 Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000) is
15 incorporated herein by reference. No amendments or later editions are
16 incorporated. Copies are available for inspections from the following person at
17 the following address: Custodian of Records, Colorado Department of Health
18 Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any
19 material that has been incorporated by reference in this rule may be examined at
20 any state publications repository library.

21 Documentary evidence must be provided at any time on or after February 27,
22 2001, if the following conditions have been met:

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

25 2) The child is under the age of 18;

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

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

31

32 5) If adopted, the child satisfies the requirements of section 101(b)(1) of the
33 Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to
34 international adoptions (admission for lawful permanent residence as IR-
35 3 (child adopted outside the United States), or as IR-4 (child coming to
36 the United States to be adopted) with final adoption having subsequently
37 occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No
38 amendments or later editions are incorporated. Copies are available for
39 inspections from the following person at the following address: Custodian
40 of Records, Colorado Department of Health Care Policy and Financing,
41 1570 Grant Street, Denver, CO 80203-1818. Any material that has been
42 incorporated by reference in this rule may be examined at any state
43 publications repository library.

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1 xiii) Extract of a hospital record on hospital letterhead.

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

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

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

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

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

9 xiv) Life, health, or other insurance record.

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

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

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

15 xv) Religious record.

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

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

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

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

23 xvi) Early school record that meets the following criteria:

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

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

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

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

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

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

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

5 1) Seneca Indian tribal census record;

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

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

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

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

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

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

16 xx) Medical (clinic, doctor, or hospital) record.

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

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

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

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

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

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

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

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

36 4) If the individual(s) making the affidavit has (have) information which
37 explains why documentary evidence establishing the applicant's claim of

1 citizenship does not exist or cannot be readily obtained, the affidavit shall
2 contain this information as well;

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

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

9 c. Evidence of citizenship for collectively naturalized individuals. If a document shows the
10 individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana
11 Islands before these areas became part of the U.S., the individual may be a collectively
12 naturalized citizen. A second document from 8.100.3.H.3. to establish identity shall also
13 be presented.

14 i) Puerto Rico:

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

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

22 ii) US Virgin Islands:

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

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

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

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

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

40 2) Evidence of TTPI citizenship, continuous residence in the NMI since
41 before November 3, 1981 (NMI local time), voter registration prior to

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1 January 1, 1975 and the applicant's statement that he or she did not owe
2 allegiance to a foreign state on November 4, 1986 (NMI local time); OR

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

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

9 d) Referrals for Colorado Birth Certificates

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

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

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

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

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

22 iii) An applicant or client who has been referred to the Department of Public Health
23 and Environment to obtain a birth certificate shall not be required to present a
24 birth certificate to satisfy the citizenship documentation requirement at
25 8.100.3.H.2. The applicant or client shall have the right to use any of the
26 documents listed under 8.100.3.H.2. to satisfy the citizenship documentation
27 requirement.

28 3. The following documents shall be accepted as proof of identity and shall accompany a document
29 establishing citizenship from the groups of documentary evidence outlined in 8.100.3.H.2.b.
30 through d.

31 a) A driver's license issued by a State or Territory either with a photograph of the individual
32 or other identifying information such as name, age, sex, race, height, weight, or eye color;

33 b) School identification card with a photograph of the individual;

34 c) U.S. military card or draft record;

35 d) Identification card issued by the Federal, State, or local government with the same
36 information included on driver's licenses;

37 e) Military dependent's identification card;

38 f) U.S. Coast Guard Merchant Mariner card;

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1 g) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal
2 document with a photograph or other personal identifying information relating to the
3 individual. The document is acceptable if it carries a photograph of the individual or has
4 other personal identifying information relating to the individual such as age, weight,
5 height, race, sex, and eye color; or

6 h) Three or more documents that together reasonably corroborate the identity of an
7 individual provided such documents have not been used to establish the individual's
8 citizenship and the individual submitted evidence of citizenship listed under
9 8.100.3.H.2.b. or 8.100.3.H.2.c. The following requirements must be met:

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

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

13 iii) All documents used must contain consistent identifying information.

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

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

20 i) Clinic, doctor, or hospital records; or

21 ii) School records.

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

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

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

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

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

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

32 d) The affidavit is not required to be notarized.

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

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

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

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

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

7 3) The affidavit is not required to be notarized.

8 k) Expired identity documents.

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

12 l) Referrals for Colorado Identification Cards

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

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

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

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

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

25 iii) An applicant or client who has been referred to the Division of Motor Vehicles to
26 obtain an identification card shall not be required to present a Colorado
27 identification card to satisfy the identity documentation requirement at
28 8.100.3.H.3. The applicant or client shall have the right to use any of the
29 documents listed under 8.100.3.H.3. to satisfy the identity documentation
30 requirement.

31 4. Documentation Requirements

32 a. Citizenship and identity documents may be submitted as originals, certified copies,
33 photocopies, facsimiles, scans or other copies.

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

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

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

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

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

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

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

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

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

29 i) Upon receiving the original documents, eligibility site staff shall make a copy of
30 the original documents and shall complete a “Citizenship and Identity
31 Documentation Received” form, stamp the copy, or provide other verification that
32 identifies that the documents presented were originals, as described in
33 8.100.3.H.4.e. i). This form, stamp, or other verification shall be attached to or
34 directly applied to the copy.

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

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

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

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

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

6 5. Record Retention Requirements

7 a. The eligibility site shall retain a paper or electronically scanned copy of an individual's
8 citizenship and identity documentation, including any verification described in
9 8.100.3.H.4.e.i), for at least five years from the ending date of the individual's last period
10 of Medical Assistance eligibility.

11 6. Name Change Provisions

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

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

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

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

22 7. Reasonable Level of Assistance

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

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

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

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

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

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

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36 8. Individuals Requiring Additional Assistance

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1 a. The eligibility site shall provide additional assistance beyond the level described in
2 8.100.3.H.7 to applicants and clients in obtaining the required citizenship and identity
3 documentation if the client or applicant:

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

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

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

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

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

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

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

17 9. Reasonable Opportunity Period

18 a. If a Medical Assistance applicant does not have the required documentation, he or she
19 must be given a reasonable opportunity period to provide the required documentation.
20 The reasonable opportunity period will begin as of the date of the Notice of Action. The
21 required documentation must be received within the reasonable opportunity period. If the
22 applicant does not provide the required documentation within the reasonable opportunity
23 period, then the applicant's Medical Assistance benefits shall be terminated.

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

26 i) For the purpose of this section only, MAGI Programs for persons covered
27 pursuant to 8.100.4.G or 8.100.4.I, include the following:
28

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

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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.

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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.

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

3 7. An applicant or member who is a live-In home care provider to a care recipient receiving a
4 Difficulty of Care Payment and who is being determined for a MAGI Medical Assistance program,
5 must meet the following requirements for Difficulty of Care payments to be excluded as countable
6 income:

7 a. The care provider receiving payments for personal care or supportive services provided
8 to a care recipient must live full-time in the same home with the care recipient; and

9 b. The care recipient must either

10 i) receiving personal care or supportive services must be enrolled in Long Term
11 Service Supports (LTSS), with additional services through a Home-Based
12 Services (HCBS) waiver program; or

13 ii) The care recipient must be enrolled in the Buy-In Program for Working Adults
14 with Disabilities, and receive additional services through the Home and
15 Community Based Services (HCBS) waiver program.

16 c. Exception: Difficulty of Care Payments are not excluded if the payments are for more
17 than 10 qualified foster individuals under the age of 19 or 5 qualified foster individuals
18 who are over the age of 19

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

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

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

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

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

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

34 i) the rent of business premises,

35 ii) wholesale cost of merchandise,

36 iii) utilities,

37 iv) taxes,

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1 v) labor, and

2 vi) upkeep of necessary equipment.

3 b. The following are not allowed as business expenses:

4 i) Depreciation of equipment;

5 1) Exception: For the purpose of calculating MAGI-based income,
6 depreciation of equipment is an allowable business expense if the
7 equipment is not used for capital improvements.

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

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

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

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

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

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

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

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

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

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

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

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1 a. Pensions and other period payments, such as:

2 i) Private pensions or disability benefits

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

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

6 iii) Workers' Compensation payments

7 iv) Railroad retirement annuities

8 v) Unemployment insurance payments

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

11 vii) Alimony and support payments

12 viii) Interest, dividends and certain royalties on countable resources

13 12. For all Medical Assistance categories, the federal Coronavirus Aid, Relief, and Economic
14 Security (CARES) Act Recovery Rebate, known as the COVID-19 Economic Stimulus, shall be
15 exempt from consideration as income.

16 13. Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra
17 $600.00 a week for qualifying individuals, is exempt as countable unearned income for all Medical
18 Assistance categories.

19 **8.100.3.L Consideration of Resources**

20 **Consideration of Resources**

21 1. Resources are counted in determining eligibility for the Aged, Blind and Disabled, and Long-Term
22 Care institutionalized and Home and Community Based Services categories of Medical
23 Assistance. Resources are not counted in determining eligibility for the MAGI Medical Assistance
24 programs, the Medicaid Buy-in Program for Working Adults with Disabilities, or the Medicaid Buy-
25 In Program for Children with Disabilities, See section 8.100.5 for rules regarding consideration of
26 resources.

27 2. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Recovery Rebate,
28 known as COVID-19 Economic Stimulus, shall be an exempt resource for the first 12 months
29 following the receipt of the Recovery Rebate, after which the remaining balance will be
30 considered a countable resource for all Medical Assistance categories which include an asset
31 test.

32 **8.100.3.M. Federal Financial Participation (FFP)**

33 1. The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of
34 groups covered under the Colorado Medical Assistance Program and also for the Medicare
35 supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain
36 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.

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

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

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

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

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

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

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

23 b. Medical services provided;

24 c. Social and economic conditions or circumstances;

25 d. Agency evaluation of personal information;

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

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

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

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

33 i. Social Security Numbers.

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

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

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

3 c. To individuals executing Income and Eligibility Verification System;

4 d. Child Support enforcement officials;

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

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

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

15 **8.100.3.O. Protection Against Discrimination**

16 1. Eligibility sites are to administer the Medical Assistance Program in such a manner that no person
17 will, on the basis of race, color, sex, age, religion, political belief, national origin, or handicap, be
18 excluded from participation, be denied any aid, care, services, or other benefits of, or be
19 otherwise subjected to discrimination in such program.

20 2. The eligibility site shall not, directly or through contractual or other arrangements, on the grounds
21 of race, color, sex, age, religion, political belief, national origin, or handicap:

22 a. Provide aid, care, services, or other benefits to an individual which is different, or
23 provided in a different manner, from that of others;

24 b. Subject an individual to segregation barriers or separate treatment in any manner related
25 to access to or receipt of assistance, care services, or other benefits;

26 c. Restrict an individual in any way in the enjoyment or any advantage or privilege enjoyed
27 by others receiving aid, care, services, or other benefits provided under the Medical
28 Assistance Program;

29 d. Treat an individual differently from others in determining whether he/she satisfies any
30 eligibility or other requirements or conditions which individuals shall meet in order to
31 receive aid, care, services, or other benefits provided under the Medical Assistance
32 Programs;

33 e. Deny an individual an opportunity to participate in programs of assistance through the
34 provision of services or otherwise, or afford him/her an opportunity to do so which is
35 different from that afforded others under the Medical Assistance Program.

36 3. No distinction on the grounds of race, color, sex, age, religion, political belief, national origin, or
37 handicap is permitted in relation to the use of physical facilities, intake and application
38 procedures, caseload assignments, determination of eligibility, and the amount and type of
39 benefits extended by the eligibility site to Medical Assistance recipients.

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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;

1 b. Required verification shall be returned by the client to the eligibility site no later than ten
2 working days after receipt of request;

3 c. When the individual is unable to complete the forms due to physical, mental or emotional
4 disabilities, or other good cause, and has no one to help him/her, the eligibility site shall
5 either assist the client or refer him/her to a legal or other resource. When initial
6 arrangements or a change in arrangements are being made, an extension of up to thirty
7 days shall be allowed. The action of the eligibility site in assistance or referral shall be
8 recorded in the case record and CBMS case comments.

9 d. The redetermination form shall require that a recipient and community spouse of a
10 recipient of HCBS, PACE or institutional services disclose a description of any interest
11 the individual or community spouse has in an annuity or similar financial instrument
12 regardless of whether the annuity is irrevocable or treated as an asset. The
13 redetermination form shall include a statement that the Department shall be a remainder
14 beneficiary for any annuity or similar financial instrument purchased on or after February
15 8, 2006 for the total amount of Medical Assistance provided to the individual.

16 e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument
17 that the Department is a preferred remainder beneficiary in the annuity or similar financial
18 instrument for the total amount of Medical Assistance provided to the individual. This
19 notice shall require the issuer to notify the eligibility site when there is a change in the
20 amount of income or principal that is being withdrawn from the annuity.

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

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

29 b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance client shall be
30 contacted by telephone or in writing so that the worker may secure the proper information
31 according to timelines defined by the Department.

32 6. —Due to the federal Coronavirus COVID-19 Public Health Emergency, the Department will continue
33 eligibility– for all Medical Assistance categories, regardless of a redetermination and/or reported
34 change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.

35 **8.100.3.Q. Continuous Eligibility (CE) for Medical Assistance programs**

36 1. Continuous eligibility applies to children under age 19, who through an eligibility determination,
37 reassessment or redetermination, are found eligible for a Medical Assistance program. The
38 continuous eligibility period may last for up to 12 months.

39 a. The continuous eligibility period applies without regard to changes in income or other
40 factors that would otherwise cause the child to be ineligible.

41 i) A 14-day no fault period shall begin on the date the child is determined eligible
42 for Medical Assistance. During the 14-day period, any changes to income or

1 other factors made to the child's case during the 14-day no fault period may
2 change his or her eligibility for Medical Assistance.

3 b. Exception: A child's continuous eligibility period will end effective the earliest possible
4 month if any of the following occur:

5 i) Child is deceased

6 ii) Becomes an inmate of a public institution

7 iii) The child is no longer part of the Medical Assistance required household

8 iv) Is no longer a Colorado resident

9 v) Is unable to be located based on evidence or reasonable assumption

10 vi) Requests to be withdrawn from continuous eligibility

11 vii) Fails to provide documentation during a reasonable opportunity period as
12 specified in section 8.100.3.H.9

13 viii) Fails to provide a reasonable explanation or paper documentation when self-
14 attested income is not reasonably compatible with income information from an
15 electronic data source, by the end of the 90-day reasonable opportunity period.
16 This exception only applies the first-time income is verified following an initial
17 eligibility determination or an annual redetermination.

18 2. The continuous eligibility period will begin on the first day of the month the application is received
19 or from the date all criteria is met. Continuous eligibility is applicable to children enrolled in the
20 following Medical Assistance programs:

21 a. MAGI-Medical Assistance, program as specified in section 8.100.4.G.2

22 b. SSI Mandatory, as specified in section 8.100.6.C

23 i.) When a child is no longer eligible for SSI Mandatory they will be categorized as
24 eligible within the MAGI-Child category for the remainder of the eligibility period.

25 c. Long- Term Care services

26 i.) When a child is no longer eligible for Long-Term Care services they will be
27 categorized as eligible within the MAGI- Child category for the remainder of the
28 eligibility period.

29 d. Medicaid Buy-In program specified in section 8.100.6.Q

30 i) Exception: Enrollment will be discontinued if there is a failure to pay premiums

31 e. Pickle

32 f. Disabled Adult Child DAC)

33 3. Children, under the age of 19, no longer enrolled in Foster Care Medicaid will be eligible for the
34 MAGI-Medical Assistance program. The continuous eligibility period will begin the month the child

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is no longer enrolled in Foster Care Medicaid as long as they meet one of the following conditions:

a. Begin living with other Relatives

b. Are reunited with Parents

c. Have received guardianship

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

8.100.4.A. MAGI Application Requirements

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

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

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

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

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

8.100.4.B. MAGI Category Verification Requirements

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

a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the COVID-19 Public Health Emergency, at the time of application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the federally-declared COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1) Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet federal and state citizenship and immigration status requirements, are only eligible to receive emergency medical services.

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

c. Earned Income: Income 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.

1 5. The criteria of age and relationship can be declared by the client unless questionable. If
2 questionable, these criteria can be established with information provided from:

3 a. official papers such as: a birth certificate, order of adoption, marriage license, immigration
4 or naturalization papers; or

5 b. records or statements from sources such as: a court, school, government agency,
6 hospital, or physician.

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

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

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

14 **8.100.4.C. MAGI Methodology for Income Calculation**

15 1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated
16 by reference. The incorporation of 26 U.S.C. § 61 (2014) excludes later amendments to, or
17 editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department
18 maintains copies of this incorporated text in its entirety, available for public inspection during
19 regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant
20 Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon
21 request. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all
22 income from all derived sources, The Modified Adjusted Gross Income calculation for the
23 purposes of determining a household's financial eligibility for Medical Assistance shall consist of,
24 but is not limited to, the following:

25 a. Earned Income:

26 i) Wages, salaries, tips;

27 ii) Gross income derived from business;

28 iii) Gains derived from dealings in property;

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

30 v) Compensation for services, including fees, commissions, fringe benefits and
31 similar items; and

32 vi) Taxable private disability income.

33 b. Unearned Income:

34 i) Interest (includes tax exempt interest);

35 ii) Rents;

36 iii) Royalties;

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1 iv) Dividends;

2 v) Alimony received counts as unearned income if the divorce or legal separation is
3 executed on or before December 31, 2018. Alimony received will not be
4 countable income if the divorce or legal separation is modified or executed on or
5 after January 1, 2019;

6 vi) Pensions and annuities;

7 vii) Income from life insurance and endowment contracts;

8 viii) Income from discharge of indebtedness;

9 ix) Income in respect of a decedent;

10 x) Income from an interest in an estate or trust;

11 xi) Social Security (SSA) income; and

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

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

15 i) Any tax exempt interest income.

16 ii) Untaxed foreign wages and salaries.

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

18 d. The following are Income exclusions:

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

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

23 iii) Child support received;

24 iv) Worker's Compensation;

25 v) Supplemental Security Income (SSI);

26 vi) Veteran's Benefits;

27 vii) The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act
28 Recovery Rebate, also known as the COVID-19 Economic Stimulus, shall be
29 exempt from consideration as income.

30 viii) Federal Pandemic Unemployment Compensation (FPUC) program, which
31 provides an extra $600.00 a week for qualified individuals, is exempt as
32 countable unearned income.

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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.

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1 f. Income of children and tax dependents:

2-4 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..

5-6 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.

7-9 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.

10-12 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.

13-16 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.

17-21 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.

22-24 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:

25-28 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.

29-33 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 210%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

34-37 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 ineligible during the federal Coronavirus COVID-19 Public Health Emergency..

38-42 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 will not shall be requested due toduring the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable explanation will be

requested from the member-. ~~If the applicant is unable to provide a reasonable explanation, paper documentation shall be requested~~.

i) During the federal Coronavirus COVID-19 Public Health Emergency t~~T~~he Department will not ~~may~~ request paper documentation when ~~only if~~ the Department does not find income to be reasonably compatible. ~~and if the applicant does not provide a reasonable explanation or if electronic data are not available~~

3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application 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;

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

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

4 b. In the case of an applicant who expects to be claimed as a tax dependent by another
5 taxpayer for the taxable year in which an initial determination or renewal of eligibility is
6 being made, the applicant's MAGI household shall be:

7 i) The Tax Dependent;

8 ii) The Tax-Filer and their spouse if living in the home;

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

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

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

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

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

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

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

23 i) The applicant;

24 ii) The applicant's spouse who lives in the household;

25 iii) The applicant's natural, adopted, and step children under the age of 19, who live
26 in the household; and

27 iv) In the case of applicants under the age of 19, the applicant's natural, adoptive,
28 and step parents and natural, adoptive, and step siblings under age 19, who live
29 in the household.

30 2. When a household includes a pregnant woman, regardless of the Medical Assistance category,
31 the pregnant woman is counted as herself plus the number of children she is expected to deliver.

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

35 4. If a child is claimed as a tax dependent by both parents who are married and who will file taxes
36 jointly but one parent lives outside of the household due to separation or pending divorce, the

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1 child's household composition is determined by non-filer rules. The parent living outside of the
2 household will not be counted as part of the household.

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

5 **8.100.4.F. MAGI Category Presumptive Eligibility**

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

10 2. To be eligible for presumptive eligibility:

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

15 b. a child under the age of 19 shall have a declared household income that does not exceed
16 133% of federal poverty level (MAGI-equivalent) and declare that the child is a United
17 States citizen or a documented immigrant.

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

21 4. The presumptive eligibility site shall forward the application to the county within five business
22 days.

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

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

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

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

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

32 **8.100.4.G. MAGI Covered Groups**

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

36 2. Children applying for Medical Assistance whose total household income does not exceed 133%
37 of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical

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1 Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department's
2 website.

3 a. Children are eligible for Children's MAGI Medical Assistance through the end of the
4 month in which they turn 19 years old. After turning 19, the individual may be eligible for a
5 different Medical Assistance category.

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

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

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

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

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

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

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

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

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

30 a. A dependent child living in the household of a parent or caretaker relative shall have
31 minimum essential coverage, in order for the parent or caretaker relative to be eligible for
32 Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is
33 considered a dependent child.

34 b. Due to the COVID-19 Public Health Emergency an applicant who is not eligible for
35 Medical Assistance but has been impacted through exposure to or potential infection with
36 COVID-19 may be eligible to receive services for COVID-19 testing only. To qualify for
37 this limited benefit,- the Applicant must not be enrolled in other health insurance and
38 meet the criteria of citizenship.

39 5. Pregnant Women whose household income does not exceed 185% of the federal poverty level
40 (MAGI-equivalent) are eligible for the Pregnant Women MAGI Medical Assistance program.
41 Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of

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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

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

4 The extension shall be applied to individuals who:

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

7 b. Are no longer eligible for coverage under the Parent/Caretaker Relative category
8 because of new or increased income from employment or hours of employment

9 i) At least one Parent/Caretaker Relative must continue to be employed and cannot
10 terminate employment without good cause. This does not need to be the same
11 person for the whole period the family is receiving Transitional Medical
12 Assistance.

13 2. Any dependent child or Parent/Caretaker Relative who was or becomes part of the Medical
14 Assistance household after the individual has begun receiving Transitional Medical Assistance is
15 eligible for the remaining months of Transitional Medical Assistance.

16 a. A dependent child in the household who received Medical Assistance through continuous
17 eligibility, but is no longer eligible for Medical Assistance based on a redetermination, is
18 eligible for the family's remaining months of Transitional Medical Assistance.

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

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

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

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

28 4. When Transitional Medical Assistance ends the case will be reassessed for all other categories of
29 Medical Assistance for which the family members may be eligible. A new application shall not be
30 required for this process.

31 5. Eligibility for Medical Assistance shall be extended for four months (beginning with the first month
32 of ineligibility) for certain families who become ineligible for Medical Assistance due solely or
33 partially to the receipt of support income, such as alimony. The extension shall be applied for a
34 family which receives assistance under Medical Assistance in at least three of the six months
35 immediately preceding the month in which the family becomes ineligible for assistance. To be
36 eligible for the four month Medical Assistance extension, the family shall meet all other eligibility
37 criteria for Medical Assistance before the alimony income is applied.

38 a. Alimony received will be countable income only if the divorce or legal separation is
39 executed on or before December 31, 2018. Alimony will not be countable income if the
40 divorce or legal separation is modified or executed on or after January 1, 2019.

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1 **8.100.4.J. Express Lane Eligibility**

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

4 1. Free/Reduced Lunch Program

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

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

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

11 iii) Children who meet all necessary eligibility requirements except verification of
12 U.S. citizenship and identity shall receive 90days of eligibility while awaiting this
13 verification.

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

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

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

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

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

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

28 2. Direct Certification

29 a. Individuals who have submitted a Food Assistance or Colorado Works application

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

32 ii) Children who meet all necessary eligibility requirements as outlined throughout
33 8.100.4 shall be automatically enrolled

34 iii) Children who meet all necessary eligibility requirements except verification of
35 U.S. citizenship and identity will receive 90 days of eligibility while awaiting this
36 verification.

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

3 v) Eligibility is based on income declared on the Food Assistance or Colorado
4 Works application as well as eligibility requirements outlined throughout this
5 volume.

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

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

12 **8.100.5. Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan Medical**
13 **Assistance General Eligibility**

14 **8.100.5.A. Application Requirements**

15 1. When an individual applies for Medical Assistance on the basis of disability or blindness, the
16 eligibility sites shall take the application and determine whether the individual is eligible for Long
17 Term Care or any of the Aged, Blind, and Disabled categories of assistance described in section
18 8.100.6. If the applicant does not qualify for Medical Assistance on one of those bases, he/she
19 shall be referred to the local Social Security office to apply for SSI.

20 a. Applicants who apply for Long-Term Care Medical Assistance on the basis of disability or
21 blindness, or who apply for the Medicaid Buy-In Program for Working Adults with
22 Disabilities or the Medicaid Buy-In Program for Children with Disabilities without a current
23 disability determination, shall complete a Medical Assistance disability determination
24 application in addition to the required Single Streamlined Application. The disability
25 determination application is not required for individuals that have already been
26 determined disabled by the Social Security Administration.

27 b. The Medical Assistance disability determination application shall be collected by a
28 designated eligibility site representative and shall be forwarded to the state disability
29 determination contractor upon completion. The state disability determination contractor
30 shall conduct a client disability determination and shall forward the determination to the
31 designated eligibility site representative.

32 c. For the Medicaid Buy-In Program for Working Adults with Disabilities, if an individual
33 does not meet the Social Security Administration definition of disability, the state disability
34 determination contractor can review the individual's circumstances to determine if the
35 individual meets limited disability.

36 d. Due to the -Coronavirus -COVID--19 Public Health Emergency-, if a person's -existing
37 determination is expired, the person shall remain enrolled in Medical Assistance. -A
38 disability determination will be verified by the state disability determination contractor as
39 soon as possible after the Emergency has ended.

40 2. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the
41 Single Streamlined Application.

42 **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~~.

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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 due to the federal COVID-19 Public Health Emergency. When the federal Public Health Emergency has ended, a reasonable explanation will be requested 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 will not~~may~~ request paper documentation when ~~only if~~ the Department does not find income to be reasonably compatible. ~~and if the applicant does not provide a reasonable explanation or if electronic data are not available.~~

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.

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

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

8 g. Additional verification-If the requested verification is submitted by the applicant, no other
9 additional verification shall be required unless the submitted verification is found to be
10 questionable on the basis of fact.

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

13 **8.100.5.C. Effective Date of Eligibility**

14 1. Eligibility for the Aged, Blind and Disabled categories shall be approved effective on the later of:

15 a. The first day of the month of the Single Streamlined Application for Medical Assistance;
16 or

17 b. The first day of the month the person becomes eligible for Medical Assistance.

18 2. The date that eligibility begins for Long-Term Care Medical Assistance is defined in section
19 8.100.7.A and B.

20 3. For the Medicaid Buy-In Program for Children with Disabilities, any child who is determined to be
21 eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits
22 during the entire month.

23 4. Clients applying for Medical Assistance under the Aged, Blind and Disabled category shall be
24 reviewed for retroactive eligibility as described at 8.100.3.E. When reviewing for retroactive
25 eligibility for an individual who is SSI eligible or applied and became SSI eligible in each of the
26 retroactive months, the applicant must:

27 a. Be aged at least 65 years; or

28 b. Meet the Social Security Administration definition of disability by:

29 i) Being approved as eligible to receive either SSI or SSDI, on or prior to the date
30 of a medical service; or

31 ii) Having a disability onset date determined on or prior to the date of a medical
32 service; and

33 c. Meet the financial requirements as described at 8.100.5.E.

34 **8.100.5.D. Medical Assistance Estate Recovery Program**

35 1. The eligibility site shall provide written information from the Department to the following people
36 explaining the provisions of the Medical Assistance Estate Recovery Program and how those
37 provisions may pertain to the applicant/client:

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1 a. Applicants age 55 and older who are institutionalized.

2 b. Applicants/clients who will turn age 55 before their next eligibility re-determination who
3 are institutionalized.

4 c. Clients age 55 and older who are approved for admittance to an institution

5 **8.100.5.E. Availability of Resources and Income**

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

10 1. Income, which includes earned and unearned income, shall be calculated on a monthly basis
11 regardless of whether it is received annually, semi-annually, quarterly or weekly.

12 2. For married couples, the income and resources of both spouses are counted in determining
13 eligibility for either or both spouses. Refer to section 8.100.7.C for exceptions.

14 3. Resources and income shall be considered available when actually available; or, shall be
15 deemed available when all of the following apply to the resources or income of the individual or
16 individual's spouse:

17 a. has any ownership interest in income or resources or equity value of a resource;

18 b. has the right, authority, or power to convert the resource or income to cash or to cause
19 the resource or income to be converted to cash; and

20 c. is not legally restricted from using the resource or income for his or her support and
21 maintenance.

22 4. Resources and income shall not be considered unavailable merely because the individual or
23 individual's spouse may need to initiate legal proceedings to access the resources or income.

24 5. If the applicant or client demonstrates with clear and convincing evidence that appropriate steps
25 are being taken to secure the resources, Medical Assistance shall not be delayed or terminated.
26 Verification of efforts to secure the resources must be provided at regular intervals as requested
27 by the Eligibility Site.

28 6. Resources will be considered available and Medical Assistance shall be denied or terminated if
29 the applicant or client refuses or fails to make a reasonable effort to secure potential resources or
30 income.

31 7. Timely and adequate notice must be given regarding a proposed action to deny, reduce, or
32 terminate assistance due to failure to make reasonable efforts to secure resources or income. If
33 upon receipt of the prior notice, the individual acts to secure the potential resource, the proposed
34 action to deny, reduce, or terminate assistance must be withdrawn, and assistance must be
35 approved or continued until the resource or income is, in fact, available.

36 8. If the resources or income has been transferred to a trust, the trust shall be submitted for review
37 to the Department to determine the effect of the trust on eligibility in accordance with section
38 8.100.7.E.

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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.

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

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

5 b. Prizes and awards

6 c. Gifts and inheritances

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

8 e. Interest or dividend payments received from any resources

9 f. Lump sum payments from workers' compensation, insurance settlements, etc.

10 g. Dividends, royalties or other payments from mineral rights or other resources listed for
11 sale within the resource limits

12 h. Income from annuities that meet requirements for exclusion as a resource

13 i. Pensions and other period payments, such as:

14 i) Private pensions or disability benefits

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

16 iii) Workers' Compensation payments

17 iv) Railroad retirement annuities

18 v) Unemployment insurance payments

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

21 vii) Alimony and support payments

22 j. Support and maintenance in kind - The support and maintenance in kind amount should
23 not be greater than one third of the Federal Benefit Rate (FBR). Use the Presumed
24 Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the
25 support and maintenance in kind amount. Use one third of the FBR if an amount is not
26 declared by the client.

27 6. For the purpose of determining eligibility for the Long Term Care and Aged, Blind, and Disabled
28 Medical Assistance categories the following shall be exempt from consideration as either income
29 or resources:

30 a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a
31 repayment agreement. Declaration of such loans is sufficient verification.

32 b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older
33 Americans Act.

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1 c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive
2 payments (lump sum) for nine months following receipt and the remainder countable as a
3 resource thereafter.

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5 d. The value of supplemental food assistance received under the special food services
6 program for children provided for in the National School Lunch Act and under the Child
7 Nutrition Act, including benefits received from the special supplemental food program for
8 women, infants and children (WIC).

9 e. Home produce utilized for personal consumption.

10 f. Payments received under Title II of the Uniform Relocation Assistance and Real Property
11 Acquisition Policies Act; relocation payments to a displaced homeowner toward the
12 purchase of a replacement dwelling are considered exempt for up to 6 months.

13 g. The value of any assistance paid with respect to a dwelling unit is excluded from income
14 and resources if paid under:

15 i) Experimental Housing Allowance Program (EHAP) payments made by HUD
16 under section 23 of the U.S. Housing Act.

17 ii) The United States Housing Act of 1937 (§ 1437 et seq. of 42 U.S.C.)

18 iii) The National Housing Act (§ 1701 et seq. of 12 U.S.C.)

19 iv) Section 101 of the Housing and Urban Development Act of 1965 (§ 1701s of 12
20 U.S.C., § 1451 of 42 U.S.C.);

21 v) Title V of the Housing Act of 1949 (§ 1471 et seq. of 42 U.S.C.); or

22 vi) Section 202(h) of the Housing Act of 1959.

23 h. Payments made from Indian judgment funds and tribal funds held in trust by the
24 Secretary of the Interior and/or distributed per capita; and initial purchases made with
25 such funds. (Public Law No 98-64 and Public Law No. 97-458).

26 i. Distributions from a native corporation formed pursuant to the Alaska Native Claims
27 Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to
28 exceed $ 2000 per individual per calendar year; stock; a partnership interest; or an
29 interest in a settlement trust. Cash payments, up to $ 2000, received by a client in one
30 calendar year which is retained into subsequent years is excluded as income and
31 resources; however, cash payments up to $ 2000 received in the subsequent year would
32 be excluded from income in the month(s) received but counted as a resource if retained
33 beyond that month(s).

34 j. Assistance from other agencies and organizations.

35 k. Major disaster and emergency assistance provided to individuals and families, and
36 comparable disaster assistance provided to states, local governments and disaster
37 assistance organizations shall be exempt as income and resources in determining
38 eligibility for Medical Assistance.

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1 l. Payments received for providing foster care.

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4 m. Payments to volunteers serving as foster grandparents, senior health aids, or senior
5 companions, and to persons serving in the Service Corps of Retired Executives (SCORE)
6 and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when
7 the value of all such payments adjusted to reflect the number of hours such volunteers
8 are serving is not equivalent to or greater than the minimum wage, and Title II and Title III
9 of the Domestic Volunteer Services Act.

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

12 o. Training allowances granted by the Workforce Investment Act (WIA) to enable any
13 individual whether dependent child or caretaker relative, to participate in a training
14 program

15 p. Payments received from the youth incentive entitlement pilot projects, the youth
16 community conservation and improvement projects, and the youth employment and
17 training programs under the Youth Employment and Demonstration Project Act.

18 q. Social Security benefit payments and the accrued amount thereof to a client when an
19 individual plan for self-care and/or self-support has been developed. In order to disregard
20 such income and resources, it shall be determined that (1) SSI permits such disregard
21 under such developed plan for self-care-support goal, and (2) assurance exists that the
22 funds involved will not be for purposes other than those intended.

23 r. Monies received pursuant to the "Civil Liberties Act of 1988" P.L. No. 100-383, (by
24 eligible persons of Japanese ancestry or certain specified survivors, and certain eligible
25 Aleuts).

26 s. Payments made from the Agent Orange Settlement Fund or any fund established
27 pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No
28 381 (E.D.N.Y).

29 t. A child receiving subsidized adoption funds shall be excluded from the Medical
30 Assistance budget unit and his income shall be exempt from consideration in determining
31 eligibility, unless such exclusion results in ineligibility for the other members of the
32 household.

33 u. The Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the
34 month it is received and for the following month.

35 v. Any money received from the Radiation Exposure Compensation Trust Fund, Including
36 the Energy Employees Occupational Illness Compensation Program Act, pursuant to P.L.
37 No. 101-426 as amended by P.L. No. 101-510.

38 w. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are
39 actual expenses for food, housing, medical items, clothing, transportation, or personal
40 needs items.

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1 x. Payments to individuals because of their status as victims of Nazi persecution pursuant
2 to Public Law No. 103-286.

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

5 z. All wages paid by the United States Census Bureau for temporary employment related to
6 the decennial Census.

7 aa. Any grant or loan to an undergraduate student for educational purposes made or insured
8 under any programs administered by the Commissioner of Education (Basic Education
9 Opportunity Grants, Supplementary Education Opportunity Grants, National Direct
10 Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program,
11 the BYRD Honor Scholarship programs and the College Work Study Program.

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

14 cc. Financial assistance received under the Carl D. Perkins Vocational and Applied
15 Technology Education Act that is made available for attendance cost shall not be
16 considered as income or resources. Attendance cost includes tuition, fees, rental or
17 purchase of equipment, materials or supplies required of all students in the same course
18 of study, books, supplies, transportation, dependent care and miscellaneous personal
19 expenses of students attending the institution on at least a half-time basis, as determined
20 by the institution.

21 dd. The additional unemployment compensation of $25 a week enacted through the
22 American Recovery and Reinvestment Act of 2009.

23 **8.100.5.G. Deeming Of Income And Resources For The OAP Program**

24 1. All aliens who apply for OAP on or after April 16, 1988, for three years after the date of admission
25 into the United States, shall have the income and resources of their sponsors other than relatives
26 deemed for their care. Refer to the Medical Assistance General Eligibility Requirements section
27 8.100.3.K for specific information on deeming of income and resources.

28 **8.100.5.H. Income Allocations and Disregards**

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

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

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

35 a. Income of spouses living together is considered mutually available for SSI related, OAP,
36 and Medicare Savings Programs (MSP).

37 b. For a person living in the household of another and not paying shelter costs, one third of
38 the Federal Benefit Rate (FBR) is counted as in-kind income and is added to the
39 countable income. This does not apply to unemancipated children.

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1 2. For the purposes of this rule, the following definitions apply:

2 a. unemancipated child is:

3 i) a child under age 18 who is living in the same household with a parent or spouse
4 of a parent, or

5 ii) a child under age 21 who is living in the same household with a parent or spouse
6 of a parent, if the child is regularly attending a school, college, or university, or is
7 receiving technical training designed to prepare the child for gainful employment.

8 b. Ineligible child is a child who is not applying or eligible for SSI.

9 c. Ineligible parent/spouse is a parent or spouse who is not applying or eligible for SSI.

10 3. Countable income is calculated by reducing the gross income by the following allocations and
11 disregards.

12 a. Income allocations are the part of the gross income that is allocated to individuals in the
13 home who are not eligible for Supplemental Security Income or Old Age Pension. The
14 allocation reduces the gross income that is deemed available to the applicant/client. The
15 allocation is deducted from the gross income prior to applying the other disregards.

16 The allocations are:

17 i) An Ineligible Child Allocation is an amount equal to one half the current year's
18 SSI FBR that is disregarded from the ineligible parents' gross income. This
19 allocation is used to meet the needs of ineligible children in the household. This
20 allocation is available for each ineligible child in the home. The amount of the
21 allocation is reduced by any of the ineligible child's own income.

22 ii) An Ineligible Parent(s) Allocation is an amount equal to the current year's SSI
23 FBR for a single individual or a couple, as applicable. This amount is used to
24 meet the needs of the ineligible parent(s) in the home with an applicant/client
25 child.

26 iii) No allocations are allowed for applicant/recipient spouses who do not have
27 children in the home.

28 b. Allocations are applied to the income in the following manner:

29 i) Allocation disregards are deducted from unearned income before earned income.

30 ii) Ineligible child allocation disregards are deducted from parents' income before
31 any standard disregards are applied.

32 iii) Ineligible parent(s) allocation disregards are deducted after any ineligible child
33 allocation disregards and after the standard income disregards.

34 4. Income disregards

35 a. $20 General Income Disregard

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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.

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1 **8.100.5.J. Income-Producing Property**

2 1. Net rental income from an exempt home or a life estate interest in an exempt home is countable
3 after the following allowable deductions:

4 a. Property taxes and insurance

5 b. Necessary reasonable routine maintenance expenses

6 c. Reasonable management fee for a professional property manager.

7 2. Non-business property that is necessary to produce goods or services essential to self- support is
8 excluded up to $6,000.

9 3. Property used in a trade or business which is essential to self-support is excluded up to a limit of
10 $6,000 if it produces 6% return of the $6,000 excluded value.

11 **8.100.5.K. Department of Veterans Affairs (VA) Payments**

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

14 1. The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical
15 Expenses (UME), as determined by the VA, shall not be used as patient payment to the medical
16 facility:

17 a. for a veteran or surviving spouse of a veteran in a medical facility other than State
18 Veterans Home; or

19 b. for a veteran or surviving spouse of a veteran in a State Veterans Home with
20 dependents.

21 2. For a veteran or surviving spouse of a veteran in a State Veterans Home with no dependents the
22 portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses
23 (UME), as determined by the VA, shall be used as patient payment to the medical facility.

24 **8.100.5.L. Reverse Mortgages**

25 1. In accordance with C.R.S. § 11-38-110, reverse mortgages payments made to a borrower shall
26 not be treated as income for eligibility purposes.

27 2. Funds remaining the following month after the payment is made will be countable as a resource.

28 3. Any payments from a reverse mortgage that are transferred to another individual without fair
29 consideration shall be analyzed in accordance with the rules on transfers without fair
30 consideration in the Long-Term Care section and may result in a penalty period of ineligibility.

31 **8.100.5.M. Resource Requirements**

32 1. Consideration of resources: Resources are defined as cash or other assets or any real or
33 personal property that an individual or spouse owns. The resource limit for an individual is
34 $2,000. For a married couple, the resource limit is $3,000. If one spouse is institutionalized, refer
35 to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses.
36 Effective January 1, 2011, the resource limits for the Qualified Medicare Beneficiaries (QMB),

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1 Specified Low Income Medicare Beneficiaries (SLMB), and Qualified Individuals 1 (QI-1)
2 programs are $8,180 for a single individual and $13,020 for a married individual living with a
3 spouse and no other dependents. The resource limits for the QMB, SLMB, and QI programs shall
4 be adjusted annually by the Centers for Medicare and Medicaid Services on January 1 of each
5 year. These resource limits are based upon the change in the annual consumer price index (CPI)
6 as of September of the previous year. Resources are not counted for the Medicaid Buy-In
7 Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with
8 Disabilities.

9 2. The following resources are exempt in determining eligibility:

10 a. A home, which is any property in which an individual or spouse of an individual has an
11 ownership interest and which serves as the individual's principal place of residence. The
12 property includes the shelter in which an individual resides, the land on which the shelter
13 is located and related outbuildings.

14 i) Only one principal place of residence is excluded for a single individual or a
15 married couple.

16 ii) The individual's ownership interest in the home must have an equity value that:

17 1) From January 1, 2006 thru December 31, 2010 is $500,000 or less, or;

18 2) Is less than the amount that results from the year to year percentage
19 increase to the $500,000 limit. The increase is based upon the consumer
20 price index for all urban consumers (all items; United States city
21 average), rounded to the nearest $1,000.

22 iii) If an individual or spouse of an individual owns a home of any value located
23 outside Colorado, and if the individual intends to return to that home, then the
24 individual does not meet the residency requirement for Colorado Medicaid
25 eligibility.

26 iv) If an individual or spouse of an individual owns a home of any value located
27 outside Colorado, and if the individual does not intend to return to that home,
28 then the home is a countable resource unless the individual's spouse or
29 dependent relative lives in the home.

30 v) If an individual or spouse of an individual owns a home located inside Colorado
31 with an equity value lower than the limit in subparagraph (1), above, and if the
32 individual intends to return to that home, then the home is considered an exempt
33 resource if:

34 1) The individual is institutionalized; and

35 2) The intent to return home is documented in writing.

36 vi) If an individual or spouse of an individual owns a home with an equity value
37 greater than the limit that is located inside Colorado, and if the individual intends
38 to return to that home, then the home is considered to be a countable resource
39 unless spouse or dependent relative lives in the home.

40 vii) If an individual or spouse of an individual owns a home of any value located
41 inside Colorado, and if the individual does not intend to return to that home, then

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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.

1 v) The client must continue reasonable efforts to sell and must submit verification of
2 these efforts to the Eligibility Site on a quarterly basis. Reasonable effort is at
3 Eligibility Site discretion.

4 vi) If the exemption is used to become eligible under the Spousal Protection rules,
5 the property shall continue to be viewed according to 8.100.7.L while efforts to
6 sell it are being made.

7 vii) Eligibility under this exemption is conditional. Once the property sells, the client
8 shall be ineligible until the resources are below the prescribed limit.

9 c. One automobile is totally excluded regardless of its value if it is used for transportation for
10 the individual or a member of the individual's household. An automobile includes, in
11 addition to passenger cars, other vehicles used to provide necessary transportation.

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

14 i) Items of personal property, found in or near the home, that are used on a regular
15 basis; or

16 ii) Items needed by the household for maintenance, use and occupancy of the
17 premises as a home.

18 iii) Such items include but are not limited to: furniture, appliances, electronic
19 equipment such as personal computers and television sets, carpets, cooking and
20 eating utensils, and dishes.

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

23 i) Items of personal property ordinarily worn or carried by the individual; or

24 ii) Articles otherwise having an intimate relation to the individual.

25 iii) Such items include but are not limited to: personal jewelry including wedding and
26 engagement rings, personal care items, prosthetic devices, and educational or
27 recreational items such as books or musical instruments.

28 iv) Items of cultural or religious significance to the individual and items required
29 because of an individual's impairment are also not counted as a resource.

30 f. The cash surrender value of all life insurance policies owned by an individual and
31 spouse, if any, is exempt if the total face value of all life insurance policies does not
32 exceed $1,500 on any person. If the total face value of all the life insurance policies
33 exceeds $1,500 on one person, the cash surrender value of those policies will be
34 counted.

35 g. Term life insurance having no cash surrender value, and burial insurance, the proceeds
36 of which can be used only for burial expenses, are not countable toward the resource
37 limit.

38 h. The total value of burial spaces for the applicant/recipient, his/her spouse and any other
39 members of his/her immediate family is exempt as a resource. If any interest is earned on

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1 the value of an agreement for the purchase of a burial space, such interest is also
2 exempt.

3 i. An applicant or recipient may own burial funds through an irrevocable trust or other
4 irrevocable arrangement which are available for burial and are held in an irrevocable
5 burial contract, an irrevocable burial trust, or in an irrevocable trust which is specifically
6 identified as available for burial expenses without such funds affecting the person's
7 eligibility for assistance.

8 j. An applicant or recipient may also own up to $1,500 in burial funds through a revocable
9 account, trust, or other arrangement for burial expenses, without such funds affecting the
10 person's eligibility for assistance. This exclusion only applies if the funds set aside for
11 burial expenses are kept separate from all other resources not intended for burial of the
12 individual or spouse's burial expenses. Interest on the burial funds is also excluded if left
13 to accumulate in the burial fund. For a married couple, a separate $1,500 exemption
14 applies to each spouse.

15 The $1,500 exemption is reduced by:

16 i) the amount of any irrevocable burial funds such as are described in the
17 preceding subparagraph, and

18 ii) the face value of any life insurance policy whose cash surrender value is exempt.

19 k. Achieving a Better Life Experience (ABLE) Accounts.

20 3. Countable resources include the following:

21 a. Cash;

22 b. Funds held by a financial institution in a checking or savings account, certificate of
23 deposit or money market account;

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

25 d. All funds in a joint account are presumed to be a resource of the applicant or client. If
26 there is more than one applicant or client account holder, it is presumed that the funds in
27 the account belong to those individuals in equal shares. To rebut this presumption,
28 evidence must be furnished that proves that some or all of the funds in a jointly held
29 account do not belong to him or her. To rebut the sole ownership presumption, the
30 following procedure must be followed:

31 i) Submit statements from all of the account holders regarding who owns the funds,
32 why there is a joint account, who has made deposits and withdrawals, and how
33 withdrawals have been spent.

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

36 iii) Correct the account title and submit revised account records showing that the
37 applicant or client is no longer an account holder or separate the funds to show
38 they are solely owned by the individual within 45 days.

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

3 f. For applications filed on or after January 1, 2006, an individual's home if the individual's
4 equity interest in the home exceeds the equity value limit described at 8.100.5.M.2.a.i)1).

5 g. Real property not exempt as the principal place of residence and not exempt as income
6 producing property with a value of $6,000 or less, as described at 8.100.5.J.

7 h. When the applicant alleges that the sale of real property would cause undue hardship to
8 the co-owner due to loss of housing, all of the following information must be obtained:

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

10 ii) Verification of joint ownership.

11 iii) A statement from the co-owner verifying the following:

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

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

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

16 4) There is no other readily available residence because there is no other
17 affordable housing available or no other housing with the necessary
18 modifications for the co-owner if he is a person with disabilities.

19 i. Personal property such as a mobile home or trailer or the like, that is not exempt as a
20 principal place of residence or that is not income producing.

21 j. Personal effects acquired or held for their value or as an investment. Such items can
22 include but are not limited to: gems, jewelry that is not worn or held for family
23 significance, or collectibles.

24 k. The equity value of all automobiles that are in addition to one exempt vehicle.

25 l. The cash surrender value of all life insurance policies owned by an individual and spouse
26 is counted if the total face value of all the policies combined exceeds $1,500 on any
27 person.

28 m. Promissory notes established before April 1, 2006 are treated as follows:

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

31 ii) In order to determine the fair market value, the applicant shall obtain three
32 estimates of fair market value from a private note broker, who is engaged in the
33 business of purchasing such notes. In order to obtain the estimates and locate
34 willing buyers, the note shall be advertised in a newspaper with state wide
35 circulation under business or investment opportunities.

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1 iii) A note or similar instrument which transferred funds or assets for less than fair
2 consideration shall be considered as a transfer for less than fair consideration
3 and a period of ineligibility shall be imposed.

4 n. Promissory notes established on or after April 1, 2006 and before March 1, 2007 are
5 treated as follows:

6 i) The value of a promissory note, loan or mortgage is an available countable
7 resource unless the note, loan or mortgage:

8 1) Has a repayment term that is actuarially sound based on the individual's
9 life expectancy, found in the tables at 8.100.7.J, for annuities purchased
10 on or after February 8, 2006;

11 2) Provides for payments to be made in equal amounts during the term of
12 the loan, with no deferral and no balloon payments made; and

13 3) Prohibits the cancellation of the balance upon the death of the lender.

14

15 ii) The value of a promissory note, loan or mortgage which does not meet the
16 criteria in outlined in 8.100.5.M.3.n.i)1)-3) is the outstanding balance due as of
17 the date of the individual's application for HCBS, PACE or institutional services
18 and is subject to the transfer of assets without fair consideration provisions as
19 outlined in section 8.100.7.F.

20 o. Promissory notes established on or after March 1, 2007 are treated as follows:

21 i) The value of a promissory note, loan or mortgage is the outstanding balance due
22 as of the date of the individual's application for HCBS, PACE or institutional
23 services and is an available countable resource, and

24 ii) A promissory note, loan or mortgage which does not meet the following criteria
25 shall be considered to be a transfer without fair consideration and shall be
26 subject to the provisions outlined at 8.100.7.F.

27 1) Has a repayment term that is actuarially sound based on the individual's
28 life expectancy as found in the tables in section 8.100.7.J for annuities
29 purchased on or after February 8, 2006;

30 2) Provides for payments to be made in equal amounts during the term of
31 the loan, with no deferral and no balloon payments made; and

32 3) Prohibits the cancellation of the balance upon the death of the lender.

33 p. Mineral rights represent ownership interest in natural resources such as coal, oil, or
34 natural gas, which normally are extracted from the ground.

35 i) Ownership of land and mineral rights. If the individual owns the land to which the
36 mineral rights pertain, the current market value of the land generally includes the
37 value of the mineral rights.

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1 ii) If the individual does not own the land to which the mineral rights pertain, the
2 individual should obtain a current market value estimate from a knowledgeable
3 source. Such sources may include:

4 1) any mining company that holds leases;

5 2) the Bureau of Land Management;

6 3) the U.S. Geological Survey.

7 **8.100.5.N. Treatment of Self-Funded Retirement Accounts**

8 1. The following regulations apply to self-funded retirement accounts such as an Individual
9 Retirement Account (IRA), Keogh Plan, 401(k), 403(b) and any other self-funded retirement
10 account.

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

13 3. Self-funded retirement accounts in the name of the applicant's spouse who is living with the
14 applicant are exempt in determining eligibility for the applicant, except as set forth in 4. below.

15 4. Self-funded retirement accounts in the name of a community spouse who is married to an
16 applicant who is applying for Long Term Care in a Long Term Care institution, HCBS or PACE,
17 are countable as a resource to the applicant and may be included in the Community Spouse
18 Resource Allowance (CSRA) up to the maximum amount allowable. The terms community
19 spouse and CSRA are further defined in the regulations on Spousal Protection in this volume.

20 5. The value of a self-funded retirement account is determined as follows:

21 a. The gross value of the account, less any taxes due, is the amount that is countable as a
22 resource, regardless of whether any monthly income is being received from the account.

23 b. If the applicant is not able to provide the amount of taxes that are due, the value shall be
24 determined by deducting 20% from the gross value of the account.

25 **8.100.5.O. Treatment of Inheritances**

26 1. An inheritance is cash, other liquid resources, non-cash items, or any right in real or personal
27 property received at the death of another.

28 2. If an Individual or individual's spouse is the beneficiary of a will, the inheritance is presumed to be
29 available at the conclusion of the probate process or within 6 months if the estate is not in
30 probate.

31 3. If an individual or individual's spouse is eligible for a family allowance in a probate proceeding,
32 that allowance will be considered available three months after death or when actually available,
33 whichever is sooner.

34 4. Evidence demonstrating that the inheritance is not available due to probate or other legal
35 restrictions must be provided to rebut the presumption.

36 **8.100.5.P. Treatment of Proceeds from Disposition of Resources**

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

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

4 2. The net proceeds are the selling price less any valid encumbrances and costs of sale.

5 3. After deducting any amount necessary to raise the individual's and spouse's resources to the
6 applicable limits, the balance of the net proceeds, in excess of the resource limits, shall be
7 considered available resources. In lieu of terminating eligibility due to excess resources, the client
8 may request that the proceeds be used to reimburse the Medical Assistance Program for
9 previous payments for Medical Assistance.

10 4. The proceeds from the sale of an exempt home will be excluded to the extent they are intended
11 to be used and are, in fact, used to purchase another home in which the individual, a spouse or
12 dependent child resides, within three months of the date of the sale of the home.

13

14

15

16 **8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility**

17 **8.100.6.A. Aged, Blind, and Disabled (ABD) General Information**

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

21 **8.100.6.B. Disability Determinations**

22 1. Beginning on July 1, 2001, the Department or its contractor shall determine whether the client is
23 disabled or blind in accordance with the requirements and procedures set forth elsewhere in this
24 volume and according to Federal regulations regarding disability determinations.

25 2. A client who disagrees with the decision on disability or blindness shall have the right to appeal
26 that decision to a state-level fair hearing in accordance with the procedures at 8.057.

27 **8.100.6.C. SSI Eligibles**

28 1. Benefits of the Colorado Medical Assistance Program must be provided to the following:

29 a. persons receiving financial assistance under SSI;

30 b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

31 c. persons receiving SSI payments based on presumptive eligibility for SSI pending final
32 determination of disability or blindness; and persons receiving SSI payments based on
33 conditional eligibility for SSI pending disposal of excess resources.

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1 2. The Department has entered into an agreement with SSA in which SSA shall determine Medical
2 Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving
3 SSI benefits as determined by SSA to be eligible for Medical Assistance.

4 3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly
5 approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the
6 necessary information for the eligibility site to authorize Medical Assistance.

7 4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and
8 obtain third party medical resources.

9 5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical
10 Assistance.

11 6. The SISC Code for this type of assistance is B.

12 7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later
13 overturned, must be approved from the original SSI eligibility date.

14 8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive
15 Medical Assistance benefits. This group includes persons whose SSI payments are being
16 withheld as a means of recovering an overpayment, whose checks are undeliverable due to
17 change of address or representative payee, and persons who lost SSI financial assistance due to
18 earned income.

19 9. If the eligibility site obtains information affecting the eligibility of these SSI recipients, they shall
20 forward such information to the local Social Security office.

21 10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective
22 date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on
23 which the individual became eligible for SSI, whichever is later.

24 a. Special Provisions for Infants

25 i) For an infant who is eligible for or who is receiving SSI, the effective date of
26 Medicaid eligibility shall be the infant's date of birth if:

27 1) the infant was born in a hospital;

28 2) the disability onset date, as reported by the Social Security
29 Administration, occurred during the infant's hospital stay; and

30 3) the infant's date of birth is within three (3) months of the date on which
31 the infant became eligible for SSI

32 **8.100.6.D. Pickle Amendment**

33 1. Beginning July 1977, Medical Assistance must be provided to an individual if their countable
34 income is below the current years SSI standard after a cost of living adjustment (COLA) disregard
35 is applied to their OASDI (excluding Railroad Retirement Benefits) and they meet all other
36 eligibility criteria. This is referred to as Pickle Disregard.

37 2. The Pickle Disregard applies to an individual who:

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1 a. lost SSI and/or OAP because of a cost of living adjustment to his/her own OASDI
2 benefits.

3 b. lost SSI and/or OAP because a cost of living adjustment to OASDI income deemed from
4 a parent or spouse.

5 c. lost OAP and/or SSI due to the receipt of, or increase to, OASDI, and would be eligible
6 for OAP and/or SSI if all COLA'S on the amount that caused them to lose eligibility is
7 disregarded from their current OASDI amount.

8 **8.100.6.E. Pickle Determination**

9 1. To determine eligibility of Medical Assistance recipients to whom the Pickle disregards apply, the
10 eligibility site must:

11 a. establish whether the person was eligible for SSI or OAP and, for the same month, was
12 entitled to OASDI;

13 b. determine the previous amount of the OASDI that caused them to lose SSI and/or OAP;

14 c. determine the current OASDI income;

15 d. subtract the previous OASDI income from the current OASDI income to find the
16 cumulative OASDI COLAs since SSI and/or OAP was lost. This is the Pickle Disregard
17 amount;

18 e. subtract the Pickle Disregard amount from the current OASDI income to get the
19 countable OASDI income.

20 2. If the countable OASDI income and all other countable income is less than the current SSI or
21 OAP standard, and the individual meets all other eligibility criteria then medical eligibility must
22 continue or be reinstated.

23 3. This disregard must also be applied to any OASDI cost of living increases paid to any financially
24 responsible individual such as a parent or spouse whose income is considered in determining the
25 person's continued eligibility for Medical Assistance.

26 4. The cost of living increase disregard specified in the preceding action must continue to be applied
27 at each eligibility redetermination.

28 5. An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be
29 contacted by the eligibility site to determine if the individual would continue to remain eligible for
30 Medical Assistance under the provisions for SSI related cases. The individual must complete an
31 application for assistance to continue receiving benefits.

32 **8.100.6.F. 1972 Disregard Individuals**

33 1. Medical Assistance must be provided to a person who was receiving financial assistance under
34 AND or Aid to the Blind (AB) for August 1972 and who – except for the October 1972 Social
35 Security (includes RRB) 20% increase amount would currently be eligible for financial assistance.
36 This disregard must also be applied to a person receiving Medical Assistance in August 1972
37 who was eligible for financial assistance but was not receiving the money payment and to a
38 person receiving Medical Assistance as a resident in a medical institution in August 1972.

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1 2. To redetermine the eligibility of Medical Assistance recipients to whom the 1972 disregard
2 applies, the eligibility site must:

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

4 b. apply the resource and income criteria specified in section 8.100.5;

5 c. subtract the 1972 disregard amount from the income;

6 d. consider the remainder against the current appropriate SSI benefit level.

7 **8.100.6.G. Individuals Eligible in 1973**

8 1. Medical Assistance must be provided to ABD persons who are receiving mandatory state
9 supplementary payments (SSP). Such persons are those with income below their December
10 1973 minimum income level (MIL).

11 2. Medical Assistance must be provided to a person who was eligible for Medical Assistance in
12 December 1973 as an inpatient of a medical facility, who continues to meet the December 1973
13 eligibility criteria for institutionalized persons and who remains institutionalized.

14 3. Medical Assistance must be provided to a person who was eligible for Medical Assistance in
15 December 1973 as an "essential spouse" of an AND or AB financial assistance recipient, and
16 who continues to be in the grant and continues to meet the December 1973 eligibility criteria.
17 Except for such persons who were grandfathered-in for continued assistance, essential spouses
18 included in assistance grants after December 1973 are not eligible for Medical Assistance.

19 **8.100.6.H. Eligibility for Certain Disabled Widow(er)s**

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

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

24 a. have been continuously entitled to Title II benefits since December 1983;

25 b. have been disabled widow(er)s in January 1984;

26 c. have established entitlement to Title II benefits prior to age 60;

27 d. have been eligible for SSI/SSP benefits prior to application of the revised actuarial
28 reduction formula;

29 e. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial
30 table; and

31 f. reapply for assistance prior to July 1, 1987.

32 **8.100.6.I. Eligibility for Disabled Widow(er)s**

33 1. Effective January 1, 1991, Medical Assistance shall be provided to disabled widow(er)s age 50
34 through 64 who lost SSI and/or OAP due to the receipt of Social Security benefits as a disabled

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1 widow(er). The individual shall remain eligible for Medical Assistance until he/she becomes
2 eligible for Part A of Medicare (hospital insurance).

3 To qualify these individuals must:

4 a. be a widow(er);

5 b. have received SSI in the past;

6 c. be at least 50 years old but not 65 years old;

7 d. no longer receive SSI payments because of Social Security payments;

8 e. not have hospital insurance under Medicare; and,

9 f. meet all other Medical Assistance requirements.

10 **8.100.6.J. Disabled Adult Children**

11 1. Medical Assistance shall be provided to an individual aged 18 or older who loses SSI due to the
12 receipt of OASDI drawn from his/her parents' Social Security Number; and:

13 a. who was determined disabled prior to the age of 22; and

14 b. who is currently receiving OASDI income as a Disabled Adult Child; and

15 c. who would continue to be eligible for SSI if:

16 i) the current OASDI income of the applicant is disregarded; and

17 ii) the resources are below the applicable limit as listed at 8.100.5.M; and

18 iii) other countable income is below the current years SSI FBR.

19 2. Disabled Adult Children are identified by the OASDI Beneficiary Identification Code (BIC) of “C”.

20 **8.100.6.K. Old Age Pension (OAP) Eligibles**

21 1. Individuals that are 65 and over are defined as the OAP-A category. Individuals who attain the
22 age of 60 but not yet 65 are defined as the OAP-B category.

23 2. Medical Assistance must be provided to persons receiving OAP-A or OAP-B and SSI (SISC B).

24 3. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI
25 eligibility criteria but are not receiving a money payment (SISC-B).

26 4. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI
27 eligibility criteria except for the level of their income (SISC-B).

28 5. Medical Assistance must be provided to persons in a facility eligible for Medical Assistance
29 reimbursement whose income is under 300% of the SSI benefit level and who, but for the level of
30 their income, would be eligible for OAP “A” or OAP “B” and SSI financial assistance. This group
31 includes persons 65 years of age or older receiving active treatment as inpatients in a psychiatric

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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

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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.

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1 4. For SLMB purposes, income of the applicant and/or the spouse shall be determined as described
2 under Income Requirements in section 8.100.5. If two or more individuals have earned income,
3 the income of all the individuals shall be added together and the $65 plus one half remainder
4 earned income disregard shall be applied to the total amount of earned income.

5 5. SLMB eligibility starts on the date of application or up to three month prior to the application date
6 for retroactive Medical Assistance.

7 6. Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.

8 7. Clients who would lose their SLMB entitlement due to annual SSA COLA will remain eligible for
9 SLMB coverage, as income disregard cases, through the month following the month in which the
10 annual federal poverty levels (FPL) update is published.

11 **8.100.6.N. Medicare Qualifying Individuals 1 (QI1)**

12 1. Medical Assistance coverage is limited to monthly payment of Medicare Part B premiums.
13 Payment of the premium shall be made by the Department on behalf of the individual.

14 2. Eligibility for this benefit is limited by the availability of the allocation set by CMS. Once the state
15 allocation is met, no further benefits under this category shall be paid and a waiting list of eligible
16 individuals shall be maintained.

17 3. Eligibility for QI1 benefits shall be effective the month in which application is made and the
18 individual is eligible for benefits. Eligibility may be retroactive up to three months from the date of
19 application, but not prior to January 1, 1998.

20 4. In order to qualify as a Medicare Qualifying Individual 1, the individual must meet the following:

21 a. be entitled to Part A of Medicare,

22 b. income of at least 120%, but less than 135% of the FPL.

23 c. resources may not exceed the standard as described in section 8.100.5.M, and

24 d. he/she cannot otherwise be eligible for Medical Assistance.

25 5. For QI1 purposes, income of the applicant and/or the spouse shall be determined as described
26 under Income Requirements in section 8.100.5. If two or more individuals have earned income,
27 the income of all the individuals shall be added together and the $65 plus one half remainder
28 earned income disregard shall be applied to the total amount of earned income.

29 6. Clients who would lose QI-1 entitlement due to annual social security COLA will remain eligible
30 for QI-1 coverage under Medical Assistance, as an income disregard case, until the next year's
31 federal poverty guidelines are published.

32 **8.100.6.O. Qualified Disabled And Working Individuals**

33 1. Medical Assistance coverage is limited to monthly payment of Medicare Part A premiums, and
34 any other Medicare cost sharing expenses determined necessary by CMS.

35 2. Effective July 1, 1990, a Qualified Disabled and Working Individual (QDWI) is an individual who:

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1 a. was a recipient of federal Social Security Disability Insurance (SSDI) benefits, who
2 continues to be disabled but lost SSDI entitlement due to earned income in excess of the
3 Social Security Administration's Substantial Gainful Activity (SGA) threshold, and;

4 b. has exhausted SSA's allowed extension of "premium free" Medicare Part A coverage
5 under SSDI, and;

6 c. has resources at or below twice the SSI resource limit as described in section 8.100.5.,
7 and;

8 d. has income less than 200% of FPL.

9 3. For QDWI purposes, income of the applicant and/or the spouse shall be determined as described
10 under Income Requirements in section 8.100.5. If two or more individuals have earned income,
11 the income of all the individuals shall be added together and the $65 plus one half remainder
12 earned income disregard shall be applied to the total amount of earned income.

13 4. An individual may be eligible under this section only if he/she is not otherwise eligible under
14 another Medical Assistance category of eligibility.

15 5. Eligibility for QDWI benefits shall be effective the month of determination of entitlement.

16 6. Eligibility may be retroactive only to the date as of which SSA approves an individual's application
17 for coverage as a "Qualified Disabled and Working Individual". However, eligibility may not begin
18 prior to 07/01/90.

19 **8.100.6.P. Medicaid Buy-In Program for Working Adults with Disabilities.**

20 1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:

21 a. Applicants must be at least age 16 but less than 65 years of age.

22 b. Income must be less than or equal to 450% of FPL after income allocations and
23 disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income allocations
24 and disregards. Only the applicant's income will be considered.

25 c. Resources are not counted in determining eligibility.

26 d. Individuals must have a disability as defined by Social Security Administration medical
27 listing or a limited disability as determined by a state contractor.

28 e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.
29
30 i) Due to the federal COVID-19 Public Health Emergency, and required by the Federal
31 CARES Act for the Maintenance of Effort (MOE), members who had a loss of
32 employment will remain in the Buy-In program until the end of the federal Public Health
33 Emergency. At the end of the federal Public Health Emergency, members will be
34 redetermined based on their current employment status. New applicants enrolled will
35 still need to meet the work requirement.

36 8

37 f. Individuals will be required to pay monthly premiums on a sliding scale based on income.

1 i) The amount of premiums cannot exceed 7.5% of the individual's income.

2 ii) Premiums are charged beginning the month after determination of eligibility. Any
3 premiums for the months prior to the determination of eligibility will be waived.

4 iii) Premium amounts are as follows:

5 1) There is no monthly premium for individuals with income at or below 40%
6 FPL.

7 2) A monthly premium of $25 is applied to individuals with income above
8 40% of FPL but at or below 133% of FPL.

9 3) A monthly premium of $90 is applied to individuals with income above
10 133% of FPL but at or below 200% of FPL.

11 4) A monthly premium of $130 is applied to individuals with income above
12 200% of FPL but at or below 300% of FPL.

13 5) A monthly premium of $200 is applied to individuals with income above
14 300% of FPL but at or below 450% of FPL./

15 iv) The premium amounts will be updated at the beginning of each State fiscal year
16 based on the annually revised FPL if the revised FPL would cause the premium
17 amount (based on percentage of income) to increase by $10 or more.

18 v) A change in client net income may impact the monthly premium amount due.
19 Failure to pay premium payments in full within 60 days from the premium due
20 date will result in client's assistance being terminated prospectively. The effective
21 date of the termination will be the last day of the month following the 60 days
22 from the date on which the premium became past due.

23 vi) Due to the federal COVID-19 Public Health Emergency, the Department will
24 waive premiums for the Medicaid Buy-In for Working Adults with Disability
25 Program during the federal COVID-19 emergency declaration. -Once the federal
26 emergency declaration has concluded, the Department will notify all members as
27 to when required premiums will resume. .

28 2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to
29 program implementation

30 3. Individuals have the option to request to be disenrolled if they have been enrolled into the
31 Medicaid Buy-In Program for Working Adults with Disabilities. This is also called "opt out."

32 **8.100.6.Q. Medicaid Buy-In Program for Children with Disabilities**

33 1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:

34 a. Applicants must be age 18 or younger.

35 b. Household income will be considered and must be less than or equal to 300% of FPL
36 after income disregards. The following rules apply:

37 i) 8.100.4.E - MAGI Household Requirements

1 ii) 8.100.5.F - Income Requirements

2 iii) 8.100.5.F.6 - Income Exemptions

3 iv) An earned income of $90 shall be disregarded from the gross wages of each
4 individual who is employed

5 v) A disregard of a 33% (.3333) reduction will be applied to the household's net
6 income.

7 c. Resources are not counted in determining eligibility.

8 d. Individuals must have a disability as defined by Social Security Administration medical
9 listing.

10 e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18
11 shall be determined for eligibility through the Medicaid Buy-In Program for Working Adults
12 with Disabilities.

13 f. Families will be required to pay monthly premiums on a sliding scale based on household
14 size and income.

15 i) For families whose income does not exceed 200% of FPL, the amount of
16 premiums and cost-sharing charges cannot exceed 5% of the family's adjusted
17 gross income. For families whose income exceeds 200% of FPL but does not
18 exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot
19 exceed 7.5% of the family's adjusted gross income.

20 ii) Premiums are charged beginning the month after determination of eligibility. Any
21 premiums for the months prior to the determination of eligibility will be waived.

22 iii) For households with two or more children eligible for the Medicaid Buy-In
23 Program for Children with Disabilities, the total premium shall be the amount due
24 for one eligible child.

25 iv) Premium amounts are as follows:

26 1) There is no monthly premium for households with income at or below
27 133% of FPL.

28 2) A monthly premium of $70 is applied to households with income above
29 133% of FPL but at or below 185% of FPL.

30 3) A monthly premium of $90 is applied to individuals with income above
31 185% of FPL but at or below 250% of FPL.

32 4) A monthly premium of $120 is applied to individuals with income above
33 250% of FPL but at or below 300% of FPL.

34 v) The premium amounts will be updated at the beginning of each State fiscal year
35 based on the annually revised FPL if the revised FPL would cause the premium
36 amount (based on percentage of income) to increase by $10 or more.

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1 vi) A change in household net income may impact the monthly premium amount
2 due. Failure to pay premium payments in full within 60 days from the premium
3 due date will result in client's assistance being terminated prospectively. The
4 effective date of the termination will be the last day of the month following the 60
5 days from the date on which the premium became past due.

6 vii) Due to the federal COVID-19 Public Health Emergency, the Department will
7 waive premiums for the Department's Children with Disabilities Program during
8 the federal emergency declaration. Once the federal emergency declaration has
9 concluded, the Department will notify all members as to when required premiums
10 will resume.

11 2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to
12 program implementation.

13 3. Verification requirements will follow the MAGI Category Verification Requirements found at
14 8.100.4.B.

15 4, Individuals have the option to request to be disenrolled if they have been enrolled into the
16 Medicaid Buy-In Program for Children with Disabilities. This is also called "opt out."

17 **8.100.7 Long-Term Care Medical Assistance Eligibility**

18 **8.100.7.A. Persons in Long-Term Care Institutions or Other Residential Placement**

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

23 For a client entering a Long-Term Care Institution from the community, the Eligibility Site must
24 notify the Single Entry Point/Case Management Agency, upon receipt of the application or client
25 request, to schedule the institutional level of care assessment. This is not applicable to a client
26 being discharged from a hospital, nursing facility or Long-Term Home Health.

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

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

34 2. Eligibility under the 300% Institutionalized Special Income category will be provided to applicants
35 who:

36 a. Have attained the age of 65 years or;

37 b. Have met the requirements according to the definition of disability or blindness applicable
38 to the Social Security Disability Insurance (SSDI) and Supplemental Security Income
39 (SSI)

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1 c. Have been institutionalized for at least 30 consecutive full days in a Long-Term Care
2 institution. The 30 consecutive full day stay may be a combination of days in a hospital,
3 Long-Term Care institution, or receiving services from a Home and Community Based
4 Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE).

5 Supporting documentation must be provided which verifies the 30 consecutive full days.
6 This documentation shall include the ULTC 100.2 and/or medical records which must be
7 verified by a physician or case manager.

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

10 i) There is a statement from a physician, or case manager that declares if the client
11 had not died, he/she would have been institutionalized for 30 consecutive full
12 days, and;

13 ii) The statement is verified by supporting documentation from the beginning of the
14 institutionalized period, which is the first 15 days, or prior to the death of the
15 client, whichever is earliest.

16 iii) Once the 30 consecutive days of institutionalization requirement has been met,
17 Medical Assistance benefits start as of the first day when institutionalization
18 began if all other eligibility requirements were met as of that date.

19 d. Are in a facility eligible for Medical Assistance Program reimbursement if the individual is
20 in a hospital or Long-Term Care institution; and

21 e. Have gross income that does not exceed 300% of the current individual SSI benefit level
22 or;

23 Are in a Long-Term Care institution (excluding hospital) whose gross income exceeds the
24 300% level and who establishes an income trust in accordance with the rules on income
25 trusts in section 8.100.7 of this volume;

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

27 1) A person 65 years of age or older, or disabled or blind receiving care in a
28 hospital, nursing facility; or

29 2) A person who is not SSI eligible needing Long-Term Care from HCBS or
30 PACE; or

31 3) A person 65 years of age or older receiving active treatment as an
32 inpatient in a psychiatric facility eligible for Medical Assistance
33 reimbursement; and

34 f. Have resources that conform with the regulations regarding resource limits and
35 exemptions set forth in section 8.100.5 of this volume; and

36 g. If married, Income and resources conform to rules set forth at 8.100.7.C and 8.100.7.K;
37 and

38 h. Have not transferred assets without fair consideration on or after the look-back date
39 defined in section 8.100.7.F.2.d. which would incur a penalty period of ineligibility in

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1 accordance with the regulations on transfers without fair consideration in section 8.100.7
2 of this volume; and

3 i. Have submitted trust documents to the Department if the individual or the individual's
4 spouse has transferred assets into a trust or is a beneficiary of trust. The Department
5 shall determine the effect of the trust on Medical Assistance Program eligibility.

6 j. Have submitted documents verifying that an annuity conforms to the regulations
7 regarding Annuities at 8.100.7.I.

8 3. An appeal process is available to children identified by C.R.S. 27-10.3-101 to 108, The Child
9 Mental Health Treatment Act, who are denied residential treatment. The appeal process is
10 outlined in the Income Maintenance Staff Manual of the Department of Human Services (9 CCR
11 2503-1). A determination made in connection with this appeal shall not be the final agency action
12 with regard to Medical Assistance eligibility

13 **8.100.7.B. Persons Requesting Long-term Care through Home and Community Based**
14 **Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE)**

15 1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry
16 Point/Case Management Agency to have met the functional level of care and will remain in the
17 community by receiving HCBS or PACE; and

18 a. are SSI (including 1619b) or OAP Medicaid eligible; or

19 b. are eligible under the Institutionalized 300% Special Income category described at
20 8.100.7.A; or

21 c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities
22 described at 8.100.6.P. For this group, access to HCBS:

23 i) Is limited to the Elderly, Blind and Disabled (EBD), Community Mental Health
24 Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI) and Supported
25 Living Services (SLS) waivers; and

26 ii) Is contingent on the Department receiving all necessary federal approval for the
27 waiver amendments that extend access to HCBS to the Working Adults with
28 Disabilities population described at 8.100.6.P.

29 2. A client who is already Medicaid eligible does not need to submit a new application. The client
30 must request the need for Long-Term Care services and the Eligibility Site must redetermine the
31 client's eligibility.

32 a. All individuals applying for or requesting Long-Term Care services must disclose and
33 provide documentation of:

34 i) any transfer of assets without fair consideration as described at 8.100.7.F; and

35 ii) any interest in an annuity as described at 8.100.7.I; and

36 iii) any interest in a trust as described at 8.100.7.E.

37 b. Failure to disclose and provide documentation of the assets described at 8.100.7.B.2.a
38 may result in the denial of Long-Term Care services.

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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)

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1 i) In the case of a Medical Assistance qualifying trust, as defined in 42 U.S.C. Sec.
2 1396a(k), the amount of the trust property that is considered available to the
3 applicant/recipient who established the trust (or whose spouse established the
4 trust) is the maximum amount that the trustee(s) is permitted under the trust to
5 distribute to the individual assuming the full exercise of discretion by the
6 trustee(s) for the distribution of the maximum amount to the applicant/recipient.
7 This amount of property is deemed available resources to the individual, whether
8 or not is actually received.

9

10

11 ii) 42 U.S.C. Sec. 1396a(k) was repealed in 1993 and is reprinted here exclusively
12 for purposes of trusts established before August 11, 1993. 42 U.S.C. Sec.
13 1396a(k) defines a Medical Assistance qualifying trust as "a trust, or similar legal
14 device, established (other than by will) by an individual (or an individual's spouse)
15 under which the individual may be the beneficiary of all or part of the payments
16 from the trust and the distribution of such payments is determined by one or
17 more trustees who are permitted to exercise any discretion with respect to the
18 distribution to the individual."

19 b. This provision does not apply to any trust or initial decrees established before April 7,
20 1986, solely for the benefit of a developmentally disabled individual who resides in an
21 Long Term Care Institution for the developmentally disabled.

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

23 2. Trusts established on or after July 1, 1994:

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

27 a. The individual or the individual's spouse,

28 b. A person, including a court or administrative body, with legal authority to act in place of or
29 on behalf of the individual or the individual's spouse, or

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

32 3. In determining an individual's eligibility for Medical Assistance, the following regulations apply to a
33 trust established by an individual:

34 a. An individual shall be considered to have established a trust if assets of the individual
35 were used to form all or part of the corpus of the trust, and if any of the following
36 individuals established the trust, other than by will:

37 i) The individual or the individual's spouse

38 ii) A person, including a court or administrative body, with legal authority to act in
39 place of, or on the behalf of, the individual or the individual's spouse;

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1 iii) A person, including a court or administrative body acting at the direction or upon
2 the request of the individual or the individual's spouse.

3 b. In the case of a trust, the corpus of which includes assets of an individual and the assets
4 of any other person(s), this regulation shall apply to the portion of the trust attributable to
5 the assets of the individual.

6 c. These regulations apply without regard to the following:

7 i) The purposes for which a trust is established;

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

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

10 iv) Any restrictions on the use of distributions from the trust.

11 4. Revocable Trusts are considered as follows:

12 a. The corpus of the trust shall be considered resources available to the individual.

13 b. Payments from the trust to or for the benefit of the individual shall be considered income
14 to the individual, and

15 c. Any other payments from the trust shall be considered assets transferred by the
16 individual for less than fair market value and are subject to a 60 month look back period
17 and a penalty period of ineligibility as set forth in the regulations on transfers without fair
18 consideration in this volume.

19 5. Irrevocable Trusts

20 If there are any circumstances under which payments from the trust could be made to or for the
21 benefit of the individual, the following shall apply:

22 a) The portion of the corpus of the trust, or the income on the corpus, from which payment
23 to the individual could be made, shall be considered as resources available to the
24 individual.

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

27 c) Payments from that portion of the corpus or income for any other purpose shall be
28 considered as a transfer of assets by the individual for less than fair market value and are
29 subject to a 60 month look back period and a penalty period of ineligibility as set forth in
30 the regulations on transfers without fair consideration in this volume.

31 d) Any portion of the trust from which, or any income on the corpus from which no payment
32 could be made to the individual under any circumstances, shall be considered as a
33 transfer of assets for less than fair market value and shall be subject to a 60 month look
34 back period and penalty period of ineligibility as set forth in the regulations on transfers
35 without fair consideration in this volume. The transfer will be effective as of the date of the
36 establishment of the trust, or the date on which payment to the individual from the trust
37 was foreclosed, if later. The value of the trust shall be determined by including the
38 amount of any payments made from such portion of the trust after such date.

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

3 a. Income Trusts

4 i) A trust consisting only of the individual's pension income, social security income
5 and other monthly income that is established for the purpose of establishing
6 income eligibility for Long Term Care institution care or Home and Community
7 Based Services (HCBS). To be valid, the trust must meet the following criteria:

8

9

10 a) The individual's gross monthly income must be above the 300%-SSI limit
11 but below the average cost of private Long Term Care institution care in
12 the geographic region in which the individual resides and intends to
13 remain. The Colorado Department of Health Care Policy and Financing
14 shall calculate the average rates for such regions on an annual,
15 calendar-year basis. The geographic regions which are used for
16 calculating the average private pay rate for Long Term Care institution
17 care shall be based on the Bureau of Economic Analysis Regions and
18 consist of the following counties:

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

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

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

27 REGION IV: (Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison,
28 Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray,
29 Pitkin, Rio Blanco, Routt, San Juan, San Miguel)

30 b) For Long Term Care institution clients, each month the trustee shall
31 distribute the entire amount of income which is transferred into the trust.
32 An amount not to exceed $20.00 may be retained for trust expenses
33 such as bank charges if such charges are expected to be incurred by the
34 trust.

35 c) The only deductions from the monthly trust distribution to the Long Term
36 Care institution are the allowable deductions which are permitted for
37 Medical Assistance-eligible persons who do not have income trusts.
38 Allowable deductions include only the following:

39 i) Personal need allowance

40 ii) Spousal income payments

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1 iii) Approved PETI payments

2 d) Any funds remaining after the allowable deductions shall be paid solely
3 to the cost of the Long Term Care institution care in an amount not to
4 exceed the Medical Assistance reimbursement rate. Any excess income
5 which is not distributed shall accumulate in the trust.

6 e) No other deductions or expenses may be paid from the trust. Expenses
7 which cannot be paid from the trust include, but are not limited to, trustee
8 fees, attorney fees and costs (including attorney fees and costs incurred
9 in establishing the trust), accountant fees, court fees and costs, fees for
10 guardians ad litem, funeral expenses, past-due medical bills and other
11 debts. Trustee fees which were ordered prior to April 1, 1996 may
12 continue until the trust terminates.

13 f) For HCBS clients, the amount distributed each month shall be limited to
14 the 300% of the SSI limit. Any monthly income above that amount shall
15 remain in the trust. An amount not to exceed $20.00 may be retained for
16 trust expenses such as bank charges if such charges are expected to be
17 incurred by the trust. No other trust expenses or deductions may be paid
18 from the trust. For the purpose of calculating Individual Cost
19 Containment or client payment (PETI), the client's monthly income will be
20 300% of the SSI limit. Upon termination, the funds which have
21 accumulated in the trust shall be paid to the Department up to the total
22 amount of Medical Assistance paid on behalf of the individual.

23 g) For a court-approved trust, notice of the time and place of the hearing,
24 with the petition and trust attached, shall be given to the eligibility site
25 and the Department in the manner prescribed by law.

26 h) The sole beneficiaries of the trust are the individual for whose benefit the
27 trust is established and the Department. The trust terminates upon the
28 death of the individual or if the trust is not required for Medical
29 Assistance eligibility in Colorado.

30 i) The trust must provide that upon the death of the individual or
31 termination of the trust, whichever occurs sooner, the Department shall
32 receive all amounts remaining in the trust up to the total amount of
33 Medical Assistance paid on behalf of the individual.

34 j) The trust must include the name and mailing address of the trustee. The
35 trustee must notify the Department of any trustee address changes or
36 change of trustee(s) within 30 calendar days.

37 k) The trust must provide that an annual accounting of trust income and
38 expenditures and an annual statement of trust assets shall be submitted
39 to the eligibility site or to the Department upon reasonable request or
40 upon any change of trustee.

41 l) The amount remaining in the trust and an accounting of the trust shall be
42 due to the Department within three months after the death of the
43 individual or termination of the trust, whichever is sooner. An extension
44 of time may be granted by the Department if a written request is
45 submitted within two months of the termination of the trust.

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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.

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1 k) The trust fund shall not be considered as a countable resource in
2 determining eligibility for Medical Assistance.

3 l) [Rule 8.110.52 B 5. b. 1) l), adopted or amended on or after November 1,
4 2000 and before November 1, 2001 was not extended by HB 02-1203,
5 and therefore expired May 15, 2002.]

6 m) Distributions from the trust may be made only to or for the benefit of the
7 individual beneficiary. Cash distributions from the trust shall be
8 considered income to the individual. Distributions for food or shelter are
9 considered in-kind income and are countable toward income eligibility.

10 n) If exempt resources are purchased with trust funds, those resources
11 continue to be exempt. If non-exempt resources are purchased, those
12 resources are countable toward eligibility.

13 o) The trust must include the name and mailing address of the trustee. The
14 Department must be notified of any trustee address changes or change
15 of trustee(s) within 30 calendar days.

16 p) The trust must provide that an annual accounting of trust income and
17 expenditures and an annual statement of trust assets shall be submitted
18 to the eligibility site or to the Department upon reasonable request or
19 upon any change of trustee.

20 q) Prior to the establishment or funding of a disability trust, the trust shall be
21 submitted for review to the Department, along with proof that the
22 individual beneficiary is disabled according to Social Security criteria. No
23 disability trust shall be valid unless the Department has reviewed the
24 trust and determined that the trust conforms to the requirements of 15-
25 14-412.8,C.R.S., as amended, and any rules adopted by the Medical
26 Services Board.

27 c. Pooled Trusts

28 i) A trust consisting of individual accounts established for disabled individuals for
29 the purpose of establishing resource eligibility for Medical Assistance. A valid
30 pooled trust shall meet the following criteria:

31 a) The individual for whom the trust is established must meet the disability
32 criteria of Social Security.

33 b) The trust is established and managed by a non-profit association which
34 has been approved by the Internal Revenue Service.

35 c) A separate account is maintained for each beneficiary; however, the trust
36 pools the accounts for the purposes of investment and management of
37 the funds.

38 d) The sole lifetime beneficiaries of each trust account are the individual for
39 whom the trust is established and the Department.

40 e) If the trust is funded with an annuity or other periodic payments, the
41 Department or the pooled trust shall be named as remainder beneficiary.

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1 f) The trust account shall be established by the disabled individual, parent,
2 grandparent, legal guardian, or the court.

3 g) The only assets used to fund each trust account are (1) the proceeds
4 from any personal injury case brought on behalf of the disabled
5 individual, or (2) retroactive payments of SSI benefits under Sullivan v.
6 Zeblev . (This provision is applicable to pooled trusts established from
7 July 1, 1994 to December 31, 2000.)

8 h) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be
9 satisfied prior to funding of the individual's trust account and approval of
10 the joinder agreement.

11 i) Following the disabled individual's death or termination of the trust
12 account, whichever occurs sooner, to the extent that the remaining funds
13 in the trust account are not retained by the pooled trust, the Department
14 shall receive any amount remaining in the individual's trust account up to
15 the total amount of Medical Assistance paid on behalf of the individual.

16 j) The pooled trust account shall not be considered as a countable
17 resource in determining Medical Assistance eligibility.

18 k) Distributions from the trust account may be made only to or for the
19 benefit of the individual. Cash distributions to the individual from the trust
20 shall be considered as income to the individual. Distributions for food or
21 shelter are considered in-kind income and are countable toward income
22 eligibility.

23 l) If exempt resources are purchased with trust funds, those resources
24 continue to be exempt. If non-exempt resources are purchased, those
25 resources are countable toward resource eligibility.

26 ii) If an institutionalized individual for whom a pooled trust is established is 65 years
27 of age or older, the transfer of assets into the pooled trust creates a rebuttable
28 resumption that the assets were transferred without fair consideration and shall
29 be analyzed in accordance with the rules on transfers without fair consideration
30 in this volume. This regulation is effective for transfers to pooled trusts after
31 January 1, 2001.

32 iii) When the individual beneficiary of an income, disability or pooled trust dies or the
33 trust is terminated, the trustee shall promptly notify the eligibility site and the
34 Department. To the extent required by these rules the trustee shall promptly
35 forward the remainder of the trust property to the Department, up to the amount
36 of Medical Assistance paid on behalf of the individual beneficiary.

37 d. Third Party Trusts

38 i) Third party trusts are trusts which are established with assets which are
39 contributed by individuals other than the applicant or the applicant's spouse for
40 the benefit of an applicant or client

41 ii) The terms of the trust will determine whether the trust fund is countable as a
42 resource or income for Medical Assistance eligibility.

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1 iii) Trusts which limit distributions to non-support or supplemental needs will not be
2 considered as a countable resource. If distributions are made for income or
3 resources, such distributions are countable as such for eligibility.

4 iv) If the trust requires income distributions, the amount of the income shall be
5 countable as income in determining eligibility.

6 v) If the trust requires principal distributions, that amount shall be considered as a
7 countable resource.

8 vi) If the trustee may exercise discretion in distributing income or resources, the
9 income or resources are not countable in determining eligibility. If distributions
10 are made for income or resources, such distributions are countable as such for
11 eligibility.

12 e. Federally Approved Trusts

13 i) If an SSI recipient has a trust which has been approved by the Social Security
14 Administration, eligibility for Medical Assistance cannot be delayed or denied.
15 Individuals on SSI are automatically eligible for Medical Assistance despite the
16 existence of a federally approved trust.

17 ii) If the eligibility site has a copy of a federally approved trust, the eligibility site
18 must send a copy to the Department.

19 7. Submission of Trust Documents and Records

20 a. The trustee of a trust which was established by or which benefits a Medical Assistance
21 Applicant or client shall submit trust documents and records to the eligibility site and to
22 the Department.

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

25 c. The eligibility site shall submit any trust which is submitted with an application or at
26 redetermination to The Department. The eligibility site shall determine Medical
27 Assistance eligibility based on the determination of The Department as to the effect of the
28 trust on eligibility.

29 **8.100.7.F. Transfers of Assets Without Fair Consideration**

30 1. Definitions. The following definitions apply to transfers of assets without fair considerations:

31 a. “Assets” include all income and resources of the individual and such individual's spouse,
32 including any interest in income or a resource as well as all income or resources which
33 the individual or such individual's spouse is entitled to but does not receive because of
34 action by any of the following:

35 i) The individual or such individual's spouse,

36 ii) A person, a court, or administrative body with legal authority to act on behalf of
37 the individual or such individual's spouse, or

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

3 b. “Fair market value” is the value of the asset if sold at the prevailing price at the time it
4 was transferred.

5 c. “Fair consideration” is the amount the individual receives in exchange for the asset that is
6 transferred, which is equal to or greater than the value of the transferred asset.

7 d. “Look-back period” means the number of months prior to the month of application for
8 long-term care services that the Department will consider for transfer of assets.

9 e. “Penalty period” means a period of time for which an applicant or client will not be eligible
10 to receive long-term care services.

11 f. “Uncompensated value” shall mean the fair market value of an asset at the time of the
12 transfer minus the value of compensation the individual receives in exchange for the
13 asset.

14 g. “Valuable consideration” shall mean what an individual receives in exchange for his or
15 her right or interest in an asset which has a tangible and/or intrinsic value to the individual
16 that is equivalent to or greater than the value of the transferred asset.

17 2. General Provisions

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

23 a. For transfers made before February 8, 2006, the look-back period is 36 months prior to
24 the date of application. For transfers made on or after February 8, 2006, the look-back
25 date is 60 months prior to the date of application.

26 b. An institutionalized individual is one who is institutionalized in a medical facility, a Long-
27 Term Care institution, or applying for or receiving Home and Community Based Services
28 (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

29 c. If an institutionalized individual or such individual's spouse transfers assets without fair
30 consideration on or after the look-back period, the transfer shall be evaluated as follows:

31 i) The fair market value of the transferred asset, less the actual amount received, if
32 any, shall be divided by the average of the regions, defined at 8.100.7.E, monthly
33 private pay cost for Long-Term Care institution care in the state of Colorado at
34 the time of application.

35 ii) The resulting number is the number of months that the individual shall be
36 ineligible for Medical Assistance. For transfers made before February 8, 2006,
37 the period of ineligibility shall begin with the first day of the month following the
38 month in which the transfer occurred. For transfers made on or after February 8,
39 2006, the period of ineligibility shall begin on the later of the following dates:

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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.

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1 i. If a transfer without fair consideration is made during a period of eligibility, a period of
2 ineligibility shall be assessed in the same manner as stated above.

3 j. Actions that prevent income or resources from being received, or reduce an individual's
4 ownership, right or interest in an asset such that the individual does not receive valuable
5 consideration as set forth on the following list, which is not exclusive, shall create a
6 rebuttable presumption that the transfer was without fair consideration:

7 i) Waiving pension income.

8 ii) Waiving a right to receive an inheritance.

9 iii) Preventing access to assets to which an individual is entitled by diverting them to
10 a trust or similar device. This is not applicable to valid income trusts, disability
11 trusts and pooled trusts for individuals under the age of 65 years.

12 iv) Failure of a surviving spouse to elect a share of a spouse's estate or failure to
13 open an estate within 6 months after a spouse's death.

14 v) Failure to obtain a family allowance or exempt property allowance from an estate
15 of a deceased spouse or parent. Such allowances are presumed to be available
16 3 months after death.

17 vi) Not accepting or accessing a personal injury settlement.

18 vii) Transferring assets into an irrevocable private annuity which was not purchased
19 from a commercial company.

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

22 ix) Refusal to take legal action to obtain a court ordered payment that is not being
23 paid, such as child support or alimony, if the benefit outweighs the cost.

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

26 xi) Purchasing a single-premium life insurance policy, endowment policy or similar
27 instrument within the look-back period, which has no cash value, and for which
28 the individual receives no valuable consideration shall be considered an
29 uncompensated transfer. The total amount of the purchase price shall be
30 considered a transfer without fair consideration.

31 **8.100.7.G. Treatment of Certain Assets as Transfers Without Fair Consideration**

32 1. Promissory notes established before April 1, 2006:

33 a. The fair market value of promissory notes is a countable resource and must be evaluated
34 in accordance with the regulations on consideration of resources in this volume.

35 b. Promissory notes with one or more of the following provisions, indicating they have little
36 or no market value, shall create a rebuttable presumption of a transfer without fair
37 consideration:

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

2 ii) A term for repayment longer than the life expectancy of the holder of the note, as
3 determined by the tables at 8.100.7.J.for annuities purchased on or after
4 February 8, 2006.

5 iii) Low payments.

6 iv) Cancellation at the death of the note holder.

7 c. Promissory notes which have been appraised by a note broker as having little or no value
8 shall create a rebuttable presumption of a transfer without fair consideration.

9 2. Promissory notes established on or after April 1, 2006 but before March 1, 2007

10 a. Subject to the look-back date described in section 8.100.7.F.2.b for the purpose of
11 calculating the penalty period of ineligibility for a transfer without fair consideration, the
12 value of a promissory note, loan or mortgage which does not meet the criteria in section
13 8.100.5.M.3.n. is the outstanding balance due as of the date of the individual's application
14 for Medical Assistance for services, described in section 8.100.7.F.2.c.

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

16 a. Subject to the look-back date described in section 8.100.7.F.2.b, for the purpose of
17 calculating the penalty period of ineligibility for a transfer without fair consideration, the
18 value of a promissory note, loan or mortgage which does not meet the criteria in section
19 8.100.5.M.3.o. is the outstanding balance due as of the date of the individual's application
20 for Medical Assistance for services, described in section 8.100.7.F.2.c..

21 4. Personal care services

22 a. Effective for agreements that were signed and notarized prior to March 1, 2007, family
23 members who provide assistance or services are presumed to do so for love and
24 affection, and compensation for past assistance or services shall create a rebuttable
25 presumption of a transfer without fair consideration unless the compensation is in
26 accordance with the following:

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

28 ii) The agreement must be signed by the applicant, or a legally authorized
29 representative, such as agent under a power of attorney, guardian, or
30 conservator. If the agreement is signed by a representative, that representative
31 may not be a beneficiary of the agreement.

32 iii) The agreement must be dated and the signature must be notarized; and

33 iv) Compensation for services rendered must be comparable to what is received in
34 the open market.

35 b. Effective for agreements that are signed and notarized on or after March 1, 2007,
36 compensation under personal service agreements will be deemed to be a transfer without
37 fair consideration unless the following requirements are met:

38 i) A written agreement was executed prior to the delivery of services; and

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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.

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

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

4 i) The spouse of such individual;

5 ii) A child of such individual who is either

6 1) Under the age of 21 years, or

7 2) Is blind or totally and permanently disabled as determined by the Social
8 Security Administration.

9 iii) A brother or sister

10 1) Who has an equity interest in the home and

11 2) Who was residing in such individual's home for at least one year
12 immediately before the date that the individual becomes institutionalized.

13 iv) A son or a daughter of such individual

14 1) Who was residing in the home for a period of at least two years
15 immediately before the date the individual becomes institutionalized and

16 2) Who provided care to such individual by objective evidence, that
17 permitted such individual to reside at home rather than in an institution.

18 3) Documentation shall be submitted proving that the son or daughter's sole
19 residence was the home of the parent. The parent's attending
20 physician(s) or professional health provider(s) during the past two years
21 must substantiate in writing that the care was provided, and that the care
22 prevented the parent from requiring placement in a Long-Term Care
23 institution.

24 b. The assets were transferred:

25 i) To the individual's spouse or to another for the sole benefit of the individual's
26 spouse.

27 ii) From the individual's spouse to another for the sole benefit of the individual's
28 spouse.

29 iii) To a trust which is established solely for benefit of the individual's child who is
30 determined to be blind or totally disabled by the Social Security Administration or
31 to that child directly for the sole benefit of the child.

32 iv) To a trust established solely for the benefit of an individual under 65 years of age
33 who is determined to be blind or totally disabled by the Social Security
34 Administration.

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

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1 i). A transfer or a trust is considered to be for the sole benefit of the spouse, blind or
2 disabled child, or a disabled individual if the transfer is arranged in such a way
3 that no individual or entity except the spouse, blind or disabled child, or disabled
4 individual can benefit from the assets transferred in any way, whether at the time
5 of the transfer or at any time in the future.

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

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

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

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

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

15

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

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

29 7. There is a rebuttable presumption the transfer without fair consideration was made for purposes
30 of Medical Assistance eligibility or avoiding the medical assistance estate recovery program.

31 a. The presumption that an asset was transferred to establish or maintain Medicaid eligibility
32 or to avoid the medical assistance estate recovery program is rebutted only if the
33 individual or individual's spouse demonstrates by providing convincing evidence that the
34 asset was transferred exclusively for some other purpose and the reason for the transfer
35 did not include Medical Assistance eligibility or avoidance of medical assistance estate
36 recovery..

37 b. A subjective statement of intent or ignorance of the transfer penalty or verbal assurances
38 that the individual was not considering Medical Assistance eligibility when the transfer
39 was made are not sufficient.

40 c. There is a rebuttable presumption that transfers without fair consideration were made for
41 the purpose of Medical Assistance eligibility in the following cases:

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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.

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1 9. If the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of
2 a trust, the trust document shall be submitted to the Colorado Department of Health Care Policy
3 and Financing to determine the effect of the trust on Medical Assistance eligibility.

4 10. Notice

5 a. The Colorado Department of Health Care Policy and Financing is an interested person
6 according to 15-14-406, C.R.S. or a successor statute.

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

10 11. Undue Hardship

11 a. The period of ineligibility resulting from the imposition of the transfer or the trust
12 provisions may be waived if denial of eligibility would create an undue hardship for an
13 individual who is otherwise eligible. Undue hardship can be established if application of
14 the transfer penalty would:

15 i) deprive the individual of medical care such that the individual's health or life
16 would be endangered; or

17 ii) deprive the individual of food, clothing, shelter or other necessities of life.

18 b. Undue hardship shall not exist when the application of the trust or transfer rules merely
19 causes the individual inconvenience or when such application might restrict his or her
20 lifestyle but would not put him or her at risk of serious deprivation.

21 c. Notice of an undue hardship exception shall be given to the applicant or client. The
22 Eligibility Site shall make a determination on the request within 15 working days from
23 when the request is received. The Eligibility Site shall issue a notice of action on the
24 determination of hardship. An adverse determination may be appealed in accordance
25 with the appeal process as described at Section 8.057 of this volume.

26 d. The facility in which an institutionalized individual is residing may file an undue hardship
27 waiver application on behalf of the individual with the individual's or his or her personal
28 representative's consent. Where the individual is unable to give consent and where the
29 personal representative of the individual has a conflict of interest concerning the
30 particular circumstance giving rise to the period of ineligibility, the facility may request an
31 undue hardship on behalf of the individual. An example of such a conflict of interest
32 would be a situation where the personal representative who is also an agent under a
33 power of attorney transfers property to himself or herself. The facility shall submit the
34 undue hardship request to the Eligibility Site and give sufficient detail of the circumstance
35 surrounding the conflict of interest and the information required below to the Eligibility
36 Site. These provisions are not intended to change the Department's requirements under
37 Section 8.057 of the Department's regulations as to who has standing to file an appeal.

38 e. An individual or representative may request that the Eligibility Site waive a transfer
39 penalty on the basis of undue hardship. The request shall be made in writing to the
40 applicant's or client's Eligibility Site case worker. The individual making the request has
41 the burden of proof and must provide clear and convincing evidence to substantiate the
42 circumstances surrounding the transfer, attempts to recover the assets, and the impact of

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1 the denial of Medicaid payments for Long-Term Care services. The request and
2 documentation shall include all of the following:

3 i) the reason(s) for the transfer including the individual's participation in the transfer
4 or grant of legal authority to another that gave rise to the transfer, and the
5 relationship between the transferor and transferee;

6 ii) evidence to prove that the assets have been irretrievably lost and that all
7 reasonable attempts made to recover the asset(s), including any legal actions
8 and the results of the attempts, including but not limited to a request for an adult
9 protection investigation (such as in a case of financial exploitation), filing a police
10 report, or filing a civil action have been exhausted or have been or are being
11 pursued; and,

12 iii) documentation such as a notice of discharge or pending discharge from the
13 facility and a physician's statement detailing how the inability to receive nursing
14 facility or community based services would result in the individual's inability to
15 obtain life-sustaining medical care or that the individual would not be able to
16 obtain food, clothing or shelter.

17 f. To the extent that the transferred assets are recovered pursuant to the attempts in (e)(ii)
18 above, the individual shall reimburse Medicaid for the funds expended as a result of an
19 approved undue hardship request.

20 g. If the transferee and the transferor of the assets for which the transfer penalty is being
21 imposed are related parties there shall be a rebuttable presumption that the transferred
22 assets are not irretrievably lost as required under (e)(ii) above. Related parties are
23 described in Section 8.100.7.G.7.c.ii of these regulations.

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

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

27 b. Convincing and objective evidence is presented proving that the resources were
28 transferred exclusively for a purpose other than to qualify or remain eligible for Medical
29 Assistance.

30 c. All of the resources transferred without fair consideration have been returned to the
31 individual.

32 d. For assets transferred before February 8, 2006, the assets were transferred more than
33 36 months prior to the date of application.

34 e. For assets transferred before February 8, 2006, the penalty period has expired based on
35 the following formula: The fair market value of the transferred asset is divided by the
36 average cost of Long Term Care institution care in the state at the time of application and
37 the resulting number of months of ineligibility has ended prior to the date of application.

38 **8.100.7.H. Life Estates**

39 1. Definitions

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1 a. "Fair Market Value" means the amount for which a property or interest in a property could
2 reasonably be expected to sell on the open market.

3 b. "Life Estate." A life estate conveys upon a grantee certain rights in property measured by
4 the life of the life estate holder or of some other person. The owner of a life estate has the
5 right to possess the property, the right to use the property, the right to obtain profits from
6 the property, and the right to sell the life estate interest in the property. The establishment
7 of a life estate on a property results in the creation of two interests: a life estate interest
8 and a remainder interest.

9 c. "Remainder Interest" means an interest in property created at the time a life estate is
10 established which gives the holder of the interest the right to ownership of the property
11 upon the death of the life estate holder. An individual holding a remainder interest is free
12 to sell his or her interest in the property unless the sale is restricted by the terms of the
13 instrument which established the remainder interest.

14 2. General Provisions

15 a. Life Estates Established before July 1, 1995

16 i) Transfer without fair consideration Treatment

17 1) The establishment of a life estate before July 1, 1995 by an individual or
18 individual's spouse shall not be considered a transfer without fair
19 consideration.

20 ii) Resource Treatment

21 1) A life estate owned by an individual or individual's spouse that was
22 established on exempt property shall be considered to be an exempt
23 resource.

24 2) A life estate owned by an individual or individual's spouse that was
25 established on countable property shall be considered a countable
26 resource.

27 i) The value of the life estate shall be determined by using the
28 methodology described at 8.100.7.H.3.

29 3) A remainder interest held by an individual or individual's spouse on
30 exempt property shall be considered an exempt resource.

31 4) A remainder interest held by an individual or individual's spouse on
32 countable property shall be considered a countable resource

33 i) The value of the remainder interest shall be determined by using
34 the methodology described at 8.100.7.H.4.a.

35 b. Life Estates Established on or after July 1, 1995

36 i) Transfer without fair consideration Treatment

37 1) The establishment of a life estate on or after July 1, 1995 on property
38 owned by an individual or individual's spouse shall be considered a

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1 transfer without fair consideration if the life estate was established within
2 the look-back period described at 8.100.7.F.2.b.

3 a) For the purpose of determining the transfer without fair
4 consideration penalty period, the amount of the transfer shall be
5 based on the value of the remainder interest, as calculated using
6 the methodology described at 8.100.7.H.4.a.

7 2) The purchase of a life estate interest in a home not owned by an
8 individual or individual's spouse on or after April 1, 2006 within the look-
9 back period described at 8.100.7.F.2.b. shall be considered a transfer
10 without fair consideration unless the purchaser lives in the home for a
11 period of at least twelve (12) consecutive months after the date of the
12 purchase.

13 a) For the purpose of determining the transfer without fair
14 consideration penalty period, the amount of the transfer shall be
15 the entire amount used to purchase the life estate.

16 b) If the payment for the life estate exceeds the value of the life
17 estate, as calculated using the methodology described at
18 8.100.7.H.3, then the difference between the amount paid and
19 the value of the life estate shall be considered to be a transfer
20 without fair consideration.

21

22 ii) Resource Treatment

23 1) A life estate owned by an individual or individual's spouse that was
24 established on exempt property shall be considered an exempt resource.

25 2) A life estate owned by an individual or individual's spouse that was
26 established on countable property shall be considered a countable
27 resource.

28 a) The value of the life estate shall be determined by using the
29 methodology described at 8.100.7.H.3.a.

30 3) A remainder interest held by an individual or individual's spouse on
31 exempt property shall be considered an exempt resource.

32 5) A remainder interest held by an individual or individual's spouse on
33 countable property shall be considered a countable resource

34 a) The value of the remainder interest shall be determined by using
35 the methodology described at 8.100.7.H.4.

36 3. Determining the Value of a Life Estate

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

38 i) Determine the fair market value of the property on which the life estate was
39 established. The fair market value shall be obtained by using the most recent

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1 actual value reported by the county assessor or from the most recent property
2 assessment notice. If the actual value is not shown on the property assessment
3 notice, the assessed value shall be divided by the appropriate property
4 assessment rate to obtain the market value.

5 ii) Multiply the fair market value of the property by the “Life Estate” factor in Column
6 1 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to
7 the life estate holder’s age as of his or her last birthday. The result is the value of
8 the life estate interest.

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

11 4. Determining the Value of a Remainder Interest

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

13 i) Determine the fair market value of the property on which the remainder interest
14 was established. The fair market value shall be obtained by using the most
15 recent actual value reported by the county assessor or from the most recent
16 property assessment notice. If the market value is not shown on the property
17 assessment notice, the assessed value shall be divided by the appropriate
18 property assessment rate to obtain the market value.

19 ii) Multiply the fair market value of the property by the “Remainder” factor in Column
20 2 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to
21 the life estate holder’s age as of his or her last birthday. The result is the value of
22 the remainder interest.

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

25 5. Life Estate Table

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

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

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

35 **8.100.7.I. Annuities**

36 1. DEFINITIONS

37 a. “Annuity” means a contract between an individual and a commercial company in which
38 the individual invests funds and in return receives installments for life or for a specified
39 number of years.

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1 b. “Annuitant” means an individual who is entitled to receive payments from an annuity.

2 c. “Annuitization Period” means the period of time during which an annuity makes payments
3 to an annuitant.

4 d. “Annuitized” means an annuity that has become irrevocable and is making payments to
5 an annuitant.

6 e. “Assignable” means an annuity that can have its owner and/or annuitant changed.

7 f. “Balloon Payment” means a lump sum equal to the initial annuity premium less any
8 distributions paid out before the end of an annuitization period.

9 g. “Beneficiary” means an individual or individuals entitled to receive any remaining
10 payments from an annuity upon the death of the annuitant.

11 h. “Department” means the Department of Health Care Policy and Financing, its
12 successor(s), or its designee(s).

13 i. “Irrevocable” means an annuity that cannot be canceled, revoked, terminated, or
14 surrendered under any circumstances.

15 j. “Non-assignable” means an annuity that cannot have its owner and/or annuitant changed
16 under any circumstances.

17 k. “Owner” means the person who may exercise the rights provided in an annuity contract
18 during the life of the annuitant. An owner can generally name himself or herself or
19 another person as the annuitant.

20 l. “Revocable” means an annuity that can be canceled, revoked, terminated, or
21 surrendered.

22 m. “Transaction” means:

23 i) The purchase of an annuity;

24 ii) The addition of principal to an annuity;

25 iii) Elective withdrawals from an annuity;

26 iv) Requests to change the distributions from an annuity;

27 v) Elections to annuitize an annuity contract; or

28 vi) Any other action taken by an individual that changes the course of payments
29 made by an annuity or the treatment of income or principal of an annuity.

30 2. Annuities purchased on or before June 30, 1995

31 a. A revocable or irrevocable annuity established on or before June 30, 1995 is not a
32 countable resource if it is annuitized and regular returns are being received by the
33 annuitant.

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1 i) Payments from the annuity to the individual or individual's spouse are income in
2 the month received.

3 b. A revocable or irrevocable annuity established on or before June 30, 1995 is a countable
4 resource if it has not been annuitized.

5 3. Annuities Established on or after July 1, 1995 but before February 8, 2006

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

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

10 ii) The annuity is annuitized for the individual or individual's spouse;

11 iii) The annuity is purchased on the life of the individual or individual's spouse; and

12 iv) The annuity provides payments for a period not exceeding the annuitant's
13 projected life expectancy based on life expectancy tables described at 8.100.7.J.

14 b. To determine if a transfer without fair consideration has occurred in the purchase of an
15 annuity, the Eligibility Site shall:

16 i) Determine the date on which the annuity was purchased;

17 ii) Determine the amount of money used to purchase the annuity and the length of
18 the annuitization period;

19 iii) Determine the age of the annuitant at the time the annuity was purchased; and

20 iv) Determine the life expectancy of the annuitant at the time the annuity was
21 purchased using the appropriate life expectancy table described at 8.100.7.J.

22 1) If the length of the annuitization period exceeds the annuitant's life
23 expectancy, then a transfer without fair consideration exists for the
24 portion of the annuitization period that exceeds the annuitant's life
25 expectancy.

26 2) If the total value of the annuity's payments during the annuitization period
27 is less than the original purchase price of the annuity, then the difference
28 shall be considered to be a transfer without fair consideration.

29 3) If the total value of the annuity's payments during the annuitization period
30 is equal to or greater than the original purchase price of the annuity, then
31 the purchase of the annuity shall not be considered to be a transfer
32 without fair consideration. However, any payments made by the annuity
33 shall be considered to be countable income in the month received.

34 4) If the annuity was purchased more than 36 months before the date of
35 application for Medicaid, then there is no transfer without fair
36 consideration penalty period. However, any payments made by the
37 annuity shall be considered to be countable income in the month
38 received.

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1 4. Annuities Established on or after April 1, 1998 but before February 8, 2006

2 a. The Eligibility Site shall determine the Minimum Monthly Maintenance Needs Allowance
3 (MMMNA) of the community spouse, if applicable.

4 i) If the monthly payment amount provided by the annuity to the community spouse
5 exceeds the MMMNA, then the amount of the annuity which causes the monthly
6 annuity payment to exceed the MMMNA shall be considered to be a transfer
7 without fair consideration in determining the institutionalized spouse's eligibility.
8 This applies only to the extent that the transferred amount causes the
9 Community Spouse Resource Allowance to exceed the maximum.

10 b. The Eligibility Site shall determine if the Individual is receiving substantially equal
11 installments from the annuity for the annuitization period of the annuity.

12 i) If the annuity is not paid in substantially equal installments, then the original
13 purchase price of the annuity shall be considered to be a transfer without fair
14 consideration.

15 c. If the annuity was purchased more than 36 months before the date of application for
16 Medicaid, then there is no transfer without fair consideration penalty period.

17 i) Any payments made by the annuity shall be considered to be countable income
18 in the month received.

19 5. Annuities Purchased on or after February 8, 2006

20 a. As a condition of Medicaid eligibility, at the time of application or redetermination, an
21 applicant or his or her spouse for Medicaid Long-Term Care services shall disclose any
22 interest that the Medicaid applicant or his or her spouse has in an annuity.

23 i) A complete copy of the annuity contract, including the most recent beneficiary
24 designation, shall be provided to the eligibility site.

25 b. By providing Medicaid Long-Term Care services, the Department shall be a remainder
26 beneficiary of any annuity in which an individual or individual's spouse has an interest.
27 The purchase of the annuity shall not be considered to be a transfer without fair
28 consideration if:

29 i) The Department is named as the remainder beneficiary in the first position for the
30 total amount of medical assistance paid on behalf of the individual; or

31 ii) The Department is named as the remainder beneficiary in the next position after
32 the community spouse or minor or disabled child.

33 iii) This provision shall not apply to annuities that are revocable and/or assignable.

34 c. The Eligibility Site shall notify the issuer of the annuity that the Department is a preferred
35 remainder beneficiary in the annuity for medical assistance provided to the
36 institutionalized individual. This notice shall include a statement requiring the issuer to
37 notify the Eligibility Site of any changes in the amount of income or principal that is being
38 withdrawn from the annuity or any other transactions, as defined at 8.100.7.I.1.,
39 regardless of when the annuity was purchased.

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1 d. If the Department is not named on the annuity as a remainder beneficiary, then the value
2 of funds used to purchase the annuity shall be deemed a transfer without fair
3 consideration and shall be subject to the penalty period provisions described at
4 8.100.7.F.

5 i) This provision shall not apply to annuities that are revocable and/or assignable.

6 e. Revocable Annuities

7 i) A revocable annuity is a countable resource. The value of the annuity is the total
8 value of the annuity principal plus any accumulated interest.

9 a) If the annuity includes a surrender charge or other financial penalty
10 (other than tax withholding or a tax penalty) for withdrawing funds from
11 the annuity, then the value of the annuity is the net amount the individual
12 would receive upon full surrender of the annuity.

13 ii) Payments from a revocable annuity are not countable as income.

14 f. Irrevocable Assignable Annuities

15 i) An irrevocable assignable annuity is a countable resource. The value of the
16 annuity is presumed to be the total value of the annuity principal plus any
17 accumulated interest.

18 a) An individual or individual's spouse can rebut the presumption by
19 providing documented offers from at least three companies who are
20 active in the market for buying and selling annuities an annuity income
21 streams. The value of the annuity shall then be the highest of the offers.

22 b) Any payments from an irrevocable assignable annuity that is considered
23 to be a countable resource are not considered to be countable income.

24 ii) An individual or individual's spouse can rebut the presumption that an irrevocable
25 assignable annuity is not a countable resource by providing documented offers
26 from at least three companies who are active in the market for buying and selling
27 annuities and annuity income streams stating their unwillingness or inability to
28 purchase the annuity or annuity income stream.

29 a) Any payments from an irrevocable assignable annuity that is not
30 considered to be a countable resource are considered to be countable
31 income in the month received.

32 g. Irrevocable Non-Assignable Annuities

33 i) An irrevocable non-assignable annuity is not considered to be a countable
34 resource.

35 ii) Payments from an irrevocable non-assignable annuity are considered countable
36 income in the month received.

37 iii) An irrevocable non-assignable annuity purchased by or for the benefit of a
38 community spouse shall not be considered to be a transfer without fair
39 consideration if:

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1 2 3 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

4 5 6 7 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.

8 9 10 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:

11 12 13 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

14 15 16 17 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.

18 19 20 21 22 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:

23 1) The annuity is considered either:

24 25 a) An Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or

26 27 28 b) A deemed Individual Retirement Account under a qualified employer plan described in Section 408(q) of the Internal Revenue Code of 1986; or

29 2) The annuity is purchased with proceeds from one of the following:

30 31 a) An Individual Retirement Account as described in Section 408(a) of the Internal Revenue Code of 1986; or

32 33 34 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

35 36 c) A simple retirement account as described in Section 408(p) of the Internal Revenue Code of 1986; or

37 38 d) A simplified employee pension plan as described in Section 408(k) of the Internal Revenue Code of 1986; or

39 40 e) A Roth IRA as described in Section 408A of the Internal Revenue Code of 1986; or

1 3) The annuity meets all of the following requirements:

2 a) The annuity is irrevocable and non-assignable; and

3 b) The annuity is actuarially sound based on the life expectancy
4 tables described at 8.100.7.J.; and

5 c) The annuity provides for payments in equal amounts during the
6 term of the annuity with no deferral and no balloon payments
7 made.

8 vi) If an irrevocable non-assignable annuity is considered to be a transfer without fair
9 consideration, then, for the purpose of calculating the transfer without fair
10 consideration penalty period, the value that was transferred shall be the amount
11 of funds used to purchase the annuity.

12 h. Annuity Transactions

13 i) If an Individual or individual's spouse undertakes any transaction, as defined at
14 8.100.7.I.1. which has the effect of changing the course of payments to be made
15 by an annuity or the treatment of income or principal of the annuity, such a
16 transaction shall be deemed to be a transfer without fair consideration,
17 regardless of when the annuity was originally purchased. For the purpose of
18 calculating the transfer without fair consideration penalty period, the value that
19 was transferred shall be the amount used to purchase the annuity.

20 a) Routine changes such as a notification of an address change or death or
21 divorce of a remainder beneficiary are excluded from treatment as a
22 transfer without fair consideration.

23

24 b) Changes which occur based on the terms of the annuity which existed
25 before February 8, 2006 and which do not require a decision, election, or
26 action to take effect are excluded from treatment as a transfer without
27 fair consideration.

28 c) Changes which are beyond the control of the individual, such as a
29 change in law, a change in the policies of the annuity issuer, or a change
30 in terms based on other factors, such as the annuity issuer's financial
31 condition, are excluded from treatment as a transfer without fair
32 consideration.

33 **8.100.7.J. Life Expectancy Tables**

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

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

39 Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text
40 in its entirety, available for public inspection during regular business hours at: Colorado

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1 Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified
2 copies of incorporated materials are provided at cost upon request.

3 **8.100.7.K. Spousal Protection - Treatment of Income and Resources for Institutionalized**
4 **Spouses**

5 1. The spousal protection regulations apply to married couples where one spouse is institutionalized
6 or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in
7 the community. Being a community spouse does not prohibit Medicaid eligibility if all criteria are
8 met. The community spouse resource allowance does not supersede the Medicaid eligibility
9 criteria.

10 2. For purposes of spousal protection, an institutionalized spouse is an individual who:

11 a. Begins a stay in a medical institution or nursing facility on or after September 30, 1989, or

12 b. Is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the
13 Elderly (PACE) on or after October 10, 1997, or

14 c. Receives Home and Community Based Services on or after July 1, 1999; and

15 d. Is married to a spouse who is not in a medical institution or nursing facility; but does not
16 include any such individual who is not likely to meet the requirements of subparagraphs
17 8.100.7.K.2.a thru c for at least 30 consecutive days.

18 3. A community spouse is defined as the spouse of an institutionalized spouse.

19

20

21

22 **8.100.7.L. Assessment and Documentation of The Couple's Resources**

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

29 **8.100.7.M. Calculation of the Community Spouse Resource Allowance**

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

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

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1 a. The total resources of the couple but no more than the current maximum allowance
2 which, changes each year beginning January 1st.; or

3 b. The increased CSRA calculated pursuant to section 8.100.7.S; or

4 c. The amount a court has ordered the institutionalized spouse to transfer to the community
5 spouse for monthly support of the community spouse or a dependent family member.

6 2. The resources allotted to the community spouse as the CSRA shall be transferred into the name
7 of the community spouse and shall not be considered available to the institutionalized spouse.
8 After the transfer of the CSRA to the community spouse, the income from these resources shall
9 be attributed to the community spouse.

10 3. The transfer of the CSRA shall be completed as soon as possible, but no later than the next
11 redetermination when the community spouse becomes institutionalizes; whichever is earlier. If the
12 transfer is not completed within this time period, the resources shall be attributed to the
13 institutionalized spouse and shall affect his/her Medical Assistance eligibility. Verification of the
14 transfer of assets to the community spouse shall be provided to the eligibility site.

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

17 4. If the community spouse is in control of resources attributed to the institutionalized spouse, but
18 fails to make such resources available for his/her cost of care, this fact shall not make the
19 institutionalized spouse ineligible for Medical Assistance, where:

20 a. The institutionalized spouse has assigned The Department any rights to support from the
21 community spouse; or

22 b. The institutionalized spouse lacks the ability to execute an assignment due to physical or
23 mental impairment but The Department has the right to bring a support proceeding
24 against the community spouse without such assignment; or

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

30 **8.100.7.N. Treatment of the Home and Other Exempt Resources**

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

35 **8.100.7.O. Determination of the Institutionalized Spouse's Income and Resource Eligibility**

36 1. The institutionalized spouse is resource eligible for Medical Assistance when the total resources
37 owned by the couple are at or below the amount of the Community Spouse Resource Allowance
38 plus the Medical Assistance resource allowance for an individual of $2,000.

39 2. The eligibility site shall determine whether the institutionalized spouse is income eligible for
40 Medical Assistance. The institutionalized spouse shall be income eligible if his/her gross income

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1 is at or below the Medical Assistance income limit for recipients of long-term care. If an income
2 trust is used the trust must be established before the MIA is calculated.

3 **8.100.7.P. Attribution of Income**

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

6 1. If payment of income from resources is made solely in the name of either the institutionalized
7 spouse or the community spouse, the income shall be considered available only to the named
8 spouse.

9 2. If payment of income from resources is made in the names of both the institutionalized spouse
10 and the community spouse, one-half of the income shall be considered available to each spouse.

11 3. If payment of income is made in the names of the institutionalized spouse or the community
12 spouse, or both, and to another person or persons, the income shall be considered available to
13 each spouse in proportion to the spouse's interest.

14 4. The above regulations of attribution of income are superseded if the institutionalized spouse can
15 establish by a preponderance of the evidence that the ownership interests in the income are other
16 than that provided in the regulations.

17 **8.100.7.Q. Calculating the Community Spouse's Monthly Income Needs**

18 1. The community spouse's total minimum monthly needs shall be determined as follows:

19 a. The current minimum monthly maintenance needs allowance (MMMNA), which is equal
20 to 150% of the federal poverty level for a family of two and is adjusted in July of each
21 year;

22 b. An excess shelter allowance, in cases where the community spouse's expenses for
23 shelter exceed 30% of the MMMNA. The excess shelter allowance is computed by
24 adding (a) and (b) together:

25 i) The community spouse's expenses for rent or mortgage payment including
26 principal and interest, taxes and insurance, and, in the case of a condominium or
27 cooperative, any required maintenance fee, for the community spouse's principal
28 residence; and

29 ii) The larger of the following amounts: the standard utility allowance used by
30 Colorado under U.S.C. 2014(e) of Title 7; or the community spouse's actual,
31 verified, utility expenses. A utility allowance shall not be allowed if the utility
32 expenses are included in the rent or maintenance charge, which is paid by the
33 community spouse.

34 iii) The excess shelter allowance is the amount, if any, that exceeds 30% of the
35 MMMNA.

36 2. An additional amount may be approved for the following expenses:

37 a. Medical expenses of the community spouse or dependent family member for necessary
38 medical or remedial care. Each medical or remedial care expense claimed for deduction
39 must be documented in a manner that describes the service, the date of the service, the

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1 amount of the cost incurred, and the name of the service provider. An expense may be
2 deducted only if it is:

3 i) Provided by a medical practitioner licensed to furnish the care;

4 ii) Not subject to payment by any third party, including Medical Assistance and
5 Medicare;

6 b. The cost of Medicare, Long Term Care insurance, and health insurance premiums. A
7 health insurance premium may be allowed in the month the premium is paid or may be
8 prorated and allowed for the months the premium covers. This allowance does not
9 include payments made for coverage which is:

10 i) Limited to disability or income protection coverage;

11 ii) Automobile medical payment coverage;

12 iii) Supplemental to liability insurance;

13 iv) Designed solely to provide payments on a per diem basis, daily indemnity or non-
14 expense-incurred basis; or

15 v) Credit life and/or accident and health insurance.

16 3. If either spouse establishes that the community spouse needs income above the level provided
17 by the minimum monthly maintenance needs allowance due to exceptional circumstances, which
18 result in significant financial duress, such as loss of home and possessions due to fire, flood, or
19 tornado, an additional amount may be substituted for the MMMNA if established through a fair
20 hearing.

21 4. The total that results from adding the current MMMNA and the excess shelter allowance shall not
22 exceed the current maximum MMMNA which is $2,175.00 for the year 2001 and is adjusted by
23 the Health Care Financing Administration in January of each year.

24

25 **8.100.7.R. Calculating the Amount of Income to be Contributed by the Institutionalized**
26 **Spouse for the Community Spouse's Monthly Needs**

27 1. The Monthly Income Allowance (MIA) is the amount of money necessary to raise the community
28 spouse's income to the level of his/her monthly needs, and shall be obtained from the monthly
29 income of the institutionalized spouse. For individuals who become institutionalized on or after
30 February 8, 2006, all income of the institutionalized spouse that could be made available to the
31 community spouse must be considered to have been made available to the community spouse
32 before an MIA is allocated to the community spouse.

33 2. The MIA shall be the amount by which the community spouse's minimum monthly needs, which is
34 the MMMNA, exceed his/her income from sources other than the institutionalized spouse. The
35 community spouse’s income shall be calculated by using the gross income less mandatory
36 deduct ions for FICA and Medicare tax.

37 3. If a court has entered an order against the institutionalized spouse for monthly support of the
38 community spouse, the MIA shall not be less than the monthly amount ordered by the court.

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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;

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1 c. A family allowance for each dependent family member who lives with the community
2 spouse.

3 i) The allowance for each dependent family member shall be equal to one third of
4 the amount of the MMMNA and shall be reduced by the monthly income of that
5 family member.

6 ii) Family member means dependent children (minor or adult), dependent parents
7 or dependent siblings of either spouse that are residing with the community
8 spouse and can be claimed by either the institutionalized or community spouse
9 as a dependent for federal income tax purposes.

10 d. Allowable deductions identified in section 8.100.7.V.

11 e. If the institutionalized spouse fails to make his/her income available to the community
12 spouse or eligible dependent family members in accordance with these regulations, that
13 income shall be applied to the cost of care for the institutionalized spouse.

14 f. No other deductions shall be allowed.

15 **8.100.7.U. Right to Appeal**

16 1. Both spouses shall be informed of the following:

17 a. The amount and method by which the eligibility site calculated the community spouse
18 resource allowance (CSRA), community spouse monthly income allowance (MIA), and
19 any family allowance;

20 b. The spouses' right to a fair hearing concerning these calculations;

21 c. The eligibility site conclusions with respect to the spouses' ownership and availability of
22 income and resources, and the spouses' right to a fair hearing concerning these
23 conclusions.

24 2. If either spouse establishes that the community spouse needs income above the level provided
25 by the minimum monthly maintenance needs allowance due to exceptional circumstances, which
26 result in significant financial duress, such as loss of home and possessions due to fire, flood, or
27 tornado, an additional amount may be substituted for the MMMNA if established through a fair
28 hearing.

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

31 **8.100.7.V. Long-Term Care Institution Recipient Income**

32 1. Determination of Income and Communication between the Long-Term Care institution and the
33 Eligibility Site Using the AP-5615 Form for Patient Payment

34 a. Sections I, II and IV of the AP-5615 form are to be completed by the Long-Term Care
35 institution for all admissions, readmissions, transfers to and from another payer source,
36 including private pay and Medicare, discharges, deaths, changes in income and/or
37 patient payment, medical leaves of absence and non-medical/programmatic leave in
38 excess of 42 days combined per calendar year.

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1 b. The initial determination of resident income for patient payment shall be made by the
2 Eligibility Site. The Eligibility Site shall notify the Long-Term Care institution of current
3 resident income.

4 c. On receipt of AP-5615 form, the Eligibility Site will, within five working days:

5 i) For an admission, a readmission or a transfer from/to private pay, Medicare, or
6 another payer source:

7 1) Verify and correct, if necessary, data entered by the Long-Term Care
8 institution.

9 2) List and/or verify the resident's monthly income adjustments and/or
10 Long-Term Care Insurance benefit payments; and compute patient
11 payment. Provide the completed AP-5615 to the Long-Term Care
12 institution.

13 3) Correct the automated system to indicate the Long-Term Care institution
14 name and provider number and to reflect the current distribution of
15 income. Submit the AP-5615 form to the Department.

16 d. For change in patient payment with respect to changes in resident income:

17 i) Verify changes in resident income, and correct if necessary. All such corrections
18 must be initialed,

19 ii) Compute patient payment and provide the completed AP-5615 to the Long-Term
20 Care institution.

21 e. For change in patient payment with respect to the post-eligibility treatment of income, the
22 Eligibility Site shall:

23 i) Review the AP-5615 form for Medicare part B premium deduction allowances for
24 the first two months of admission.

25 ii) If client is already on the Medicare Buy-In program for Medicare part B, do not
26 adjust patient payment on AP-5615 form for the Medicare premium deduction. If
27 client is not on the Buy-In program, adjust AP-5615 form for the Medicare
28 premium deduction for the first two months of Long-Term Care institution
29 eligibility.

30 iii) If the client has a Medicare D premium, the Eligibility Site shall use the amount
31 as an income adjustment/deduction in the patient payment calculation and
32 complete the AP-5615 form.

33 f. For resident leave of absence:

34 i) Non-Medical/Programmatic Leave. When combined non-medical/programmatic
35 days in excess of 42 days are reported, verify adherence to the restrictions and
36 conditions of section 8.482.44.

37 ii) Medical Leave/Hospitalization. Verify that the patient payment is apportioned
38 correctly between the nursing facility and the hospital so that no Medicaid
39 payment is requested for the period. See also section 8.482.43.

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1 iii) The nursing facility may wait until the end of the month to complete the AP-5615
2 form for an ongoing hospitalization.

3 g. For change in payer status:

4 i) If Medicare or insurance is a primary payer during the month, verify the nursing
5 facility's calculation of the patient payment.

6 ii) Complete and provide the AP-5615 to the nursing facility.

7 h. For discharge or death of resident:

8 i) Verify the date of death or discharge, and verify the correct patient payment
9 including the resident's monthly income for the discharged month, and the
10 amount calculated by per diem. All corrections must be initialed.

11 ii) Note if the resident entered another Long-Term Care institution and, if so, enter
12 the name of the new Long-Term Care institution in the system.

13 iii) In the event the resident may return to the same facility, the AP-5615 form may
14 be completed at the end of the month for discharges due to hospitalization.

15 i. For discontinuation of Long-Term Care eligibility:

16 i) Initiate and send an AP-5615 form to the Long-Term Care institution within 5
17 working days of the date of determination that the client's eligibility will be
18 discontinued. Indicate the date the discontinuation will be effective.

19 j. Failure to provide a correct and timely AP-5615 to the Long-Term Care institution may
20 result in the refusal of the Department to reimburse such Long-Term Care institution care.
21 The AP-5615 form is required in order for a Prior Authorization Request (PAR) to be
22 issued for Long-Term Care institution claim reimbursement.

23 k. General Instructions:

24 i) The AP-5615 form must be verified and a signed AP-5615 form returned to the
25 Long-Term Care institution.

26 ii) The AP-5615 form must be signed and dated by the director of the Eligibility Site
27 or by his/her designee.

28 iii) AP-5615 forms may be initiated by either the Long-Term Care institution or
29 Eligibility Site. If the Eligibility Site is aware of information requiring a change in
30 financial arrangements of a resident, and a new AP-5615 form is not forthcoming
31 from the Long-Term Care institution, the Eligibility Site may initiate the revision to
32 the AP-5615 form. In such case, one copy of the AP-5615 form showing the
33 changes will be sent to the Long-Term Care institution.

34 l. The Department may deduct excess payments from the Eligibility Site administrative
35 reimbursement as stated in the Colorado Department of Human Services Finance Staff
36 Manual, Volume 5 if the Eligibility Site fails to:

37 i) Perform the duties as detailed in this section; or

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1 ii) Adhere to the limitations on a reduced patient payment; as detailed in section
2 8.100.7.V.4; or

3 iii) Notify the Long-Term Care institution within 5 working days of any changes in
4 resident income, provided the Long-Term Care institution is not authorized to
5 receive the resident's income; and excessive Medicaid funds are paid to the
6 Long-Term Care institution as a result of this negligence.

7 2. Collection of Patient Payment

8 a. It shall be the responsibility of the Long-Term Care institution to collect from the client, or
9 from the client's family, conservator or administrator, the patient payment, which is to be
10 applied to the cost of client care. The Department is not responsible for any deficiency in
11 patient payment accounts, due to failure of the Long-Term Care institution to collect such
12 income.

13 b. If, however, the Long-Term Care institution is unable to collect such funds, through
14 refusal of the resident or the resident's family, conservator, administrator or responsible
15 party to release such income, the Long-Term Care institution shall immediately notify the
16 Eligibility Site.

17 c. When notified by the Long-Term Care institution of the refusal of the client or the client's
18 family, conservator administrator or responsible party to pay the patient payment due, the
19 Eligibility Site shall immediately contact the refusing party. If, after such contact, the party
20 still refuses to release such income, the action shall be deemed a failure to cooperate,
21 and the Eligibility Site shall proceed to discontinue Medicaid benefits for the resident.

22 3. Calculation of Patient Payment

23 a. Specific instructions for computing the patient payment amount are contained in this
24 volume under The “Status of Long-Term Care institution Care” Form, AP-5615

25 b. Once an applicant for Nursing Facility Medical Assistance has been determined eligible
26 for Medical Assistance, the Eligibility Site shall determine the patient payment due to the
27 Nursing Facility which is to be applied to the Medicaid reimbursement for the cost of care.
28 That patient payment is calculated by:

29 i) Determining all applicable income of the recipient

30 ii) Deducting all applicable allowable monthly income adjustments, which include:

31 1) Personal Needs Allowance

32 2) If applicable, Monthly Income Allowance for the community spouse.

33 3) If applicable, Family Dependent Allowance

34 4) If applicable, Home Maintenance Allowance

35 5) If applicable, Trustee/Maintenance Fees: actual fees, with a maximum of
36 $20 per month

37 6) If applicable, Mandatory Income Tax Withheld

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1 7) Mandatory garnishments repaying Federal assistance overpayment

2 8) Medical or remedial care expenses that are not subject to payment by a
3 third party:

4 a) Medicare Part B Premium expenses, if applicable, are deductible
5 only for the first and second month in the Nursing Facility.

6 b) Medicare Part D Premium expenses, if applicable, are ongoing
7 deductions.

8 c) Other medical and remedial expenses covered under the
9 Nursing Facility PETI (NF PETI) program are not deductible. NF
10 PETI-approved expenses are allowed only for residents with a
11 patient payment, but do not change the patient payment amount.
12 For NF PETI, see the Section 8.482.33 in this volume "Post
13 Eligibility Treatment of Income".

14 c. Long-Term Care Insurance

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

21 i) If Long-Term Care insurance is received for the month, and:

22 1) If, after all deductions, the client has income available for a patient
23 payment, add this to the amount of the Long-Term Care insurance to
24 determine the total patient payment.

25 a) If the total amount is greater that the allowable cost of care, the
26 Long-Term Care insurance is applied before the client's income,
27 or;

28 b If after all deductions, the client does not have income available
29 for the patient payment, only the Long-Term Care insurance
30 payment is used.

31 d. Personal Needs Allowances

32 i) Non-Veteran related personal needs allowance

33 1) Prior to January 1, 2015 the personal needs allowance base amount is
34 $50 per month.

35 2) Effective January 1, 2015 the personal needs allowance base amount is
36 $75 per month and will be adjusted annually at the same rate as the
37 statewide average of the nursing facility per diem rate net of patient
38 payment pursuant to C.R.S. § 25.5-6-202(9)(b)(I). Each yearly
39 adjustment will set a new base amount.

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1 2 a) The first annual rate adjustment to the new $75 base amount will occur on January 1, 2015.

3 ii) Veterans-related personal needs allowance

4 5 6 7 8 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.

9 10 11 12 13 14 15 16 17 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.

18 19 20 21 22 23 24 25 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.

26 27 28 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.

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35 36 37 38 39 40 41 42 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

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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.

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1 ii) For a Long-Term Care institution recipient with no family at home, an amount in
2 addition to the personal needs allowance may be reserved for maintenance of
3 the recipient's home for a temporary period, not to exceed 6 months, if a
4 physician has certified that the person is likely to return to his/her home within
5 that period.

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

10 The Home Maintenance Allowance:

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

15 2) Beginning July 1, 2018

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

18 Claimable utility costs will be limited to the lessor of the following
19 amounts:

20 The standard utility allowance used by Colorado under 7 U.S.C.
21 2014(e) (2018), which is hereby incorporated by reference.

22 The incorporation of 7 U.S.C. 2014(e) (2018) excludes later
23 amendments to, or editions of, the referenced material. Pursuant
24 to § 24-4-103(12.5), C.R.S., the Department maintains copies of
25 this incorporated text in its entirety, available for public inspection
26 during regular business hours at: Colorado Department of Health
27 Care Policy and Financing, 1570 Grant Street, Denver CO
28 80203. Certified copies of incorporated materials are provided at
29 cost upon request.

30 Or;

31 The individual's actual, verified, utility expenses.

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

36 (1) The Department will calculate the Individual Needs
37 Standard by dividing the Federal Minimum Monthly
38 Maintenance Needs Allowance maximum by the Federal
39 Minimum Monthly Maintenance Needs Allowance
40 (MMMNA), described at 8.100.7.Q, which is in place on
41 January 1st of each calendar year. The result of this

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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.

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1 vii) Medicare assesses a co-insurance payment for a QMB recipient; the recipient's
2 patient payment cannot be used for payment of Medicare co-insurance.

3 b. Patient payment may not be waived in the following instances:

4 i) Transfers between nursing facilities, except that the patient payment for the
5 receiving facility may be waived if the patient payment has already been
6 committed to the former nursing facility; or

7 ii) Discharges from nursing facility to a hospital or other medical institution when
8 Medicaid is paying for services in the medical institution; or

9 iii) Changes from private pay within the facility and the patient payment is not
10 already committed for care provided under private pay status; or

11 iv) The death of the resident.

12 c. The Eligibility Site shall verify and approve partial month patient payments due to
13 transfers, discharges or death when calculated by the nursing facility based upon the
14 nursing facility's per diem rate.

15 d. The amount of SSI benefits received by a person who is institutionalized is not
16 considered when calculating patient payment.

17 5. Responsibilities of the Eligibility Site Regarding the Personal Needs Fund

18 a. It shall be the responsibility of the Eligibility Site to explain to the resident the various
19 options for handling the personal needs monies, as well as the resident's rights to such
20 funds. The resident has the option to allow the Long Term Care institution to hold such
21 funds in trust.

22 b. It shall be the responsibility of the Eligibility Site to assure that the Long Term Care
23 institution properly transfers or disposes of the resident's personal needs funds within 30
24 days of discharge from the Long Term Care institution, or transfer to another Long Term
25 Care institution.

26 c. The Eligibility Site shall notify the State Department if they become aware that a Long
27 Term Care institution has retained personal needs funds more than 30 days after the
28 death of a resident.

29 6. For rules regarding post eligibility treatment of income, see the section in this volume titled "Post
30 Eligibility Treatment of Income"

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