Colorado Department Health Care Policy and Financing

General Aged, Blind, and Disabled Medical Assistance User Desk Reference Guide

Contents

A. Introduction

This reference guide covers general program rules and policies for both the Aged, Blind, and Disabled (ABD) populations as well as Long-Term Care (LTC) populations. These procedures coincide with the rules pertaining to these categories which can be found in 10 CCR 2505-10 Volume 8 under 8.100.5.

ABD Medicaid is a state/federal program that provides health coverage for residents that are aged, blind, or disabled. Medicaid is also known as Medical Assistance. Federal rules for this program are based on Social Security policies.

There are different programs of Aged, Blind and Disabled Medicaid:
(For specific details of these programs, please refer to their particular section in either the LTC Medicaid User Desk Reference Guide or the Aged, Blind, and Disabled Medicaid User Desk Reference Guide.)

- SSI-related Medicaid
- Long-Term Care
- Home and Community Based Services (HCBS)
- Breast and Cervical Cancer Program (BCCP)
- Medicare Savings Programs (MSP): Qualified Medicare Beneficiary (QMB), Special Low Income Medicare Beneficiary (SLMB), Qualified Individual- 1 (QI-1), and Qualified Disabled Working Individual (QDWI)
- Low Income Subsidy (LIS)

1. Benefits under more than one category and Medicare Eligibility

It is possible for a client to be eligible and active on more than one program of Medical Assistance. This happens when a client is approved for one program, such as MSP, but requires the care that is provided through another program, such as LTC. In this case, the client would receive benefits from both categories of Medicaid.

Medi*care* and Medic*aid* are 2 separate benefit programs. Medicaid **is** administered by the Department of Health Care Policy and Financing. Medicare is administered by the Centers for Medicare and Medicaid Services. Any questions regarding Medicare benefits should be directed to CMS at 1-800-MEDICARE. A client may be able to receive both Medicare and Medicaid. This happens when a client receives Medicare in conjunction with their Social Security benefits and also qualifies for Medicaid.

B. Application

If a client is approved for SSI, the application for SSI is considered the Medicaid application, and the SSI recipient shall not be required to submit an application to an eligibility site to be assessed for Medicaid eligibility. The date the client submits the application to the Social Security Administration (SSA) is considered their application date.

Clients applying for ABD Medical assistance often need help with completion of the application and with obtaining all documents needed for eligibility determination. The client may be assisted by any person they choose.

An interview is ***NOT*** required for any Medical Assistance program. An application cannot be denied for "No Show" if the client failed to come in for their Food Assistance (or other category of assistance) interview/appointment. If the client does not show for their interview for another category of assistance, all information and verification needed must be requested via the mail. If verification is not submitted, then the case can be denied for failure to provide verification. "No Show" denials are not an acceptable form of denial for Medicaid.

An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within 3 months after the date of death, the application should be processed as if the client were alive. If the application is filed more than 3 months after the date of death, the client is not eligible.

1. Processing standards (8.100.3.D)

An initial application requiring a disability determination shall be processed as soon as possible, but no later than 90 days following receipt of an application. An initial application for any program not requiring a disability determination shall be processed as soon as possible, and no later than 45 days following receipt of the application. The deadline covers the period from the date of receipt to the date the eligibility site mails a notice of its decision to the client. Exceptions to this may occur, but must be documented in the case file and in CBMS case comments. Exceptions can include: When the eligibility site cannot reach a decision because the client or an examining physician delays or fails to take a required action, or when there is an administrative or other emergency beyond the agency's control.

The agency must document the reasons for delay in the client's case record.

The agency must not use the time standards as a waiting period before determining eligibility, or as a reason for denying eligibility (because it has not determined eligibility within the time standards).

2. Disability Determination (8.100.5.A.2)

A client must be determined aged, blind or disabled as defined by SSA to be eligible for any of the ABD categories of Medicaid. This means that if the client is not already receiving SSA benefits (for disability or blindness), the contractor, currently ARG (Action Review Group), will need to assess the client and determine if they meet the disability requirement. All clients for these programs must complete a Disability Determination Application in addition to the Colorado Medical Assistance Application. ARG will conduct their disability determination and notify the eligibility site of their findings. Upon completion and submission to the eligibility site, the eligibility site is responsible for forwarding such application to ARG at the following address:

Action Review Group
PO Box 340
Olyphant, PA 18447

Please provide an adequate number of ARG Release forms with the application. There should be a release form for every medical source the client tells you about or writes down and three additional release forms must also be signed. These additional forms allow ARG to contact any new medical sources since the date of application or any discovered medical sources that the client did not mention. Failure to include these additional release forms will result in a delay of processing time.

3. Effective Date of Eligibility (8.100.5.C)

Medical Assistance begins on the date the application was received (date stamp) or the date the client becomes eligible. This date can vary, and often times depend on the date the client is deemed to be disabled by either ARG or SSA. The begin date can also change because of a client serving a Period of Ineligibility (POI) due to a Transfer without Fair Consideration (TWFC). Please see the LTC Medicaid User Desk Reference Guide for more information on Periods of Ineligibility.

Example:
Ms. Dove applied for Aid to the Needy Disabled (AND) and Long-Term Care (LTC) on 6/14/2007. On 7/3/2007, her AND case was approved, her LTC case was pending a disability determination by ARG but she is otherwise eligible for benefits. ARG assessed her on 8/29/2007 and determined that she is disabled, but her disability did not begin until 8/2/2007. Her Medicaid would start 8/2/2007, when she became disabled.

a. Effective Begin Date For SSI recipients

The client does not receive an SSI payment until the first full month after SSA determines them eligible for SSI. However, the Medicaid State Plan allows for Medicaid to begin on the application date. The SSI application date is the Medicaid application date which makes the client Medicaid eligible before receiving payment. This is called the "gap month". See section on a. Retroactive Coverage for SSI cases below for further information.

Colorado's State Plan only allows the eligibility begin date to be the actual application date and not the beginning of the month of the application for ABD programs. Therefore, the days in the gap month prior to the application date need to be reviewed for 3 month retroactive coverage.

Example:
Mr. Spring applied for SSI on 9/16/2008 and was approved on 12/19/2008, with a disability. He had a medical expense on 9/7/2008. His Medicaid begins effective 9/16/2008, when he applied for SSI. Mr. Spring would need to be reviewed for retroactive coverage in order to cover the medical bill prior to the application date of 9/16/2008.

4. 3 Month Retroactive Coverage (8.100.3.E and 8.100.5.C.2)

If a client incurred a medical expense within three months prior to the application date, they may be able to have that expense paid by Medicaid. The client must be eligible during the month they are requesting the retroactive coverage, meaning that they must meet all income, resource and disability requirements.

Example:
Mrs. Evergreen applied on 12/12/2008, and requested retroactive coverage for a bill for 11/3/2008 trip to the hospital. In order to be eligible, she will need to provide verification of all resources she held in 11/08, all income she received in 11/08, and verification showing she was disabled in 11/08 (this may come from ARG).

A client can request retroactive coverage at anytime, and does not need to do so at the time of application.

Examples:

Example #1

Mr. Everest applies in June, and in October receives a bill for medical services he received in May, he can request Medicaid services to be retroactively covered.

Example #2

Mr. Evans applied for Medicaid in March of 2006 and now needs to have an expense he incurred in February of 2006 covered. He can request that it be covered, and as long has he meets all eligibility requirements, will have the bill paid by Medicaid.

If a client is found eligible for retroactive coverage, the provider will need to bill Medicaid in order for the bill to get paid. The client will most likely need to inform the provider to do so.

For more information on the begin date for all categories of Medicaid, please reference the State Plan on page 24 of Attachment 2.6-A.

- For the Family and Children's categories, eligibility begins the first day of the month of application. Retroactive coverage for Family and Children's Medicaid can begin on the first day of the three month retroactive period. E.g. the application date was 11/12/2008. The client is requesting retroactive coverage for 08/12/2008. For Family and Children's categories, the eligibility begin date can be retroactive to 08/01/2008. The medical bill from 8/12/2008 will be eligible for payment by Medicaid.

- For the ABD categories, eligibility begins on the date of application. Retroactive coverage for ABD categories can begin effective three months back from the original application date. E.g. the application date was 11/18/2008. The client is requesting retroactive coverage for 08/12/2008. For ABD categories, the eligibility begin date can only be retroactive to 08/18/2008. The medical bill from 8/12/2008 will not be eligible for payment by Medicaid.

a. Retroactive Coverage for SSI cases

When a client becomes Medicaid eligible by receiving Supplemental Security Income (SSI), their medical coverage begins as of the SSI application date. As with other Medicaid programs, the applicant may be reviewed for retroactive coverage up to 3 months prior to this application date.

Historically, SSI Medicaid has not provided retroactive coverage because SSI benefits are not paid retroactively. The Department has reviewed this policy and has determined that retroactive coverage is allowed within the SSI category of Medicaid.

Currently, CBMS does not allow retroactive coverage for the Adult Medicaid (AM)-SSI Mandatory category. CBMS will be corrected to allow retroactive coverage in the AM-SSI Mandatory category in the future. In the interim, please follow the procedure.

In order to be determined eligible for retroactive coverage within this category, a client or their representative must:

1. Initiate a request
   - Client or representative can contact the eligibility site and submit a retroactive request date

2. Provide requested verification
   - Provide applicable verification listed on the manual verification request letter sent by the eligibility site

3. Declare a Medical Expense
   - The medical expense must have been incurred during the 3 months preceding the date of their SSI application. If client does not declare, this information may be located within SVES.

4. Have countable income below the current SSI income limit
   - Limit for 2013 = $710 (single) $1,066 (couple)

5. Have countable resources below the current SSI income limit
   - Limit for 2013 = $2000 (single) $3000 (couple)

6. Meet Social Security Administration's (SSA) Disability Criteria
   - This can be met by Disability Onset Date or an approved determination from the state Disability Contractor

- If the client has a Disability Onset Date that covers the retroactive request date, a disability application is not required
- If the disability onset date does not cover the request date or the client does not have a disability onset date, then a Disability Determination Application must be completed, submitted and approved

If the Retroactive request date is within the SSI application month, the client will only need to meet the disability requirement.

Eligibility Site Process:

Initial Research

When a request for retroactive coverage is received, initial research within CBMS should be completed prior to requesting additional information from the client to process the request. The following process should be followed:

1. Go to the **Clear/Inquire on Individual** screen
2. Enter the client's demographic information and click on **Search**
   - Client will need to have an existing AM-SSI Mandatory case in active, pending or closed status
3. Go to Search **SDX/BENDEX Master** screen
4. Enter client SSN and click on **Search**
5. Find the **SSI Application Date** field
   - This is the Medicaid application date. Client's eligibility begin date for AM should currently be this date. The retroactive request date can be 3 months prior to this date.
6. Go to **Search Medical Spans Data** screen
7. Enter client's State ID, click on **Search**, click on **Select**
   - There should be an existing medical span with a Begin Date that matches the SSI Application Date. If the existing medical span covers the retroactive request date, it is not necessary to complete this process.
8. Under **Interface Activities**, Select **SVES Request**
9. Enter client's SSN
10. Click on **Open**
11. Select **Title XVI**
12. Click on **Find**
13. Click on **Select**
14. Click on **Save Icon**
15. Under **Interface Activities**, Select **Search SVES Data**
16. Click on **Open**
17. Enter client's SSN
18. Select **Title XVI** Report Type
19. Click on **Search**

20. Click on **Detail**
21. Click on **SSI Application** tab
22. Find the **Disability Onset Date** field
    - This date must cover the retroactive request date. If not, the client will need to complete a Disability Determination Application as indicated above to be sent to the state Disability Contractor.
23. Find the **Unpaid Medical Expense Ind [Y/N]** field
    - If there is a "Y" in this field, there are unpaid medical expenses for the client. If there is a "N" in this field, there are no unpaid medical expenses that were declared to SSA. A retroactive coverage request can still be processed if there is a "N" in this field. The client or representative should have declared a medical expense when they initiated the request.

Additional Information Request

Once the initial research is completed, additional information may be required to complete the request. The following process should be followed to request this information:

1. Send a **Redetermination Notice** to request income, resource and medical expense information for the time period the client is requesting coverage.
   - This is not required if the retroactive request date is within the SSI application month

2. If client does not provide verifications with the Redetermination Notice, send the client a manual verification request letter (your site's verification request) to request applicable verifications. At this time, CBMS does not generate a verification checklist for AM-SSI Mandatory clients.

3. As soon as information and verifications are received, review client information to determine if the client would have been SSI eligible IF they would have applied.
   - Income and resource eligible
   - Disability

4. If the client does not provide the Redetermination Notice, requested verifications or does not meet eligibility criteria for the retroactive request, send a manual denial notice to the client. Please use language below:

   Your request for Retroactive Medical Assistance to cover your past medical bills has been denied. We cannot approve coverage prior to your application date because you do not meet the eligibility criteria for the program or you did not provide requested verification.

   The relevant Medicaid rules can be found at 10 CCR 2505-10, 8.100.3.E; 8.100.5; 8.100.5.M.1

Complete Retroactive Request

Once it has been determined that the client is Medicaid eligible prior to their SSI Application Date, the following process should be followed and completed within the **same business day** in order to update the existing medical span:

If the AM case is **Active**, the AM case will need to be **Closed**:

1. Under **Intake and Case Maintenance**, select **CBMS Web Interactive Interview**
2. Enter AM case #
3. Click on **Open**
4. Go to **Case Individual** screen
5. Select Client
6. Select **Adult Medical Assistance**
7. Update the **Requesting Assistance** field from **Yes** to **No**
8. Do not update the **Effective Begin Date (EBD)** or **Request Date**
9. Click on the **Save Icon**
10. Run **EDBC**
11. Authorize AM closure
12. If there are financial programs attached to the AM case, do not authorize those programs.
13. Remove all discontinuance notices from the print queue
14. Follow the **Application Initiation** steps below

If the AM case is **Pending**, the AM application will need to be **Cancelled**:

1. Go to **CBMS Web Interactive Interview**
2. Enter AM case #
3. Click on **Open**
4. Select AM Application #
5. Under **Application Initiation**, select **Cancel Application**
6. Select **Client Requested** as the **Cancel Reason**
7. Click on the **Save Icon**
8. Run **EDBC**
9. Authorize AM denial
10. Remove all denial notices from the print queue
11. Follow the **Application Initiation** steps below

If the AM case is **Closed**, the AM case will not need to be rescinded:

1. Follow the **Application Initiation** steps below
2. Only create an **SSI Details** record for the time period the client was eligible for SSI

- Update **Receiving** field to **Yes** with **EBD** of Retroactive request date
- Click on **Save Icon**
- Update **Receiving** field to **No** with EBD of first of the month following the month the client was originally closed for AM (review medical span to see original end date)

3. Authorize approval and denial month(s) to re-close case

Once the AM case is closed, **initiate a new application** for AM:

1. Under Application, select CBMS Web Application Initiation
2. Click on Add
3. **Application Date** = retroactive request date
4. **Program Requested** = Adult Medical Assistance
5. Enter all applicable information throughout the AI queue
6. Attach the new AM application to the existing AM case (do not create a separate case)
7. Continue through CBMS Web Interactive Interview
8. Enter all application information throughout the II queue based on information that was verified.
9. All applicable **EBD**'s should be updated to reflect the retroactive request date, not 3 months prior to including the **SSI Details** screen.
10. Run **EDBC**
11. Authorize AM Approval
12. If there are financial programs attached to the AM case, authorize those programs.
13. Review all notices in the print queue and remove those that are not applicable.
14. Add a detailed **Case Comment** that includes the following information:
    - Retroactive request received, from whom and retroactive request date
    - Reason for manual closure or application cancellation (retroactive request)
    - Income verified (if applicable)
    - Resource verified (if applicable)
    - Medical expense declared
    - Disability verified
    - Eligibility results (approved for time period or not, if not, why)
    - New eligibility begin date for AM-SSI Mandatory

Once the AM case is **authorized**:

1. Check med spans the following day for accuracy.
2. Contact client and/or provider to notify them and let them know they can submit claims back to the retroactive request date within 3 business days.

This procedure is reference in Agency Letter HCPF 11-015.

C. Verification (8.100.5.B)

1. Required Information and Verification

- Social Security Number (SSN) (number only-request card only if questionable)
- Income (earned income can be self-declared if the client provides a Social Security Number and meets the criteria to be verified through IEVS, see the General Medicaid User Desk Reference Guide for more information)
- Non-citizen status (if applicable)
- Disability (as determined by SSA or ARG)
- Assets/resources
- Citizenship and identity (if not exempt)

Accept self declaration for all other items, unless you document them as questionable.

a. Social Security Number

A client does not need to provide a document or social security card, only the number. The SVES interface in CBMS will verify the validity of the SSN entered for each person. If the SVES system returns a mismatch record, then the client must provide verification of that the SSN. They must also verify the number if the number is already used for another client within CBMS.

- Verify the SSN only once
- Do not require family/household members who are not applying for assistance to supply a SSN
- Do not require or verify SSNs of clients who receive emergency services only

b. Income

Verify all sources of non-exempt income for clients and recipients. Whenever possible, verify unearned income using the interfaces and other computer systems (i.e., ACSES, CUBS, SDX, BENDEX, etc).

The client is responsible for providing verification of income that cannot be obtained through interfaces. Under these circumstances, income must be verified by the client through other sources (i.e. award letters, etc.).

If a client is having difficulty obtaining verification, the eligibility worker may assist the client by:

- Performing collateral contact with the entity on behalf of the client
- Referring the client to an agency where the verification can be obtained
- Giving the client the contact information of someone who can provide the verification

c. Non-Citizen Status

A client who indicates they are not a citizen must provide an official government document that lists his/her non-citizen status and registration number if they are applying for Medicaid not based on an emergency. Emergency Medicaid clients are not required to produce non-citizen documents. The client does not need to provide the original non-citizen document, a copy is

acceptable. Verify the individual's non-citizen status by checking Systematic Alien Verification for Entitlement (SAVE) system. Clients who do not provide proof of non-citizen status can qualify for Emergency Medicaid.

Do not re-verify non-citizen status unless the client reports a change in citizenship or non-citizen status, or if the document the client submitted is expired, and the client's status cannot be re-verified using SAVE.

d. Disability

Any person who is not over the age of 65 or who does not meet the SSA definition of disability, needs to be considered disabled for Medicaid and must complete a disability determination application. The following persons are deemed to be either aged or disabled by the SSA and do not need to complete a disability determination application:

- Receiving SSI or SSDI,
- Aged 65 or older

e. Resources/Assets

Verification of resources is mandatory for clients requesting ABD Medicaid programs.

Also verify resources of community spouses for LTC Medicaid or HCBS waiver programs.

If reported resources exceed the resource limit, do not pursue verification.

- Do not verify cash on hand
- Do not verify exempt resources

Examples:

Example #1

A client's principle place of residence is not counted in determining his/her Medicaid eligibility. Do not require verification of its value in determining Medicaid eligibility.

Example #2

Mr. Ives has $6,000 in a checking account. Since he is over the resource limit of $2,000, the checking account does not need to be verified.

2. Verification Requirements at Application

The time period for processing an application for ABD Medicaid is 45 days and 90 days for a disability determination. Notify the client of the specific verifications required within the processing time. CBMS gives the client a minimum of 70 days to return DRA verification and a minimum of ten (10) calendar days to provide any other verification.

CBMS will send a verification checklist to the client listing what verification is needed to process their case. CBMS will also determine the due date for the verification, and include it on the

verification checklist. Please see HCPF training materials regarding Medical Assistance Verification for more information.

Remember, on any combination application (for example, client applying for Medicaid and Food stamps and OAP), the Medicaid portion of the application **cannot** be denied for failure to attend an interview. All verifications must be requested via the mail within the processing timeframes.

Example:

Mr. Schmidt submits an application on 8/9/2007 for Food Stamps, Old Age Pension and Adult Medicaid. He does not come back in for his interview on 8/10/2007. The worker will need to send a request for verification via the mail to the client for any information/documentation/verification that is missing. The application must be either approved or denied by 11/9/2007, so the verification must be requested prior to 10/29/2007 to give the client the 10 day time frame to submit verification.

3. Verification Requirements at Redetermination

Information that does not change (i.e., SSN, citizenship and Identity) will not need to be re-verified at redetermination.

Any information that could change needs to be re-verified at redetermination. This includes:

- Disability
- Assets/resources
- Non-citizen status- if changed

Example:

Mrs. Lilly applied April 2007 and her RRR is due in March of 2008. No information has changed, she is still working at the same job, and her disability determination is current. The only verification she would need to provide would be any updates to assets. Her income should be verified through IEVS and she does not yet require an update in her disability determination.

4. Questionable Verification

Information is questionable when:

- There are inconsistencies in the client's oral and/or written statements
- There is conflicting information between what the client is declaring/ stating and what has been verified
- The client or his/her representative is unsure of the accuracy of his/her own statements
- The information submitted is unclear or vague (i.e., information provided, but is not clear)

5. Providing Assistance

If verification can be obtained from other sources, such as CBMS interfaces, the eligibility site worker must use those sources to verify any information before requesting verification from the

client. If verification cannot be obtained via other sources, then the eligibility worker should request the verification from the client.

Release of Information-
If a verification source requires a written release in order to obtain necessary verifications, have the client sign a Release of Information form. The signed Rights and Responsibilities section of the application can be used as a valid Release of Information form. Both the Colorado Medical Assistance Application and the Application for Assistance contain clauses which give third parties permission to release information and verification.

When a source requires a written release:

- Explain the requirement to the client
- Ask the client, his/her spouse or authorized representative to sign the necessary release form(s), if necessary

Deny or discontinue benefits only when:

- The missing verification is necessary to determine eligibility, and
- The client is unwilling or unable to provide the verification directly and it cannot be verified through another source such as collateral contact

6. Failure to Provide Information

Deny or terminate benefits when all of the following are true:

- The client has been given adequate notice of the verification required and failed to submit the verification
- The verification cannot be verified through another source such as collateral contact
- You need the requested verification to determine current eligibility

Do not deny current eligibility because a client does not verify some past circumstance not affecting current eligibility (such as verification required for a retroactive month or a job that started and ended in the past).

D. Income

1. Assistance Unit (8.100.3.A.11)

The Assistance Unit, formerly referred to as the Medicaid Budget Unit (MBU) includes the individual who is applying for Medicaid and anyone who lives with them, who is legally responsible for them, or for whom the client is legally responsible. Spouses who live together are in each other's assistance unit. This means that the income and resources of both spouses are counted when determining Medicaid eligibility for either or both spouses. The assistance unit for this situation/living arrangement is two.

An exception to the Assistance Unit policy involves SSI Supplemental Security Income. If one spouse is applying for Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse

is not included in the other spouse's assistance unit. For this situation you would again have a one person assistance unit when determining the Medicaid eligibility of the non-SSI spouse.

2. SSI and SSDI

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits are financial programs administered by SSA. The two programs provide financial payment to clients whom are determined disabled by SSA, and both programs use the same disability requirements. The difference in the two programs is noted in the chart below:

Differences between SSDI and SSI	
SSDI	**SSI**
referred to as SSDI, SSD, Title II or Title 2	referred to as SSI, Title XVI, or Title 16
must have worked 5 of the last 10 years to qualify	no work history required
no resource limit	$2,000 resource limit for individuals $3,000 resource limit for married couples
benefits can be back paid up to 1 year before SSDI application	benefits can only be paid as of the application date and after
no paid benefits for the first 5 months of disability	no waiting period for benefits after disability determined
can get Medi*care* after 2 years of benefits	can get Medic*aid*

The amount the recipient receives also varies. SSDI pays a higher amount than SSI. If a recipient receives a monthly SSDI payment less than the monthly SSI payment, they may be eligible to receive an SSI payment that when counted in conjunction with the SSDI payment will make their total monthly income equal to the maximum SSI payment. Because SSI is a supplemental income benefit, a client can only receive SSI when they have resources below $2,000 for an individual or $3,000 for a couple. The client must also be under the SSI income limit to receive SSI. If a client is receiving SSDI benefits, they will only receive the additional SSI benefits if their income and resources are below the SSI limits.

3. Income disregards (8.100.5.H)

Each category of Medical assistance allows certain disregards and deductions to be subtracted from the client's income to determine if the client's income is below the limit. For specific information on what disregards are given for each category, please refer to the income section in each of the user guides.

E. Resources (8.100.5.M)

The resource limit for the OAP and SSI related categories of Adult Medicaid programs is $2,000 for an individual and $3,000 for a married couple.

For the MSP programs, the 2013 limit is $8,580 for an individual and $13,620 for a married couple.

For the LTC and HCBS categories, the resource limits are as follows:
$2,000 for an individual
$3,000 for a couple who is institutionalized in different rooms
$4,000 for a couple who is institutionalized in the same room
$115,920 for the community spouse of an institutionalized individual

Add together all countable, available resources of the members of the assistance unit including:

- Joint accounts
- Burial assets
- Savings account
- Checking account
- Cash available
- Stocks, bonds, CDs
- Life insurance
- Non-burial trusts
- Reverse mortgage
- Property not otherwise excluded (see below)

The resources must be within the appropriate limit to qualify for Medicaid. Clients with resources in excess of the appropriate limit are ineligible for Medicaid.

The current equity value or balance of all resources must be verified.
The acceptable types of verification vary on the type of resource. Examples of verification types can include current:

- Statement from a financial institution for any liquid resources
- Assessor's value of real property
- Blue book value for vehicles

Do not count income as a resource in the month it was received when determining the countable resource amount.

Example:

Mr. Johnson has $2600.00 in his checking account for the month of March. Of that amount, $700.00 is unearned income that he received in March. His countable resource amount is $1900.00.

1. Exempt resources (8.100.5.M.2)

The following are exempt:

- Principle place of residence
- 1 vehicle per household (if there is more than one vehicle, exempt the vehicle with the highest value)
- Household goods if not held for investment reasons

- Personal effects if not held for investment reasons
- Burial spaces

2. Availability (8.100.5.E)

A resource is available when:

- It can be sold, transferred, or disposed of by the owner or the owner's representative, and
- The owner has a legal right to the money obtained from sale of the resource, and
- The owner has the legal ability to make the money available for support and maintenance

Consider a resource as unavailable if:

- The client lacks the ability to provide legal access to the resources, and
- No one else can access the resources

3. Disposing of Assets

Disposing of Assets is the process of reducing the resources an individual possesses in order to qualify for Medicaid. It is spending one's money until the appropriate resource limit is reached.

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

It is also important to note that disposing of resources does not mean that the resources must be spent on care, i.e. medical care and/or the nursing facility. Disposing of resources means that the funds are used to purchase items at their "fair market" value. In this regard, one must distinguish disposing of resources from "gifting," i.e. giving something away or making a purchase for less than "fair market value". The purchase of clothes, a television, a haircut or other similar items are for fair market value and do not constitute "gifts." Gifts or purchases for less than fair market value are penalized by Medicaid and the penalties result in periods of ineligibility for Medicaid. Please refer to the LTC User Desktop Guide for more information.

4. Burial Policies (8.100.5.M.2.O)

- Irrevocable Policies of any value are exempt.
- Revocable Policies of up to $1500 are exempt. Any policy worth $1500 or over is countable.

Up to $1500 of revocable burial funds are exempt if the funds are being held in an account or trust that is solely for the use of burial expenses. Any interest that accumulates on such funds is exempt as long as it is kept in the account and it is not transferred out to another countable resource (such as a checking or savings account). If determining eligibility for a couple, each person receives their own $1500 exemption. Such funds must be kept separate from other countable resources (for example, the burial funds cannot be combined with a savings account).

If such funds are combined, all combined funds, including the burial, will be counted against the case.

The $1500 exemption is reduced by:

- The dollar amount of any irrevocable burial funds and,
- The *face value* of any life insurance policy whose *cash surrender value* is exempt

If a client was determined to be over resources due to their burial policy, but is found eligible for OAP financial assistance, Medical coverage will be approved for such client under the Health Care Plan.

Example:

Mrs. Nelson owns a personal life insurance policy with a face value of $25,000 and a cash surrender value of $1500. She also has a revocable burial fund for herself in the amount of $2500.

The exemption for the burial fund is as follows:
$1500 exemption - $25,000 life insurance = $0 exemption
All $2500 of the burial funds are countable against the case.

5. Life Insurance (8.100.5.M.2.l)

Face value is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions. Cash value means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it.

Count the cash value of all life insurance policies. For persons age 65 or over, blind or disabled, count it only when the total face value of all policies owned by each person exceeds $1,500. Do this calculation for each ABD person. In determining the face value, do not include any life insurance which has no cash value.

Life insurance policies always have a face value, but do not always have a cash value. Term life insurance is limited to a defined time period as stated in the policy and does not usually have cash value. Group life insurance is usually term insurance and usually has no cash value.

a. Countable value of life insurance policies:

Life insurance is countable on Adult Medicaid. However, if the face value of the insurance is less than $1500, then the life insurance will not count.

Example:

Life insurance policy face value $6,000- $6,000 is over the $1500 limit so the full cash value in resources would count against the case. A life insurance policy face value of $1250 is less than the $1500 limit so $0 will count against the case.

6. Reverse mortgages (8.100.5.L)

A reverse mortgage loan is a loan, or an agreement to lend, which is secured by a first mortgage on the borrower's principal residence. The terms of the loan specify regular payments to the

borrower. Repayment (through sale of the residence) is required at the time all the borrowers have died, or when the client has sold the residence or moved to a new one.

Treat reverse mortgage loan payments to the borrower as resources in the month received and thereafter. Do not count undisbursed funds (not yet paid to the borrower) as resources. They are considered equity in the borrower's residence.

7. Lump Sum Payments

Lump sum payments (rather than recurring payments) from such sources as insurance policies, Railroad Retirement, and Unemployment Compensation benefits, are counted as an income in the month received. Any amount of the payment that remains unspent the following month will be counted as a resource, and will continue to count as a resource until it is spent.

Example*:*

Mrs. Parsley received a lump sum payment of $3489 for her Short Term Disability claim on 9/8/2006. $3489 counts as income in 9/06 and any remaining amount counts as a resource on her case beginning 10/2006 and until the amount remaining is below the resource limit.

a. Retroactive Social Security Lump Sum Payments (8.100.3.L.1.c)

A retroactive payment means it is paid later than the month in which it is due. The unspent portion of retroactive SSI and Retirement, Survivors, Disability Insurance (RSDI) benefits are excluded from resources for the nine calendar months following the month in which the individual receives the benefits.

Do not count a retroactive SSA or SSI payment as a resource either in the month of receipt or nine months following the month the payment is received.

After nine months, treat any remaining available portion as a resource.

Example:

Mr. Jones was approved for SSDI on 6/3/2007 and received a lump sum payment of $2648 in 7/2008. He received a check in that amount and never cashed it. In April 2008 his case closed down for being over resources. The full balance of the lump sum remained in his account for over 9 months, which put him over resource limit.

8. Personal Property (8.100.5.M.2.i & 8.100.5.M.2.j)

Exempt Property:

Do not count household goods as a resource if such items are:

- Personal property, found in or near the home, that are used on a regular basis; and
- Items needed by the household for maintenance, use and occupancy of the premises as a home

Examples of household goods include but are not limited to:

- Furniture,
- Appliances,
- Electronic equipment such as personal computers and television sets,

- Carpets,
- Cooking and eating utensils, and
- Dishes

Items that are acquired or held because of their value or as an investment are not considered household goods and are countable.

Do not count personal effects as a resource if such items are:

- Personal property originally worn or carried by the individual, or
- Articles otherwise having an intimate relation to the individual

Examples of personal effects include but are not limited to:

- Personal jewelry including wedding and engagement rings,
- Personal care items,
- Educational or recreational items such as books or musical instruments,
- Items of cultural or religious significance to an individual, such as ceremonial attire, or
- items required because of an individual's physical or mental impairment, such as prosthetic devices or wheelchairs

Items that are acquired or held because of their value or as an investment are not considered personal effects and would be countable resources on the case. Investments such as these should be entered into the Liquid Assets screen in CBMS.

9. Vehicles (8.100.5.M.2.h)

Vehicle means any vehicle used for transportation. Vehicles need not be registered in order to be considered a resource. Vehicles used for transportation include but are not limited to cars, trucks, motorcycles, boats, snowmobiles. A temporarily broken down vehicle used for transportation meets the definition of an automobile.

Equity value is: The vehicle's wholesale value as given in a standard guide on motor vehicle values (blue book), or the value as estimated by a sales representative at a local dealership (appraisal), minus any encumbrances (loans or mortgages) that are recorded on the vehicle's title as liens.

Do not increase a vehicle's value by adding the value of low mileage or other factors, such as optional equipment or apparatus' for the handicapped.

Count vehicle values as follows:
One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual's/couple's household.

When an individual owns more than one automobile apply the exclusion as follows:

- Apply the total exclusion to the automobile with the greatest equity value if the eligible individual/couple own more than one automobile used for transportation of the eligible individual/couple or a member of the individual's/couple's household.

The equity value of any automobile, other than the one wholly excluded is a resource when it:

- Is owned by an eligible individual/couple; and
- Cannot be excluded under another provision (e.g. property essential to self-support, plan to achieve self-support)

F. Med Spans

The medical spans shown in CBMS will show the time span for which a client was eligible or ineligible for Medical Assistance. The coding of the span will show for which category of assistance the client was approved. Each category of assistance has its own coding which can be seen in the Med Spans. Please refer to the Med Spans Guide in the County and Medical Assistance training material on the HCPF website for a listing of the codes used on the Med Spans screen.

Following authorization of an approval, medical spans should appear in CBMS the following day.

The information from CBMS could take 48-72 hours to transmit to the MMIS, which means providers cannot see the eligibility for at least 2 days.

G. Benefits

Benefits for Medicaid Programs vary. Some programs offer full Medicaid services while others will not cover medical services and instead will help with paying of premiums for Medicare. Please refer to the individual program details to find out what services are provided.

For a brief list of covered services please refer to the Medicaid Benefits Fact Sheet on the Department's website.

If a client has questions regarding their benefits and whether or not a specific service is covered, please direct them to the Medicaid Customer Service.

H. Technical Assistance

Colorado Department of Human Services (CDHS) HelpDesk

Role

The State Help Desk assists with application and network support to CBMS users. The Help Desk is the first point of contact for CBMS issues. If the Help Desk is unable to resolve a user's problem, they enter a 'help desk ticket' request which is routed to the appropriate program or network support group for handling. A 'help desk ticket' Identifies problems within CBMS or within a particular case.

When to Contact

The Help Desk is available to assist eligibility sites with the following:

- CBMS password reset
- Data entry issues
- Help Desk Tickets
- Clearance
    - Choosing the correct client
    - Choosing the correct client or state ID

- SIDMOD-***AFTER*** the 24 hour period

Contact Info: Phone: 303-866-5204 or 1-877-487-4871
Email: PC.Helpdesk@state.co.us
After hours (OIT): 303-239-4357 or 1-877-632-2487
The hours of the CDHS Help Desk are 7 AM – 5 PM.
Please note: No password re-sets are done after hours, including weekends and State holidays.

ACS Provider Services

Role

ACS, the Medicaid fiscal agent, Provider Services offers assistance to Medicaid providers on provider enrollment, provider billing training, eligibility verification, prior authorizations, and claims submission and payment. Additional benefit and billing information is available to Medicaid providers via the Medicaid Provider Bulletins. The fiscal agent distributes the Medicaid provider bulletin monthly.

When to Contact

Providers and others should contact ACS when clients have billing issues that have not been resolved. ACS Provider Services is available Monday-Friday from 8:00am – 5:00pm, except for state holidays. Contact ACS Provider Services for assistance with:

- Claims and Billing
- Benefit Authorization/Verification
- Prior Authorizations
- Provider Enrollment
- Provider Billing Training

ACS Provider Services can be reached at (303) 534-0146, option 3; 1-800-237-0757, option 3; Fax: (303) 534-0439; and www.colorado.gov/hcpf and click on 'Provider.'

ABD Eligibility Specialist

Role

The ABD Eligibility Specialist implements policy for the ABD Medicaid program and overall program operations as well as providing eligibility site training. The ABD Eligibility Specialist also manages the ABD Medicaid program and policy.

When to Contact

Contact the ABD Eligibility Specialist regarding program policy and training requests at Medicaid.Eligibility@hcpf.state.co.us .

Medicaid Customer Service

Role

The Customer Service Contact Center is available to assist individuals by phone, email, fax, or mail. The Contact Center has English and Spanish speaking representatives, as well as a Language Line. The Language Line provides interpretation services for individuals with a limited English speaker in over 170 languages.

You can call 303-866-3513 (within Metro Denver), or 1-800-221-3943 (outside Metro Denver); e-mail at customer.service@hcpf.state.co.us; fax at 303-866-3220, or write to Colorado Department of Health Care Policy and Financing, Customer Service, 1570 Grant Street, Denver, Colorado 80203-1818.

When to Contact

Encourage Medicaid clients to contact Medicaid Customer Service for assistance with:

- Understanding medical benefits
- Obtaining assistance when billed by providers
- Finding Medicaid providers
- Complaints about providers

HealthColorado

Role

Health*Colorado* provides assistance to Medicaid clients with selecting a Medicaid Managed Care Health Plan. **Health***Colorado* provides objective and useful information on available health plans, doctors and hospitals.

When to Contact

Newly eligible clients receive information about their health plan choices from HealthColorado. All Denver county Medicaid clients must choose a Medicaid health plan. If they do not choose a health plan within 30 days, they are enrolled with Denver Health Medicaid Choice. In all other counties, clients remain on Basic (Fee for Service) Medicaid unless they call HealthColorado and choose a health plan. Fee for Service clients can see any provider that accepts Medicaid.
Clients can call 303-839-2120 in the Denver Metro area, or 1-888-367-6557 outside the metro area.

Ombudsman for Medicaid Managed Care

Role

The Ombudsman for Medicaid Managed Care assists Medicaid clients with complaints and appeals related to both their physical health managed care health plan and behavioral health managed care plan.

When to Contact

Providers and community partners are encouraged to refer clients to the Ombudsman for Medicaid Managed Care. The Ombudsman can help when clients have problems with their health plan, an issue with the quality of care they or their family member is receiving, assistance with filing a grievance, or assistance in exercising their health care rights.
Clients can contact the Ombudsman for Medicaid Managed Care at 303-830-3560 or 1-877-435-7123; e-mail at help123@maximus.com; fax at 303-832-8352, or write to the Ombudsman for Medicaid Managed Care, 303 East 17th Avenue, Suite 105, Denver, Colorado 80203.

I. Definitions

1931 Medical Assistance is a Medical Assistance category for families, qualified pregnant women and children with limited income provided under section 1931 of Title XIX of the Social Security Act.

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.

Alien is a person who was not born in this country and who is not a naturalized citizen.

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

Applicant is a person who has submitted an application for public benefits.

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.

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

Case 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.

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.

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

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

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

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

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

Colorado Medical Assistance Application is the designated application for the Family and Children's Medical Assistance Program and the CHP+ Program.

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)

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 defined in this volume as a child residing in the home under the age of 18 or between the ages of 18 and 19 who is a full time students in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19.

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.

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

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

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

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

Family and Children's Medical Assistance is a group of Medical Assistance categories that provides medical coverage for children, adults with dependent children, and pregnant women.

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

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

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.

Legal Immigrant is an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the immigration and naturalization service as an actual or prospective permanent resident of whose extended physical presence in the United States is known to and allowed by the immigration and naturalization service.

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

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

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

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

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

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

Qualified Alien is an individual who is one of the following:
1. Defined as a qualified alien under 8 United States Code section 1641.
2. Defined as a qualified alien by the attorney general of the United States under the authority of Public Law 104-208, section 501.
3. An Indian described in 8 United States Code section 1612(b)(2)(e).

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

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

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

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a GED.

Single Purpose Application is the designated application used to determine eligibility for Aged, Blind, and Disabled Medical Assistance Program categories and financial assistance.

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

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

State Only Prenatal is a state funded medical program that provides prenatal and post-partum medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.

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

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

Unearned Income is defined for purposes of this volume as any income received from sources other than employment.