Colorado Dental Health Care Program for Low-Income Seniors Operations Manual

Fiscal Year 2023-24

Effective July 1, 2023

COLORADO
Department of Health Care Policy & Financing

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ARTICLE I. PROGRAM OVERVIEW

Section I.01 What is the Senior Dental Program?

In 2014, the General Assembly created the Colorado Dental Health Care Program for Low-Income Seniors (Senior Dental Program) through Senate Bill (SB) 14-180 to promote the health and welfare of low-income seniors. To create the new Senior Dental Program, the legislation consolidated services provided by the Colorado Department of Public Health & Environment (CDPHE) through the Colorado Dental Care Act of 1977 with other dental services for low-income seniors. It also gave the Department of Health Care Policy & Financing (the Department) the authority to administer the new Senior Dental Program, which resides in Section 25.5-4-402, C.R.S., and provides low-income seniors access to patient-centered dental care. The following segment of the SB 14-180 legislative declaration illustrates the program's purpose:

> The general assembly hereby determines, finds, and declares that:
>
> (b) By relocating and reorganizing the "Colorado Dental Care Act of 1977", which provided dental services to certain eligible seniors, the state department can align those dental health care services with adult dental benefits provided through other dental health care programs for seniors and thereby target the resources effectively to low-income seniors who may not qualify for those programs.

During fiscal year (FY) 2014-15, CDPHE and the Department transitioned the Colorado Dental Care Act of 1977 to the Senior Dental Program at the Department. This transition consisted of defining grant criteria, establishing program rules, and awarding grant monies to Qualified Grantees. Grants for the Senior Dental Program were issued by the Department on July 1, 2015, and qualified seniors could start receiving dental services on that date. The Senior Dental Program rules were first established on Jan. 9, 2015, and are located at 10 CCR 2505-10, Section 8.960 and on the Department's website.

Contingent upon appropriation by the General Assembly the annual funding for the Senior Dental Program is $4 million. The Department administers the Senior Dental Program by distributing grant funds to Qualified Grantees. Grant funding must be used to provide dental services to adults who are 60 years of age or older, at or below 250% of the current Federal Poverty Guidelines (FPG), do not qualify for Health First Colorado or the Old Age Pension Health and Medical Care Program, do not have private dental coverage, and are a Colorado resident.

Section I.02 Senior Dental Advisory Committee

SB 14-180 recognized the importance of continuing stakeholder participation in the Senior Dental Program and established the Senior Dental Advisory Committee (DAC). The DAC is comprised of 11 members appointed by the Department's executive director and consists of the following:

1. One member representing the Department;
2. One dentist in private practice providing dental care to the senior population who represents a statewide organization of dentists;
3. One dental hygienist providing dental care to seniors;

4. One representative of either an agency that coordinates services for low-income seniors or the office in the Department of Human Services responsible for overseeing services to the elderly;
5. One representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b;
6. One representative of an organization of safety-net health providers that are not community health centers;
7. One representative of the University of Colorado, School of Dental Medicine;
8. Two consumer advocates;
9. One senior who is eligible for services under the program; and
10. One representative of a foundation with experience in making dental care grants.

The DAC not only serves as a forum where the Department and the stakeholder community can discuss the Senior Dental Program, it also makes recommendations to the Medical Services Board regarding rules.

In 2019, the General Assembly passed House Bill (HB) 19-1326, giving the DAC the authority to determine the maximum amount per procedure that can be spent by the program's Grantees. This law also requires that the maximum amount per procedure not be less than the reimbursement schedule for fee-for-service dental fees under Health First Colorado.

Section I.03 Definitions

1. Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.
2. Colorado Indigent Care Program or CICP means the Colorado Indigent Care Program as authorized by state law at Title 25.5, Article 3, Part 1, C.R.S.
3. Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.
4. C.R.S. means the Colorado Revised Statutes.
5. Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
6. Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.
7. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.

8. Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.
9. Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty guidelines (FPG) for a household of that size.
10. Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is not eligible for dental services under Health First Colorado or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or Client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans.
11. Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.
12. Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues, including pulpectomy.
13. Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.
14. Health Professional Shortage Areas or HPSAs means shortage designation identifies an area, population, or facility experiencing a shortage of health care services.
15. Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).
16. Health First Colorado means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2022).
17. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.
18. Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Client Co-Pay.
19. Max Client Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.
20. Medicare means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.

21. Medicare Advantage Plans mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.
22. Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2022).
23. Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
24. Palliative Treatment for dental pain means emergency treatment to relieve the Client of pain; it is not a mechanism for addressing chronic pain.
25. Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal disease progression.
26. Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.
27. Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.
28. Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.
29. Qualified Grantee or Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:
    a. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2022);
    b. A community-based organization or foundation;
    c. A Federally Qualified Health Center, safety-net clinic, or health district;
    d. A local public health agency; or
    e. A private dental practice.
30. Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.
31. Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.
32. Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the Client.

33. Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3406, C.R.S. (2022).

ARTICLE II. Grant Applications

Section II.01 Evaluation of Grant Applications

Grant applications submitted by potential Grantees of the Senior Dental Program are due February 1st every year and will be for the following fiscal year.

Current Grantees of the Senior Dental Program are mandated to complete a new grant application every fourth year for renewal into the Senior Dental Program.

Grant applications will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1. The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any applicant.
2. The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.
3. Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:
    a. Outreach to and identify Eligible Seniors;
    b. Collaborate with community-based organizations; and
    c. Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.
4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department and past grant fund expenditure, if applicable.

Section II.02 Grant Awards

The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Senior Dental Program.

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1. Identify and outreach to Eligible Seniors and Qualified Providers;
2. Demonstrate collaboration with community-based organizations;
3. Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;
4. Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and monies spent for a minimum of six (6) years;
5. For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare

Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage; Non-urgent dental services;

6. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;
7. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and
8. Submit an annual report.

Grantees will receive a contract letter informing them of the grant award for the fiscal year. A contract will then be sent to all grantees using DocuSign.

ARTICLE III. APPLICANT ELIGIBILITY FOR SDP

Section III.01 Age Requirement

1. All individuals must be 60 or over to qualify for the program.
    - Grantees must obtain a photo ID to show proof of age.
2. If an applicant provides an unexpired Colorado Indigent Care Program (CICP) or Hospital Discounted Care (HDC) card, they must still provide proof of their age.

Section III.02 Income Requirement

1. All individuals must be 250% of the most currently published Federal Poverty Guidelines (FPG) for a household their size.
    - The FPGs may be obtained at: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
2. If an applicant provides an unexpired CICP or HDC card they do not have to provide any other income information, as they qualify.
3. An applicant should provide an income statement of what their income is per month. I.e., a Social Security stub, pension stub, etc.
4. If an applicant cannot provide proof of their income, they may self-declare their income. The Grantee can use a current internal form or type a letter stating the amount the applicant makes and they may sign the form. The applicant can also write a letter and sign it stating the amount they make per month or year. NOTE: We caution that this should only be used in cases when the applicant cannot provide proof and should not be a standard that is used in all cases.

Section III.03 Colorado Resident

A Colorado resident is a person who currently lives in Colorado and intends to remain in the state. If the applicant is unable to provide actual proof of Colorado residency, they are allowed to self-declare their intent to remain in Colorado.

1. If an applicant provides an unexpired CICP or HDC card they do not have to provide any other information regarding residency as they qualify.

2. The following questions can be used to assist in determining if the applicant is a Colorado resident:
    - Where is the applicant's primary home? A primary home is the place of residence where a person lives and the place where that person, whenever absent, intends to return, regardless of the length of absence. A primary home cannot be a business address or a vacant lot or a post office box.
    - Is the applicant employed in the state of Colorado?
    - Is there a current lease, mortgage bill, or utility bill for the applicant's primary home?
    - Does the applicant have a current Colorado Driver's License or Identification Card?

Section III.04 Health First Colorado or Private Dental Insurance

1. An applicant cannot qualify for Health First Colorado or have private dental insurance.
    - If the applicant is under 65 years of age and meets the income threshold of Health First Colorado, they must supply a Health First Colorado denial letter to qualify for the Senior Dental Program.
    - If an applicant provides an unexpired CICP card they qualify for the program, as long as they are 60 or over.
2. The Grantee must check the Department's web portal to see if the individual currently is on Health First Colorado.
    - The Grantee can obtain web portal access by contacting the Department.
    - A print screen of the web portal check should be put in the applicant's file for audit purposes. The web portal is different from DentaQuest, a screen print of DentaQuest will not be accepted in lieu of the web portal print screen.
3. If an applicant has a Medicare Advantage Plan (MAP) and dental insurance is embedded in the plan, it is not considered private dental insurance.
4. If an applicant has a MAP but also purchased a supplemental to receive extra dental coverage, the supplemental is considered private dental insurance.

ARTICLE IV. INVOICES

Section IV.01 Invoice Information

1. All procedures must be completed prior to billing the Department. Invoices are always due by the 15th of the following month. If the 15th falls on a state nonwork day the invoice will be due on the previous workday. For example, if the 15th falls on a Sunday, the invoice will be due on the 13th, the previous Friday. Any invoices submitted past the deadline date will be paid the following invoice month.

2. Grantees may bill the Department the entire treatment plan at once, or they may bill procedure by procedure from the treatment plan. No matter how it is billed to the Department, the procedures must be completed prior to the Department being billed for that procedure. Treatment plans can cross fiscal years. Procedures completed within a fiscal year must be paid within that fiscal year, unless the Grantee is waiting for a payment on a patient that has Medicare. This will be the only time that the Department will pay for a procedure going into the next fiscal year. The Grantee must show proof that Medicare was billed prior to the end of the fiscal year for the Department to pay for the procedure.
3. Approximately one month prior to a new fiscal year the Department will upload new workbooks into the Grantee's SharePoint site. The workbook will contain a summary page, invoice instructions page, and a tab for each month of the fiscal year for the Grantee to submit. It will also contain an updated fee schedule, if applicable. Some columns of the invoice are password protected and cannot be changed by the Grantee due to auto populated information. To ensure that all required cells can be filled in, the Grantee should ensure the "open in desktop" has been clicked. If this has not been done it may cause the Grantee the inability to fill in cells for tooth numbers, surfaces, and quadrants.
4. All invoices must be submitted to the Department via the Grantee's SharePoint site. Access to this site may be obtained through contacting the Department.

Section IV.02 Summary Page

1. The summary page tab of the "Invoices and Summary" workbook will be populated by the Department when the Grantee receives the workbook. This page will show:
    - Grantee name, address, and contact information
    - Expenditures
    - Grant award and running total

Section IV.03 Invoice Instructions

The Invoice Instructions tab contains the information that should be entered in each cell of the invoices and if it auto populates.

Section IV.04 Monthly Invoice Tabs

1. There will be 12 tabs going from July through June, same as the state fiscal year.
2. The invoice contains the following cells:
    - Client's name - Must have first, middle initial, and last name. If no middle name it must be entered as NMI. Do not use any symbols, this includes commas, periods, etc.
    - Gender - Should be entered as M or F.
    - Client's Zip Code - Should be the zip code of the Client's home residence.

- Date of Birth - Should be entered as xx/xx/xxxx and should match the ID used to prove age.
- Has Medicare - Should be entered as Y or N.
- Date of Service - Should be the date the procedure was completed and should be entered as xx/xx/xxxx.
- Treating Provider - Should be the name of the individual that completed the procedure.
- Location Zip Code - Should be the zip code of the location of where the procedure was performed.
- Procedure Code - This is a drop-down list of procedures and the correct procedure should be selected.
- Procedure Description - This automatically populates based on the procedure code selected.
- Tooth Numbers - Tooth numbers should be listed if the fee schedule indicates it. Tooth numbers are only 1 - 32 and cannot contain letters as baby teeth are not covered by the program.
- Tooth Surfaces - Tooth surfaces should be listed if the fee schedule indicates it.
- Quadrants - Quadrants should be listed if the fee schedule indicates it.
- Patient Co-Pay Amt - The max copay amount that is listed on the fee schedule would need to be entered into the invoice as it does not automatically update. The reason for this is not all Grantees charge a copay. If an amount entered is over the max co-pay amount, the procedure will not be added into the total amount of the invoice.
- Max Program Fee - This is the max procedure amount listed on the program's fee schedule, it will auto populate.
- Amt Less Than Max Fee - If the Grantee is going to bill less than the max program fee, this amount would be entered here.
- Total Max Allowable Fee - This total will be the sum of the co-pay and the max program fee, it will auto populate.
- Amt Billed to HCPF - This is the amount that will be billed to the Department.
- Total Treatment Costs - This is the sum of all procedures from the "Amt Billed to HCPF".
- Total Administration Costs (7% of total Treatment Costs) - There is a 7% administration fee that will be paid to Grantees. For example, if the total treatment costs were $5,000 the 7% fee would be $350.00 ($5,000 x 7%). It is up to each Grantee if they will take the 7% or use it on treatments for the Clients.

3. After the invoice is submitted to SharePoint, the Department will review all procedures billed. If there are procedures that were billed incorrectly, i.e., double

billed on the invoice, was billed prior, not enough time between the same procedure, etc., the Department will remove them from the invoice. The Department will then inform the Grantee the procedures removed and the new invoice amount.

4. Procedures from the following month cannot be on the invoice. For example, if the Grantee submits a February invoice, March procedures cannot be on the February invoice. However, past procedures can be on an invoice as long as it is within the same fiscal year. For example, if the Grantee is submitting the May invoice, any procedures from July through April can be on the May invoice. June will be the final invoice for every fiscal year. Grantees can add any procedures to the June invoice that did not get billed previously. If any procedures are missed and not put on the June invoice, the Grantee will not receive payment. The only exception to this is for a Client that is on Medicare and the Grantee is waiting for payment from Medicare before billing the Department. For example, if a Grantee bills Medicare for a procedure in May but does not hear back from Medicare until August, the Grantee can bill the Department for that procedure even though it crossed fiscal years. However, the Grantee must provide proof that Medicare was billed for that procedure prior to the end of the fiscal year.
5. If there are numerous errors on the invoice the Department will contact the Grantee and let them know of the errors. The errors will need to be corrected and then the invoice uploaded again in the Grantee's SharePoint site.
6. Grantees will receive an email from the Department when the invoice has been paid and when they should see the funds in their accounts.

ARTICLE V. Audits

The Senior Dental Program will conduct an audit once a year. Audits will be performed at random times throughout the year and can be performed up to four times per year.

- The yearly Audit period will reflect the previous fiscal year's Senior Dental Program documents beginning on July 1st through June 30th, unless otherwise indicated by the Department.
- The Department will randomly select Client files for each Grantee and send the audit list via email to the approved Grantee contact person on file.
- Clients that receive Immediate Dentures are automatically added to the audit list.
- The Grantees shall have 30 days to upload this data into their SharePoint drive. Extensions may be granted for due cause.
- All files selected will be reviewed to ensure they were not part of Health First Colorado during the time of service.

1. The SDP program documents required in each Client file for review by the Department includes:

- An Unexpired CICP or HDC program card. The Client automatically qualifies for the Senior Dental Program as long as they are 60 or over, with a valid photo ID.
- Age verification, an unexpired photo Identification card – usually a Colorado Driver's License.
- Proof of income can be several types of documentation, please see section on income.
- Copy of Medicare and MAP Cards, include fee schedule (if available).
- The Department web portal verification form. The file must show the patient is NOT currently in Health First Colorado or the Old Age Pension Health and Medical Care Program. Other dental eligibility web portal forms will not be accepted by the Department.
- Health First Colorado Denial Documentation – If the Client's age is 60 to 64 and is at or below 138% FPG (Federal Poverty Guidelines) and is not on Health First Colorado or one of the MSP (Medicare Savings Programs), a Health First Colorado denial letter is required.
- Patients 65 years or older do not need a Health First Colorado denial letter.
- Consent form if Immediate Dentures were delivered, the Informed Consent for Immediate Dentures form must be in the Client's file. The Consent form must have both the dentist and Client's signature on file.
- Grantee ledger showing the dental services completed. Ledger should match what was billed to the Department and should include:
    - ❖ Client Name
    - ❖ Client's zip code
    - ❖ Date of Service
    - ❖ Treating Provider
    - ❖ Location zip code
    - ❖ Procedure Code
    - ❖ Tooth Number(s)
    - ❖ Quadrants
    - ❖ Patient Copay
    - ❖ Amount if less than maximum program fee
    - ❖ Total
    - ❖ Billed to HCPF

2. The Department reviews the Client documents for eligibility, accuracy and completeness. The items include, but are not limited to:

- Unexpired CICP or HDC card.

- Unexpired photo ID to verify age.
- The Department web portal verification form.
- Copies of Medicare & MAP cards, if applicable.
- Proof of Income.
- Medicare denial letter, if applicable.
- Duplicate billing, if a service was previously paid to the same or related. provider procedures must be reimbursed back to the Department.
- Billing the same procedures more than what the fee schedule allows.
- Overcharge of allowable max Client co-payment fee.
- Incorrect, missing, or illegible ledger for services provided.
- Billing prior to the date of service.

3. A Corrective Action Plan (CAP) will be issued to Grantees to address specific discrepancies found during the audit. A review summary and CAP form will be completed by the Department showing what the findings were. The Grantee will be required to submit the following forms within 30 days of the CAP being issued:
   - The completed and signed CAP form. Must provide a detailed outline on the action taken to mitigate the issue and to prevent its recurrence.
   - Copies of missing documents (program documents, ledgers, photo ID's).
4. If the required SDP program documents listed below cannot be produced, then the Client does not qualify for the program, and procedures billed to the program must be reimbursed back to the Department.
   - Photo ID to verify program age requirements.
   - Proof of income.
   - Missing procedure ledgers showing service date, procedure codes, tooth number, quadrants, amount billed, and co-payments.

ARTICLE VI. APPENDIX

Section VI.01 Senior Dental Program Eligibility and Other Health Programs

The table below illustrates what program categories can and cannot be used in conjunction with the Senior Dental Program.

Health First Colorado Programs for Adults	Description of Programs	FPG	Senior Dental Prog Eligible	Effective Date
Health First Colorado for Adults	Adults age 19 through 64 without a dependent child in the home.	133% FPG	No	Backdates up to 90 days from Health First Colorado application.

Programs for Adults with Disabilities	Description of Programs	FPG	Senior Dental Prog Eligible	Effective Date
Brain Injury Waiver (BI)	Provides home or community-based alternative to hospital or specialized nursing facility care for persons with a brain injury. Must be 16 years of age or older.	300% SSI	No	
Colorado Choice Transitions (CCT)	Helps transition Health First Colorado members out of nursing homes and long-term care facilities and	133% FPG	No	

Programs for Adults with Disabilities	Description of Programs	FPG	Senior Dental Prog Eligible	Effective Date
	into home and community-based settings.			
Community Mental Health Supports Waiver (CMHS)	Provides home or community-based alternative to nursing facility care for people with major mental illness.	300% SSI	No	
Developmental Disabilities Waiver (DD)	Provides people with developmental disabilities services and supports that allow them to continue living in the community.	300% SSI	No	
Elderly, Blind, & Disabled Waiver (EBD)	Provides an alternative to nursing facility care for elderly, blind, or physically disabled persons, as well as individuals living with HIV/AIDS.	300% SSI	No	
Family Support Services Program (FSSP)	Provides support for families who have children with developmental	N.A.	No	

Programs for Adults with Disabilities	Description of Programs	FPG	Senior Dental Prog Eligible	Effective Date
	disabilities or delays with costs that are beyond those normally experienced by other families.			
Health First Colorado Buy-In Program for Working Adults with Disabilities	Buy-In for adults who are 16 through 65 years of age, employed, and have a qualifying disability. Monthly premium based on the family's income.	450% FPG	No	Backdates up to 90 days from Health First Colorado application
Spinal Cord Injury Waiver (SCI)	Provides home or community-based alternative for people with a spinal cord injury in the Denver Metro Area	300% SSI	No	
Supported Living Services Waiver (SLS)	Provides supported living in the home or community to persons with developmental disabilities	300% SSI	No	

Senior Adult Programs	Description of Programs	FPG	CICP Eligible	Effective Date
Old Age Pension (OAP)-A and B-Medical	Disabled or 65 and over. Financial payment entitles clients for a category of Medical Assistance, either Health First Colorado or Health Care Program.	76.9% FPG	No	Backdates up to 90 days from Health First Colorado application.
Old Age Pension (OAP-State Only) and HCP-B State Only	Not eligible for Health First Colorado.	76.9% FPG	Yes	Eligibility begins date of application or date eligibility is established, whichever is later.

Medicare Savings Programs (MSP)	Description of Programs	FPG	CICP Eligible	Effective Date
Specified Low-Income Medicare Beneficiary Program (SLMB)	State pays for Medicare Part B premiums.	Monthly income of $1,234 for individuals, $1,666 for couples	Yes	Backdates up to 90 days from application.
Qualified Individual Program (QI1)	State pays for Medicare Part B premiums. Granted on a first-come, first-served basis with priority for	Monthly income of $1,386 for individuals, $1,872 for couples	Yes	Backdates up to 90 days from application.

Medicare Savings Programs (MSP)	Description of Programs	FPG	CICP Eligible	Effective Date
	people who received QI the previous year.			
Qualified Disabled and Working Individual (QDWI)	State pays for Medicare Part A premium. Must be working disabled person under age 65 and not receiving other medical assistance from the state	Monthly income of $2,044 for individuals, $2,764 for couples	Yes	
Qualified Medicare Beneficiary Program (QMB)	State pays for Part A and B premiums and Medicare deductibles, coinsurance, and copays.	Monthly income of $1,032 for individuals, $1,392 for couples	Yes	Effective 1st day of month following the month of eligibility determination.
Medicare-Health First Colorado –QMB (Dual Eligible)	65 years or older, disabled status under Social Security, or Railroad Retirement assistance with Medicare premiums and out of pocket Health First Colorado expenses.	100% FPG	No	Effective 1st day of month following the month of eligibility determination.