Title of Rule: Revision to the Medical Assistance Rule concerning Verified Information at Renewal, Section 8.100.3.P
Rule Number: MSB 22-12-08-A
Division / Contact / Phone: Eligibility Policy Section/ Ana Bordallo / 303-866-3558

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 section 8.100.3.P to update the lookback period of three months to six months when determining if a case has up-to-date information as part of the ex-parte review at renewal. Policy received guidance from CMS that allows states the flexibility to determine whether verified information is considered up-to date and states can consider information verified within the last 6 months. The lookback period determines if a member's case has up-to-date information, if not, this information is requested at renewal. System updates have been made to implement this change.

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:

   CMS provided guidance that states have the flexibility to determine if verified information is considered reliable information available to the state agency verified within the last 6 months. The Department has made updates from 3 to 6 months in December within the Colorado Benefits Management system. This rule aligns our regulations with both Federal and system changes.

3. Federal authority for the Rule, if any:

   42 CRF § 435.916, § 435.948, and § 435.949

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

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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 rule will impact members who have a renewal coming due and enrolled in a MAGI/Non-MAG Medical Assistance program. This rule update benefits a member who continues to meet all criteria eligible by helping them remain eligible without having to provide verifications at renewal.

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 determine if a case needs up-to-date information at renewal during the ex-parte review for MAGI/Non-MAG Medical Assistance program.

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

   The Department expects that updating the look back period for renewals during the ex parte reviews from 3 months to 6 months will have a no impact to the Department due to previous systems updates that allow for electronic verification of income in real time.

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

   There is no cost to the Department associated with this policy. The probable benefit of this policy is to ease the burden on members during the renewal process as they will have more chances to provide the relevant documents. The cost of inaction is the current renewal process can be more burdensome on individual members. There are no obvious benefits to inaction.

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

   There are no less costly methods of increasing the look back period during renewals from 3 months to 6 months.

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

   There were no alternative methods considered for the proposed rule

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.P. Redetermination of Eligibility

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

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

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

2. The eligibility site shall promptly redetermine eligibility when:

   a. it receives and verifies information which indicates a change in a member's circumstances which may affect continued eligibility for Medical Assistance; or

   b. it receives direction to do so from the Department.

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

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

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

   The redetermination form shall direct members to verify that the information provided is accurate or to report any changes to the information. Members must complete and the return the redetermination with necessary verifications and the signature form. If a member fails to sign the

signature form or comply with any of these requirements, the member will be terminated from the program for failure to complete the redetermination process.

The following procedures relate to mail-out redetermination:

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

b. Members shall provide requested forms, verifications and information to the eligibility site within 10 working days;

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

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

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

f. Members who return properly completed redetermination forms and requested information during the reconsideration period shall not be required to submit a new application for eligibility. If redetermination forms and requested information are not returned within 90 days after termination, the member must submit a new application to obtain enrollment in the program.

g. For individuals who are determined to be eligible for Medical Assistance within the reconsideration period, the effective date of coverage will be the first day of the month in which the redetermination form was returned. If the member has a gap in coverage due to submitting the redetermination within the reconsideration period, the member can request up to three months in retroactive coverage.

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

a. due to incomplete information, the request form shall be mailed to the member with a letter specifying the items that require completion. The member shall return the completed request form to the eligibility site no later than ten working days.;

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

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