Colorado Department Health Care Policy and Financing

Long-Term Care Medical Assistance User Desk Reference Guide

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A. Introduction

This reference guide covers program categories, rules and State Plan Options that affect Medicaid Eligibility for individuals who are requesting Long-Term Care services or applying for them under the LTC category. The LTC category is also referred to as the 300% Institutionalized Special Income Group. These procedures coincide with the rules pertaining to these categories which can be found at 10 CCR 2505-10 Volume 8 under 8.100.7.

B. Long-Term Care Services

Overview

Long-Term Care (LTC) services are provided to clients who are in a Long-Term Care medical institution or in the community through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

To gain access to LTC services, a client must meet all eligibility criteria for the appropriate category of Medicaid. Each eligibility criteria is covered in detail throughout this guide.

All clients and their spouses who apply for or request LTC services must:

1. Be at least 65 years old or have a full Social Security disability determination.

2. Meet the institutionalization requirements by being assessed to need HCBS or PACE or be in a medical institution for 30 full consecutive days.

3. Meet the income and resource guidelines.

4. Declare and provide verification of:

    Any ownership interest in an annuity

    Any transfer of assets within 5 years prior to applying or requesting LTC services

    Any ownership interest in a trust

    Any resources listed under the General Medicaid User Desk Reference Guide of countable and exempt resource types.

Failure to disclose and provide documentation of these assets may result in the denial of Long-Term Care services.

When a child under the age of 18 is determined to meet the institutional requirement, parental income and resources will cease to be deemed available to the child because the child is institutionalized and not living in the parents' home.

C. How a client applies for or requests LTC services

Application for Medical Assistance and Medicaid Disability Application

All new applicants or those who are only eligible for the State Only Medical Plan must submit a complete application.

If under age 65, if the client is not eligible for SSI or SSDI or if the client only has a limited disability determination a Medicaid Disability Application must also be submitted.

Request for Long-Term Care (LTC) Medical Services Form

The Request for Long-Term Care Medical Services form cannot be used by new applicants.

The Request for Long-Term Care Medical Services form is a way for clients who are already Medicaid eligible to request LTC services without having to go through the entire application process. This form is also referred to as the LTC Services Request form.

The Request for Long-Term Care Services form also serves as an asset declaration form. Clients are required to declare their ownership interest in any assets or if they have transferred any assets within 5 years of requesting LTC services. The clients must provide verifications of all declared assets.

For Medicaid eligible clients who have not had an asset evaluation, never been determined disabled and never been assessed for LTC services, a Medicaid Disability Application and verification of all of the declared assets c must be provided with the Request for LTC services form.

For SSI, Medicaid eligible clients:

Clients who are already SSI eligible are not required to submit a full application. However, they must complete the Request for Long-Term Care Services form.

Verification of all declared assets must be provided.

For Family Medicaid, CHP+ clients:

Clients who are Family Medicaid or CHP+ can use the Request for LTC Services form to be redetermined under the LTC category.

Because these clients typically have not been eligible for SSI or SSDI, they must go to SSA and apply for these programs.

They must complete a Medicaid Disability Application if under age 65.

For Working Adults with Disabilities Buy-in clients:

Working Adults with Disabilities clients can complete the Request for LTC Services form.

D. Eligibility Criteria

1. Being aged 65+ or determined disabled by SSA standards

Individuals who are eligible for and/or receiving either SSI or SSDI are already determined disabled. If not, they must submit a Medicaid Disability Application to the State Disability Contractor. For more information please refer to the General Aged, Blind and Disabled Desk Reference Guide.

2. Income Guidelines for Determining Eligibility

Income limits

Please refer to the General Medicaid User Desk Reference Guide for a list of income types that are exempt.

LTC income eligibility rules are based upon the Supplemental Security Income (SSI) regulations and the SSI Federal Benefit Rate (FBR).

The LTC income limit is 300%, or 3 times, the current year SSI FBR.

A client can be over the 300% income limit and still meet the income criteria if they create an income trust that is approved by the Department's Trust Officer. The income limit for an income trust is based upon the nursing facility monthly private pay rate for the region in which the client resides. The income goes into the income trust and is typically used as a patient payment to the nursing facility. Because there is not a patient payment for a hospital, income trust eligibility is not available for a client who is institutionalized in a hospital.

The regions for the income trust eligibility limits are defined at 8.100.7.E.6 and are as follows:

> **REGION I:** (Adams, Arapahoe, Boulder, Broomfield, Denver, Jefferson)
>
> **REGION II:** (Cheyenne, Clear Creek, Douglas, Elbert, Gilpin, Grand, Jackson, Kit Carson, Larimer, Logan, Morgan, Park, Phillips, Sedgwick, Summit, Washington, Weld, Yuma)
>
> **REGION III:** (Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, El Paso, Fremont, Huerfano, Kiowa, Lake, Las Animas, Lincoln, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache, Teller)
>
> **REGION IV:** (Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison, Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel)

The regional nursing facility monthly private pay rates change on January 1 of each year. The updated rates are communicated in the Department's Cost of Living Adjustments (COLA) agency letter which is posted on the HCPF web site. A CBMS communication is sent when the agency letter has been posted.

The income of a spouse who remains in the community is not counted toward the applicant spouse who is determined to be institutionalized by residing in a nursing facility or by receiving

Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Income disregards

LTC does not allow any income disregards. When evaluating income for eligibility purposes, gross income is used. Earned, unearned and in-kind income types are counted.

Department of Veterans Affairs (VA) Payments

VA pension payments for aid and attendance (A&A) and unreimbursed medical expenses (UME), are not countable as income when determining eligibility.

1. The A&A and/or UME are not used as a patient payment if:
    a. A veteran or surviving spouse of a veteran is in a medical facility other than State Veterans Home; or
    b. A veteran or surviving spouse of a veteran in a State Veterans Home with dependents.
2. The A&A and/or UME are used as a patient payment if a veteran or surviving spouse of a veteran is in a State Veterans Home with no dependents at home.

3. Resources (Assets) Guidelines for Determining Eligibility (8.100.5.M)

Please refer to the General Aged, Blind and Disabled Desk Reference Guide for a list of countable and exempt resource types.

The resource limits for the LTC category are:

- $2,000 for an individual
- $3,000 for a married couple institutionalized in different rooms
- $4,000 for a couple institutionalized in the same room

There is an increased resource allowance for a spouse who remains in the community when the other spouse is institutionalized. Please see the section on Spousal Impoverishment in this guide for more information.

4. Institutionalization and functional level of care

A client must be institutionalized for 30 full consecutive days or be assessed to meet the functional level of care.

A client is considered to be institutionalized when he/she has been in a medical facility (such as a hospital or nursing facility) for 30 consecutive days or when they have been assessed to need LTC services in the community through HCBS or PACE.

A stay shorter than 30 full days in a single facility can be combined with other stays and a HCBS/PACE assessment to meet the 30 day requirement. When combining, the stays and/or assessment must be consecutive.

Verification of the 30 consecutive day stay must be provided by the medical facility. Admit and discharge records are examples of acceptable verification.

5. Eligibility requirement in case of death prior to 30 days

If a client dies prior to the 30th consecutive full day, the institutionalization can still be established if medical records support a physician's statement declaring that if the client had not died, he/she would have been institutionalized for 30 consecutive full days.

The statement must be from a qualified medical professional.

The documentation supporting the declaration must be from the beginning of the institutionalized period or prior to the death of the client, whichever is earliest. The beginning of a 30 day institutionalization is the first 15 days.

Once the 30 consecutive days of institutionalization requirement has been met, Medical Assistance benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date.

6. Certification for HCBS/PACE

The level of care assessment is performed by either a Single Entry Point (SEP) or Community Centered Board (CCB) case management agency. Each county or region has a different contractor as the SEP or CCB.

These links list county specific SEPs and CCBs.

The SEP or CCB does the functional assessment using the Uniform Long-Term Care (ULTC) 100.2 assessment tool. Once the assessment has been performed, the SEP/CCB communicates the result to the eligibility worker with a certification or "cert".

7. Responsibilities in Scheduling the Assessment

The SEP/CCB must be notified as soon as possible to schedule a level of care assessment. The responsibility of contacting the SEP/CCB depends upon if the client is in the community or a medical facility.

Eligibility site/worker

The eligibility site/worker is responsible for contacting the SEP/CCB to schedule the assessment as soon as the application or request for Long-Term Care services is received.

Nursing facilities

Nursing facilities are responsible for contacting the SEP/CCB to schedule the assessment when:

- A client is being admitted to the nursing facility from the community.
- A client is being discharged to the community into HCBS/PACE

Hospitals

A hospital discharge planner must schedule the assessment when:

- a client is being discharged to the community and needs HCBS
- A client is being discharged to a nursing facility

When a hospital is discharging a client to a nursing facility, the hospital and nursing facility must coordinate to get the assessment scheduled.

A hospital stay does not require an assessment.

8. Case Management agencies SEP/CCB

The SEP CCB must perform the assessment within 10-days of being notified.

Once the level of care assessment has been determined, the case management agency must communicate the result to the eligibility worker.

E. Transfers of Assets Without Fair Consideration (TWOFC)

Transferring assets without fair consideration is the disposing of assets without getting fair compensation in return. This is done by outright giving away or gifting the asset or by selling the asset for less than fair market value. This applies to both exempt and non-exempt assets.

5 year (60 month) Look-back Period

If a client transfers their assets within 5 years (60 month) from the date of application they will be subject to a period where Medicaid will not pay for Long-Term Care services. This is called the Period of Ineligibility (POI). The Period of Ineligibility section of this guide shows how to calculate the POI.

The client is required to declare any transfers within the look-back period on the application or request for LTC services form. Clear and convincing verifications of the transfer must be provided to get a complete picture. If other possible assets transfers are discovered during the review of the verifications, you may request further verifications. If no asset transfer is declared on the application, the client is only required to provide verifications of the assets for the month of application or 3 months prior if requesting a back-date.

Any transfers of assets outside of the look-back period are no longer subject to a POI calculation.

Definitions:

Assets - includes all income and resources of the individual and such individual's spouse, including any interest in income or a resource as well as all income or resources which the individual or such individual's spouse is entitled to but does not receive because of action by any of the following:

1. The individual or such individual's spouse,
2. A person, a court, or administrative body with legal authority to act on behalf of the individual or such individual's spouse, or
3. Any person, court or administrative body acting at the direction of or upon the request of the individual or such individual's spouse.

Fair Market Value - is the value of the asset if sold at the prevailing price at the time it was transferred.

Fair consideration - is the amount the individual receives in exchange for the asset that is transferred, which is equal to or greater than the value of the transferred asset.

Look-back period - means the number of months prior to the month of application for Long-Term Care services that the Department will consider for transfer of assets.

Penalty period - means a period of time for which an applicant or client will not be eligible to receive Long-Term Care services.

Uncompensated value - means the fair market value of an asset at the time of the transfer minus the value of compensation the individual receives in exchange for the asset.

Valuable consideration - means what an individual receives in exchange for his or her right or interest in an asset which has a tangible and/or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset.

F. Treatment of Certain Assets

1. Life Estates

A life estate is an interest in real property that entitles the life estate owner the right to possess, use and obtain profits from the property. The life estate owner also has the right to sell their life estate interest in the property. The life estate is valid for the lifetime of the owner or some other person, usually a spouse, included in the life estate.

When a life estate is established on a property, it results in the creation of two interests:

A life estate interest, which is held by the **life estate owner**, also called a **life tenant**; and

A remainder interest, which is held by the **remainderman**.

A life estate is generally created in two different ways:

1. A person who owns real property transfers a remainder interest to another person while retaining the life estate interest.

2. A person purchases a life estate interest in another person's real property.

The life estate terminates upon the death of the life estate owner.

Rights and responsibilities of the life estate owner

The life estate owner has the right to possess, use and obtain profits from the property. The life estate owner also has the right to sell their life estate interest in the property unless the sale is restricted by the terms of the life estate.

However, the life estate owner is also responsible for paying the mortgage, taxes and insurance on the property and for the upkeep and repair.

The life estate owner cannot sell the property or the remainder interest.

Right and Responsibilities of the Remainderman

The remainderman has the right to ownership of the property when the life estate owner dies. An individual holding a remainder interest is free to sell his or her interest in the property unless the sale is restricted by the terms that established the remainder interest.

The remainderman does not have the right to occupy, possess or otherwise use the property until the life estate is terminated.

Life Estates as a Transfer Without Fair Consideration

The establishment of a life estate outside of the 5 year (60 month) look-back period is not a transfer without fair consideration.

The establishment of a life estate within the look-back period is a transfer without fair consideration.

The value of the asset transferred is limited to the remainder interest.

The purchase of a life estate interest in a home not owned by an individual or individual's spouse within the look-back period is a transfer without fair consideration unless the purchaser lives in the home for a period of at least twelve (12) consecutive months after the date of the purchase.

For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be the entire amount used to purchase the life estate.

If the payment for the life estate exceeds the value of the life estate calculation then the difference between the amount paid and the value of the life estate shall be considered to be a transfer without fair consideration.

Life estates as a resource

A life estate or remainder interest owned by an individual or individual's spouse that was established on exempt property shall be considered to be an exempt resource.

A life estate or remainder interest owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.

Determining the value of the life estate and remainder interest

The factors used to determine the value of the life estate and the remainder interest is found in the Life Estate Table at Appendix 1. The factors are listed in the table by the age of the individual.

If a life estate is established on property owned by one individual, then use the age of that individual to find the factor in the table.

If a life estate was established on property held by spouses in joint tenancy, then use the age of the youngest spouse to find the factor in the table.

The fair market value of the property shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the

actual value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

Calculating the value of a life estate interest:

1. Determine the fair market value of the property on which the life estate was established.

2. Find the factor in **column 1** of the life estate table using the current age of the life estate holder.

3. Multiply the fair market value of the property by this factor. The result is the value of the life estate interest.

Calculating the value of a remainder interest:

1. Determine the fair market value of the property on which the life estate was established.

2. Find the factor in **column 2** of the life estate table using the current age of the life estate holder.

3. Multiply the fair market value of the property by this factor. The result is the value of the life estate interest.

The life estate tables are located at Appendix 1.

2. Annuities

An annuity is a contract between an individual and a commercial company. The individual invests funds and, in return, the company provides installment payments for life or for a specified number of years. The payments are made to the individual who invested the funds or to someone to whom that that person names.

An annuity can be a countable resource, an exempt resource with countable income or transfer without fair consideration. The purchase date and the terms of the annuity contract and/or prospectus are needed to evaluate the annuity.

Definitions applicable to annuities:

Annuitant: Means an individual who is entitled to receive payments from an annuity.

Annuitization Period: Means the period of time during which an annuity makes payments to an annuitant.

Annuitized: Means an annuity that has become irrevocable and is making payments to an annuitant.

Assignable: Means an annuity that can have its owner and/or annuitant changed.

Balloon Payment: Means a lump sum equal to the initial annuity premium less any distributions paid out before the end of an annuitization period.

Beneficiary: Means an individual or individuals entitled to receive any remaining payments from an annuity upon the death of the annuitant.

Department: Means the Department of Health Care Policy and Financing, its successor(s), or its designee(s).

Irrevocable: Means an annuity that cannot be canceled, revoked, terminated, or surrendered under any circumstances.

Non-assignable: Means an annuity that cannot have its owner and/or annuitant changed under any circumstances.

Owner: Means the person who may exercise the rights provided in an annuity contract during the life of the annuitant. An owner can generally name himself or herself or another person as the annuitant.

Prospectus: Means an annuity contract overview that describes the details, costs and available benefits of the annuity.

Revocable: Means an annuity that can be canceled, revoked, terminated, or surrendered.

Transaction: Means any action taken by an individual that changes the course of payments made by an annuity or the treatment of income or principal of an annuity. This includes, but is not limited to:

1. The purchase of an annuity;
2. The addition of principal to an annuity;
3. Elective withdrawals from an annuity;
4. Requests to change the distributions from an annuity;
5. Elections to annuitize an annuity contract.

Annuity requirements

Disclosure

Any individual who is applying for or requesting Long-Term Care services is required to disclose any ownership interest the individual or their spouse has in an annuity. This includes providing a complete copy of the annuity contract and/or prospectus and the most recent beneficiary designation.

The disclosure must be on the application or on the Request for Long-Term Care Services form. This disclosure applies even if the client has been determined eligible under a different category of Medicaid.

Naming the Department as remainder beneficiary

For any annuity purchased on or after February 8, 2006 the Department must be named as the remainder beneficiary in:

1. The first position if there is not a community spouse or minor or disabled child; or

2. The second position after the community spouse or minor or disabled child.

If the Department is not named as a remainder beneficiary the annuity is a transfer without fair consideration.

Notice of Remainder Beneficiary Interest

Notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity using the Notice of Remainder Beneficiary Interest found on HCPF Agency letter 06-018.

The form includes a statement requiring the issuer to notify the Eligibility Site of any changes in the amount of income or principal that is being withdrawn from the annuity or any other transactions, regardless of when the annuity was purchased.

Annuities Purchased Prior to June 30, 1995

The annuity can be revocable or irrevocable and not count as a resource as long as it has been annuitized and regular payments are being received by the annuitant.

If the annuity has not been annuitized, it is a countable resource.

Income from an annuity

Annuities provide the owner with a set monthly payment.

Payments from an annuity are countable income in the month received if:

1. The annuity is irrevocable and non-assignable; or

2. The annuity is an irrevocable and assignable and it has been determined not to be a countable resource through the rebuttal process described in this guide.

Payments from an annuity are not counted as income if:

1. The annuity is revocable; or

2. The annuity is Irrevocable and non-assignable but determined to be a countable resource.

Analyzing an Annuity as an Resource

Revocable Annuity

Count a revocable annuity as a resource.

The value of the revocable annuity is the total current value of the annuity principal plus any accumulated interest.

If there is a surrender charge or other financial penalty (other than tax withholding or a tax penalty) for withdrawing funds from the annuity, then the value of the annuity is the net amount the individual would receive upon full surrender of the annuity.

Irrevocable assignable annuities

Count an irrevocable assignable annuity as a resource. The resource value is presumed to be the total value of the annuity principal plus any accumulated interest.

The presumption that the irrevocable assignable annuity is a **countable resource** can be rebutted if an individual or individual's spouse provides:

1. Documented offers from at least three companies who are active in the market for buying and selling annuities and annuity income streams; and

2. A statement of their unwillingness or inability to purchase the annuity or annuity income stream.

The **presumed value** can be rebutted if an individual or spouse provides:

1. Documented offers from at least three companies who are active in the market for buying and selling annuities and annuity income streams.

2. The value of the annuity shall then be the highest of the offers.

Irrevocable Non-Assignable Annuities

An Irrevocable non-assignable annuity is not a countable resource. The Department still must be named a remainder beneficiary.

An irrevocable non-assignable annuity can still be a transfer without fair consideration.

If an irrevocable non-assignable annuity is determined to be a transfer without fair consideration, then, for the purpose of calculating the POI the value that was transferred is the amount of funds used to purchase the annuity.

If the annuity meets any of the following conditions it is not a transfer:

1. The annuity is considered to be:

    a. An Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986

    b. A deemed Individual Retirement Account under a qualified employer plan described in Section 408(q) of the Internal Revenue Code of 1986; **or**

2. The annuity is purchased with proceeds from one of the following:

    a. An Individual Retirement Account as described in Section 408(a) of the Internal Revenue Code of 1986; or

    b. An account established by an employer or association of employers as described in Section 408(c) of the Internal Revenue Code of 1986; or

    c. A simple retirement account as described in Section 408(p) of the Internal Revenue Code of 1986; or

d. A simplified employee pension plan as described in Section 408(k) of the Internal Revenue Code of 1986; or

e. A Roth IRA as described in Section 408A of the Internal Revenue Code of 1986; or

3. The annuity meets all of the following requirements:

a. The annuity is irrevocable and non-assignable; and

b. The annuity is actuarially sound based on the life expectancy tables listed at Appendix 2; and

c. The annuity provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

Analyzing an annuity as a transfer without fair consideration

Annuities that meet these conditions are not transfers without fair consideration

An annuity purchased outside of the 5 year (60 month) look-back period is no longer subject to the transfer without fair consideration penalty period.

Revocable and irrevocable non-assignable annuities are not transfers because they are countable resources owned by the applicant or spouse.

An irrevocable non-assignable annuity that has been purchased by or for the benefit of a **community spouse** is not a transfer without fair consideration if:

1. The Department is named as the remainder beneficiary in the first position for the total amount of Medical Assistance paid on behalf of the institutionalized individual; or

2. The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

An irrevocable non-assignable annuity purchased by or for the benefit of an **institutionalized individual** shall not be considered to be a transfer without fair consideration if:

1. The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2. The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

Annuities determined to be a transfer without fair consideration

If an annuity is determined to be a transfer without fair consideration the amount used to purchase the annuity is the value. The value is the amount used to calculate the Period of Ineligibility (POI).

The annuity is a transfer without fair consideration if it was purchased within the 5 year (60 month) look-back period and if any of the following exist:

1. The Department is not named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or

2. The Department is not named as the remainder beneficiary in the next position after the community spouse or minor or disabled child.

3. The annuity is not issued by a commercial company, such as an insurance company or financial institution.

4. The term of the annuity is not actuarially sound, meaning: the value as of the date of annuitization is not expected to pay out in full within the expected lifetime of the person based upon the life expectancy tables listed at Appendix 2 of this guide.

5. The annuity payments of principal and interest are not annuitized and are not being made in equal monthly installments during the term of the annuity.

To determine if the purchase of the annuity was a transfer, follow these steps:

1. Determine the date on which the annuity was purchased. If outside of the look-back period it is no longer a transfer.

2. Determine the amount of money used to purchase the annuity and the length of the annuitization period;

3. Determine the age of the annuitant at the time the annuity was purchased; and

4. Determine the life expectancy of the annuitant at the time the annuity was purchased using the appropriate life expectancy table at Appendix 2 of this guide.

If the length of the annuitization period exceeds the annuitant's life expectancy, then a transfer without fair consideration exists for the portion of the annuitization period that exceeds the annuitant's life expectancy.

If the total value of the annuity's payments during the annuitization period is less than the original purchase price of the annuity, then the difference shall be considered to be a transfer without fair consideration.

If the total value of the annuity's payments during the annuitization period is equal to or greater than the original purchase price of the annuity, then the purchase of the annuity shall not be considered to be a transfer without fair consideration.

Annuity transactions

Any annuity transactions made by an individual or individual's spouse are considered to be a transfer without fair consideration, regardless of when the annuity was purchased if the transaction:

1. Changes the course of payments to be made by an annuity; or

2. Changes the treatment of income or principal of the annuity

The following transactions are not considered to be a transfer without fair consideration:

1. Routine changes such as a notification of an address change or death or divorce of a remainder beneficiary.

2. Changes which occur based on the terms of the annuity which existed before the look-back period and which do not require a decision, election, or action to take effect are excluded from treatment as a transfer without fair consideration.

3. Changes which are beyond the control of the individual, such as a change in law, a change in the policies of the annuity issuer, or a change in terms based on other factors, such as the annuity issuer's financial condition, are excluded from treatment as a transfer without fair consideration.

G. Determining the Period of Ineligibility (POI)

If an institutionalized individual or the spouse of such individual disposes of assets without fair consideration within the 5 year (60 month) look-back period, the individual shall be subject to a Period of Ineligibility (POI) for Long-Term Care services.

During the POI, the Long-Term Care services that Medicaid will not cover include Nursing Facility care, Home and Community Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE).

There is no maximum period of ineligibility.

The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and other Medical Assistance services.

Dividing the POI between spouses

If a transfer results in a period of ineligibility for an individual, and the individual's spouse becomes institutionalized (nursing facility or HCBS) and is otherwise eligible for Medical Assistance, the period of ineligibility shall be divided equally between the spouses.

If one spouse dies or is no longer institutionalized (NF or HCBS), any months remaining in the period of ineligibility shall be assigned to the spouse who remains institutionalized (nursing facility or HCBS).

Determining the Period of Ineligibility

The value of the transferred assets is the fair market value at the time of application. If an asset is transferred after the client is eligible, the fair market value in the month of the transfer is used. The applicant or client must provide verification showing the current fair market value of the asset.

If there are multiple assets transferred, add all of the values together to get the total amount of the transfer.

If the asset was sold for less than fair market value, subtract the amount received from the fair market value. The result is the amount transferred.

If nothing was received in return for the asset, then the entire fair market value is the amount transferred.

Calculating the POI:

1. Determine the total amount of the transfer

2. Divide this total by the average monthly nursing facility private pay rate of all regions. (This amount is communicated at the beginning each year in the Cost Of Living Adjustment (COLA) agency letter.)

3. The resulting number is the number of months and partial month days that the individual is ineligible for Long-Term Care services. The days are the decimal portion of the result.

4. To get the partial month days, multiply 30 days by the decimal amount from the above result. Round up the result to the nearest whole number. This is the number of partial month days of ineligibility.

Example:

An application for LTC Medicaid is submitted on February 24, 2012. Four years before applying for Medicaid, the applicant gifted his home to his adult daughter. At the time of application, the fair market value of the home is $184,567.

1. Reference the COLA letter to find the current year's average monthly private pay rate. For 2012, it is $6,623.

2. Divide the asset transferred value of $184,567 by the average monthly private pay rate of $6,623 to come up with the months and days in decimal form.

   $187,567 ÷ $6,623 = 28.32 months.

3. To get the number of days, multiply 30 days by the decimal remainder of .32:

   30 X .32 = 9.60 days. Round up the .60 to get 10 days.

4. The Period of Ineligibility is 28 months and 10 days, or, 2 years, 4 months and 10 days.

The Period of Ineligibility Begin Date

A client can only begin serving a POI when he/she is determined otherwise eligible. A POI cannot begin until any other POI penalty has ended.

1. For initial applicants, the POI begins on the date on which the individual is determined otherwise eligible for LTC services;

2. For clients who transfer an asset after they have been eligible for Medicaid, the POI begins the first day of the month following the month in which the transfer occurred.

H. Undue Hardship

When a client is determined eligible with a POI for Long-Term Care services, the notice to the client shall include the client's right to request that the POI be waived due to it causing an undue hardship.

An undue hardship can be established only if clear and convincing evidence proves that the imposition of the POI would:

1. Deprive the individual of medical care that, without which, would cause the individual's life or health to be endangered; or

2. Deprive the individual of food, clothing, shelter or other necessities of life.

An undue hardship cannot be established if the POI is shown to only cause the individual inconvenience or a restriction in lifestyle.

Request for an Undue Hardship Review

The request for an undue hardship may be made by the client or their authorized representative. If the client or representative wishes, they can grant consent to the nursing facility where the client resides to request an undue hardship waiver. The consent shall be in the form of a signed statement.

In situations where the client is unable to grant the facility consent and/or the personal representative has a conflict of interest involving the circumstance that caused the POI, the nursing facility may submit a request for undue hardship.

The request for an undue hardship must be submitted in writing to the eligibility worker. The party making the request has the burden of proof to provide the clear and convincing evidence that substantiates an undue hardship. All of the evidence should be included at the time the request is submitted to ensure a prompt and accurate determination.

The documentation that must be submitted with the undue hardship request must include all of the following:

1. The reason(s) why there transfer happened, including:

    a. A description of the individual's participation in the transfer; or

b. If legal authority was granted to a different individual who transferred the assets, a description of his or her participation; and

c. A description of the relationship between the transferor and the transferee.

2. Clear and convincing evidence that proves that reasonable attempts to recover the assets have been unsuccessful and the assets have been irretrievably lost. The evidence must show that reasonable attempts are being pursued or that they have been exhausted.

3. Reasonable attempts include, but are not limited to:

a. Any legal or civil actions taken to recover the assets.

b. Any involvement of Adult Protection through the Department of Human Services to investigate exploitation.

c. Filing police reports.

d. Investigations into financial exploitation.

4. Documentation such as a notice of discharge or pending discharge from the facility and a physician's statement detailing how the inability to receive nursing facility or community based services would result in the individual's inability to obtain life-sustaining medical care or that the individual would not be able to obtain food, clothing or shelter.

Once a complete request for an undue hardship review has been received, the eligibility worker must make a determination within 15 days and provide notice to the individual of whether the undue hardship request is granted or denied.

I. Spousal Impoverishment

Overview

The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community. The rules are in place to help the spouse who remains in the community from becoming impoverished.

The rules help maintain the spouse in the community by:

1. Allowing the community spouse to keep a greater amount of resources above what the institutionalized spouse is allowed.

2. Allowing a portion of the institutionalized spouse's income to be given to the community spouse instead of being used as a patient payment to the nursing facility.

The community spouse can retain this status as long as he/she remains married to the institutionalized spouse and is not in a medical institution for 30 or more consecutive days.

A community spouse will not be considered to be in a medical institution if he/she is not likely to meet the institutional requirements for at least 30 consecutive days.

A community spouse may be Medicaid eligible if all criteria are met. However, the community spouse resource allowance does not supersede the Medicaid eligibility criteria. A community spouse must be below the resource limit for LTC Medicaid or other Medicaid programs.

Definitions

Community Spouse: Is the spouse who remains in the community and who is married to an institutionalized spouse.

Community Spouse Resource Allowance (CSRA): Is the greater amount of resources in addition to the institutionalized spouse's that a Community Spouse is allowed to retain.

Excess Shelter Allowance: Is an amount of shelter expenses for the community spouse that exceeds the shelter allowance.

Institutionalized spouse: Is a Medicaid eligible individual, who is in a medical institution or nursing facility, enrolled in the Program of All Inclusive Care for the Elderly (PACE) or receives Home and Community Based Services (HCBS) and is married to a spouse who is not in a medical institution or nursing facility.

Minimum Monthly Maintenance Needs Allowance (MMMNA): Means the minimum amount of income that the community spouse needs to live in the community. This amount is based upon 150% of the federal poverty level for a family of two.

MMMNA Max: Is the maximum amount of income a community spouse is allowed from a monthly income allowance.

Monthly Income Allowance (MIA): Is an amount of the institutionalized spouse's income that can go to the community spouse instead of toward a patient payment.

Shelter Allowance: Is an amount of income, equal to 30% of the MMMNA, that is presumed to be used by the community spouse to pay for shelter.

Income for eligibility (8.100.7.P.)

Using only the applicant's/institutionalized spouse's income determine whether the institutionalized spouse is income eligible for Medical Assistance.

Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the Long Term Care institution.

If an income trust is used the trust must be established before the MIA is calculated.

The income of the community spouse is not deemed available to the institutionalized spouse and is not counted when determining the institutionalized spouse's eligibility.

1. Income from resources made solely in the name of either the institutionalized spouse or the community spouse, the income shall be considered available only to the named spouse.

2. Income from resources made in the names of both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each spouse.

3. Income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.

4. The above regulations of attribution of income are superseded if the institutionalized spouse can establish by a preponderance of the evidence that the ownership interests in the income are other than that provided in the regulations.

When one spouse is applying and one spouse remains in the community:
Only use the applicant's income in determining eligibility.

The community spouse's income does not count toward the applicant.

When both spouses are applying for HCBS:
Use each spouse's own income. Spouses incomes do not count toward each other.

When a community spouse is applying for HCBS:
Use the community spouse's own income and income received from the MIA.

Resources

The resources of both spouses are counted in determining eligibility for either or both spouses. A total of all exempt and non-exempt resources must be evaluated at the time of application.

Please refer to the General Medicaid User Desk Reference Guide for a list of countable and exempt resource types.

The resource limits for spouses are:

- $2,000 for an individual in an institution or on HCBS/PACE with a community spouse
- $3,000 for a married couple institutionalized in different rooms
- $4,000 for a couple institutionalized in the same room
- The community spouse can have a greater amount or resources in addition to the institutionalized spouse. This is the Community Spouse Resource Allowance (CSRA). For 2012, the CSRA is $113,640.
- An amount of resources determined under Increasing the CSRA in this guide.

Calculation of the Community Spouse Resource Allowance (CSRA) (8.100.7.M.)

The CSRA is the largest of the following amounts:

1. The total resources of the couple but no more than the current CSRA plus the individual $2,000 allowance.

2. The increased CSRA determined in the Increasing the CSRA section of this guide.

3. The amount a court has ordered the institutionalized spouse to transfer to the community spouse for monthly support of the community spouse or a dependent family member.

When determining the CSRA:

Spouses are considered to be married unless they are divorced. Separation is not recognized.

1. Get verification of all the resources owned by the couple at the time of application.

2. Total all of the countable resources, whether they are owned jointly or individually.

   There are no exceptions for pre-nuptial or post-nuptial agreements.

3. If the total of the countable resources is at or below the current years CSRA plus the individual $2,000 resource limit, the couple is resource eligible.

   If the total of countable resources is over the CSRA plus the individual $2,000 resource limit, the couple is over the resource limit.

Transferring the resources into the community spouse's name

If the couple is resource eligible, they must transfer all but $2,000 of the resources into the community spouse's name as soon as possible. If this is not done before the next redetermination, the resources still in the institutionalized spouse's name will jeopardize his/her eligibility. Verification of the transfer must be provided by the client.

Once the CSRA is established, and approved do not look at the community spouse's resources again unless he/she applies for Medical Assistance. This is true even if the community spouse becomes institutionalized but does not apply for Medical Assistance.

Once the resources have been transferred into the name of the community spouse, the income from these resources shall be attributed to the community spouse.

Special circumstances

A community spouse may be in control of resources attributed to the institutionalized spouse and fail to make the resources available for his/her cost of care. If this happens, it should not make the institutionalized spouse ineligible for Medical Assistance as long as:

1. The institutionalized spouse has assigned the Department any rights to support from the community spouse; or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but The Department has the right to bring a support proceeding against the community spouse without such assignment; or

3. The eligibility site determines that the denial of eligibility would work an undue hardship upon the institutionalized spouse. For the purposes of this subparagraph, undue hardship means that an institutionalized spouse, who meets all the Medical Assistance

eligibility criteria except for resource eligibility, has no alternative living arrangement other than the medical institution or Long Term Care institution.

Calculating the Community Spouse's Monthly Income Allowance (MIA) (8.100.7.Q.)

The MIA is an amount of the institutionalized spouse's income (if any) that can go to the community spouse instead of toward a patient payment. This income is meant to supplement the community spouse's income to meet his/her expenses in the community.

For a spouse institutionalized in a nursing facility, the income available for the MIA is what remains after the personal needs allowance and/PETI allowances.

An institutionalized spouse on HCBS or PACE is allowed to keep the 300% income limit as a personal needs allowance. The only available income for a MIA is income that would go into an income trust.

The minimum amount of income a community spouse needs to cover expenses is determined by the Minimum Monthly Maintenance Needs Allowance or MMMNA. This is 150% of the federal poverty level for a household of 2 and changes July 1 of each year. This is communicated through an agency letter and CBMS communication.

The actual expenses may be greater than the MMMNA and the community spouse can receive a greater amount of the institutionalized spouse's income. However this cannot exceed the MMMNA Maximum amount. This is set each year on January 1 and communicated on the Cost Of Living Adjustment (COLA) agency letter and through a CBMS communication.

If either spouse establishes that the community spouse needs income above the level provided by the MMMNA due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

If a court has entered an order against the institutionalized spouse for monthly support of the community spouse, the MIA shall not be less than the monthly amount ordered by the court.

Make adjustments to the MMMNA and/or the MIA on a monthly basis for any continuing change in circumstances that exceeds $50 a month.

Dependent family member

If there are family members who are dependent children (minor or adult), dependent parents or dependent siblings of either spouse that are residing with the community spouse and can be claimed by either the institutionalized or community spouse as a dependent for federal income tax purposes.

If an allowance is needed for a family member one third of the amount of the MMMNA can be allowed for each member. The amount shall be reduced by the monthly income of that family member.

Income of the community spouse

The amount of the community spouse's income used in the MIA calculation is gross income less the mandatory deductions for Federal Insurance Contributions Act (FICA) and Medicare tax.

If the community spouse's income cannot be verified through the IEVS, SDX or BENDEX interfaces, physical verification must be provided.

Expenses of the community spouse

The community spouse must provide verification of the allowable expenses which include shelter, utility and medical/remedial.

Utility

Do not allow a utility allowance utility expenses are included in the rent or maintenance charge, paid by the community spouse.

Utility expenses are the larger of the following amounts:

1. The standard utility allowance used by Colorado under U.S.C. 2014(e) of Title 7; or

2. The community spouse's actual, verified, utility expenses.

Medical/remedial

Medical expenses for necessary medical or remedial care must be documented. The documentation must include:

1. A description of the service

2. The date of the service

3. The amount of the cost

4. The name of the service provider

Medical expenses must be provided by a medical practitioner licensed to furnish the care.

The medical expenses must not be subject to payment by any third party insurance including Medical Assistance and Medicare.

Medicare, Long-Term Care insurance, and health insurance premiums are allowable. A health insurance premium may be allowed in the month the premium is paid or may be prorated and allowed for the months the premium covers.

Non-allowable expenses

Expenses for the following are not allowed:

1. Insurance premiums for coverage that is limited to disability or income protection coverage;

2. Automobile insurance premiums for medical payment coverage;

3. Premiums for supplemental to liability insurance;

4. Premiums for insurance designed solely to provide payments on a per diem basis, daily indemnity or non-expense-incurred basis; or

5. Premiums for credit life and/or accident and health insurance.

Allowable expense examples

Examples of Shelter Expenses	Examples of Utility Expenses	Examples of Medical/Remedial Expenses
Mortgage (principal & interest) or rent	Heating or fuel: butane, coal, propane, firewood, natural gas, heating oil, etc.	Medical expenses not covered by insurance
Home owner's or renter's insurance	Cooling or air conditioning	Eye care
Home Owner Association (HOA) fees	Utility costs and installation: Phone, internet, electricity, etc.	Dental care: dentures, oral surgery for dentures, emergency dental
Up-keep and repairs: lawn care, snow removal, etc.	Sewer	Dialysis
Property taxes	Water	Diabetic supplies
		Prescriptions
		Transportation
		Service animal
		Medicare A, B and D

Calculating the Monthly Income Allowance

Use the worksheets for Treatment of Institutionalized Spouse's Income to help with the MIA calculation.

They are located on the HCPF web site under the Training and Reference Documents

1. Get a total of the allowable expenses.
2. Subtract the current year's Shelter Allowance from the total allowable expenses.

   The result is the actual expenses for the community spouse or individual MMMNA.

3. Get a total of the community spouse's income.
5. Compare the income to the Individual MMMNA.

a. If the individual MMMNA result is more than the community spouse's income:

Subtract the income from the expenses

The result is the allowable MIA

b. If the income is greater than the individual MMMNA the community spouse has income enough on his/her own to cover the expenses. No MIA is allowed.

If the expenses are more than the MMMNA Max, only the MMMNA Max is allowed.

Increasing the Community Spouse Resource Allowance (8.100.7.S.)

The CSRA shall be increased above the maximum amount if additional resources are needed to raise the community spouse's monthly income to the level of the Minimum Monthly Maintenance Needs Allowance (MMMNA).

In making this determination the items listed below are calculated in the following order:

1. The community spouse's MMMNA;

2. The community spouse's own income; and

3 The Monthly Income Allowance (MIA) contribution that the community spouse is eligible to receive from the institutionalized spouse.

4. If the community spouse's own income plus the MIA from the institutionalized spouse's income is less than the MMMNA, additional available resources can be shifted to the community spouse to bring his/her income up to the level of the MMMNA.

Determining the increased CSRA

The additional resources necessary to raise the community spouse's income to the MMMNA is determined by the cost of a single-premium lifetime annuity with monthly payments equal to the difference between the MMMNA and the community spouse's income.

The following steps determine the amount of resources to be shifted:

1. The applicant shall obtain three estimates of the cost of an annuity that would generate enough income to make up the difference between the MMMNA and the combined community spouse's income as described above.

2. The amount of the lowest estimate shall be used as the amount of resources to increase the CSRA.

3. The applicant shall not be required to purchase the annuity in order to have the CSRA increased.

The CSRA shall not be increased if the institutionalized spouse refuses to make the monthly income allowance (MIA) available to the community spouse.

J. Long-Term Care Institution Recipient Income

Each month the institutionalized spouse is in a nursing facility he/she is required to use all of his/her income as a patient payment. If the institutionalized spouse fails to make his/her income available to the community spouse or eligible dependent family members in accordance with these regulations, that income shall be applied to the cost of care for the institutionalized spouse. The following deductions reduce the patient payment and are deducted in the following order.

1. The personal needs allowance of $50 or $90 for Veterans
2. The MIA for the community spouse.
3. The family allowance for each dependent family member who lives with the community spouse.
4. Allowable deductions identified in 10 CCR 2505-10 Volume 8 under 8.100.7.V
6. No other deductions shall be allowed.

The income and patient payment are communicated between the nursing facility and the eligibility site on the 5615. Please refer to the 5616 training on the HCPF web site for further instruction.

K. Trusts

Please refer to 10 CCR 2505-10 Volume 8 under 8.100.7.E.

L. 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.

M. 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.

N. 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.'

Long-Term Care Medicaid (LTC) Eligibility Specialist

Role

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

When to Contact

Contact the LTC 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.

O. Definitions

300% Institutionalized Special Income Group is a Medical Assistance category that provides Long-Term Careservices to aged or disabled individuals.

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)

Community Centered Boards are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Community Spouse is the spouse of an institutionalized spouse

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.

An institutionalized individual is one who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Institutionalized Spouse is a Medicaid eligible client who begins a stay in a medical institution or nursing facility on or after September 30, 1989, or is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or receives Home and Community Based Services (HCBS) on or after July 1, 1999; and is married to a spouse who is not in a medical institution or nursing facility. An institutionalized spouse does not include any such individual who is not likely to be in a medical institution or nursing facility or to receive HCBS or PACE for at least 30 consecutive days.

Irrevocable means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than outlined in the document

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.

Appendix 1 Life Estate Tables

Age	Column 1 Life Estate	Column 2 Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520

Age	Column 1 Life Estate	Column 2 Remainder
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970

Age	Column 1 Life Estate	Column 2 Remainder
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304

Age	Column 1 Life Estate	Column 2 Remainder
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641

Age	Column 1 Life Estate	Column 2 Remainder
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591

Age	Column 1 Life Estate	Column 2 Remainder
108	.10068	.89932
109	.04545	.95455

Appendix 2 Annuity Tables

Table 1:

LIFE EXPECTANCY TABLE – **MALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006**

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	71.80	**30**	44.06	**60**	18.42	**90**	3.86
1	71.53	**31**	43.15	**61**	17.70	**91**	3.64
2	70.58	**32**	42.24	**62**	16.99	**92**	3.43
3	69.62	**33**	41.33	**63**	16.30	**93**	3.24
4	68.65	**34**	40.23	**64**	15.62	**94**	3.06
5	67.67	**35**	39.52	**65**	14.96	**95**	2.90
6	66.69	**36**	38.62	**66**	14.32	**96**	2.74
7	65.71	**37**	37.73	**67**	13.70	**97**	2.60
8	64.73	**38**	36.83	**68**	13.09	**98**	2.47
9	63.74	**39**	35.94	**69**	12.50	**99**	2.34
10	62.75	**40**	35.05	**70**	11.92	**100**	2.22
11	61.76	**41**	34.15	**71**	11.35	**101**	2.11
12	60.78	**42**	33.26	**72**	10.80	**102**	1.99
13	59.79	**43**	32.37	**73**	10.27	**103**	1.89
14	58.82	**44**	31.49	**74**	9.27	**104**	1.78

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
15	57.85	**45**	30.61	**75**	9.24	**105**	1.68
16	56.91	**46**	29.74	**76**	8.76	**106**	1.59
17	55.97	**47**	28.88	**77**	8.29	**107**	1.50
18	55.05	**48**	28.02	**78**	7.83	**108**	1.41
19	54.13	**49**	27.17	**79**	7.40	**109**	1.33
20	53.21	**50**	26.32	**80**	6.98	**110**	1.25
21	52.29	**51**	25.48	**81**	6.59	**111**	1.17
22	51.38	**52**	24.65	**82**	6.21	**112**	1.10
23	50.46	**53**	23.82	**83**	5.85	**113**	1.02
24	45.55	**54**	23.01	**84**	5.51	**114**	0.96
25	48.63	**55**	22.21	**85**	5.19	**115**	0.89
26	47.73	**56**	21.43	**86**	4.89	**116**	0.83
27	46.80	**57**	20.66	**87**	4.61	**117**	0.77
28	45.88	**58**	19.90	**88**	4.34	**118**	0.71
29	44.97	**59**	19.15	**89**	4.09	**119**	0.66

Table 2:

LIFE EXPECTANCY TABLE – **MALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8, 2006**

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	74.14	**30**	45.90	**60**	19.72	**90**	3.70
1	73.70	**31**	44.96	**61**	18.96	**91**	3.45
2	72.74	**32**	44.03	**62**	18.21	**92**	3.22
3	71.77	**33**	43.09	**63**	17.48	**93**	3.01
4	70.79	**34**	42.16	**64**	16.76	**94**	2.82
5	69.81	**35**	41.23	**65**	16.05	**95**	2.64
6	68.82	**36**	40.30	**66**	15.36	**96**	2.49
7	67.83	**37**	39.38	**67**	14.68	**97**	2.35
8	66.84	**38**	38.46	**68**	14.02	**98**	2.22
9	65.85	**39**	37.55	**69**	13.38	**99**	2.11
10	64.86	**40**	36.64	**70**	12.75	**100**	2.00
11	63.87	**41**	35.73	**71**	12.13	**101**	1.89
12	62.88	**42**	34.83	**72**	11.53	**102**	1.79
13	61.89	**43**	33.94	**73**	10.95	**103**	1.69
14	60.91	**44**	33.05	**74**	10.38	**104**	1.59
15	59.93	**45**	32.16	**75**	9.83	**105**	1.50
16	58.97	**46**	31.29	**76**	9.29	**106**	1.41
17	58.02	**47**	30.42	**77**	8.77	**107**	1.33
18	57.07	**48**	29.56	**78**	8.27	**108**	1.25

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
19	56.14	**49**	28.70	**79**	7.78	**109**	1.17
20	55.20	**50**	27.85	**80**	7.31	**110**	1.10
21	54.27	**51**	27.00	**81**	6.85	**111**	1.03
22	53.35	**52**	26.16	**82**	6.42	**112**	0.96
23	52.42	**53**	25.32	**83**	6.00	**113**	0.89
24	51.50	**54**	24.50	**84**	5.61	**114**	0.83
25	50.57	**55**	23.68	**85**	5.24	**115**	0.77
26	49.64	**56**	22.86	**86**	4.89	**116**	0.71
27	48.71	**57**	22.06	**87**	4.56	**117**	0.66
28	47.77	**58**	21.27	**88**	4.25	**118**	0.61
29	46.84	**59**	20.49	**89**	3.97	**119**	0.56

Table 3: LIFE EXPECTANCY TABLE – **FEMALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006**

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	78.79	**30**	50.15	**60**	22.86	**90**	4.71
1	78.42	**31**	49.19	**61**	22.06	**91**	4.40
2	77.48	**32**	48.23	**62**	21.27	**92**	4.11
3	76.51	**33**	47.27	**63**	20.49	**93**	3.84
4	75.54	**34**	46.31	**64**	19.72	**94**	3.59
5	74.56	**35**	45.35	**65**	18.96	**95**	3.36
6	73.57	**36**	44.40	**66**	18.21	**96**	3.16
7	72.59	**37**	43.45	**67**	17.48	**97**	2.97
8	71.60	**38**	42.50	**68**	16.76	**98**	2.80
9	70.61	**39**	41.55	**69**	16.04	**99**	2.64
10	69.62	**40**	40.61	**70**	15.35	**100**	2.48
11	68.63	**41**	39.66	**71**	14.66	**101**	2.34
12	67.64	**42**	38.72	**72**	13.99	**102**	2.20
13	66.65	**43**	37.78	**73**	13.33	**103**	2.06
14	65.67	**44**	36.85	**74**	12.68	**104**	1.93
15	64.68	**45**	35.92	**75**	12.05	**105**	1.81
16	63.71	**46**	35.00	**76**	11.43	**106**	1.69
17	62.74	**47**	34.08	**77**	10.83	**107**	1.58
18	61.77	**48**	33.17	**78**	10.24	**108**	1.48
19	60.80	**49**	32.27	**79**	9.67	**109**	1.38
20	59.83	**50**	31.37	**80**	9.11	**110**	1.28
21	58.86	**51**	30.48	**81**	8.58	**111**	1.19
22	57.89	**52**	29.60	**82**	8.06	**112**	1.10

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
23	56.92	**53**	28.72	**83**	7.56	**113**	1.02
24	55.95	**54**	27.86	**84**	7.08	**114**	0.96
25	54.98	**55**	27.00	**85**	6.63	**115**	0.89
26	54.02	**56**	26.15	**86**	6.20	**116**	0.83
27	53.05	**57**	25.31	**87**	5.79	**117**	0.77
28	52.08	**58**	24.48	**88**	5.41	**118**	0.71
29	51.12	**59**	23.67	**89**	5.05	**119**	0.66

Table 4: LIFE EXPECTANCY TABLE – **FEMALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8, 2006**

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	79.45	**30**	50.53	**60**	23.06	**90**	4.47
1	78.94	**31**	49.56	**61**	22.24	**91**	4.15
2	77.97	**32**	48.60	**62**	21.43	**92**	3.86
3	77.00	**33**	47.63	**63**	20.63	**93**	3.59
4	76.01	**34**	46.67	**64**	19.84	**94**	3.35
5	75.03	**35**	45.71	**65**	19.06	**95**	3.13
6	74.04	**36**	44.76	**66**	18.30	**96**	2.93
7	73.05	**37**	43.80	**67**	17.54	**97**	2.75
8	72.06	**38**	42.86	**68**	16.80	**98**	2.58
9	71.07	**39**	41.91	**69**	16.07	**99**	2.43
10	70.08	**40**	40.97	**70**	15.35	**100**	2.29
11	69.09	**41**	40.03	**71**	14.65	**101**	2.15
12	68.09	**42**	39.09	**72**	13.96	**102**	2.02
13	67.10	**43**	38.16	**73**	13.28	**103**	1.89
14	66.11	**44**	37.23	**74**	12.62	**104**	1.77
15	65.13	**45**	36.31	**75**	11.97	**105**	1.66
16	64.15	**46**	35.39	**76**	11.33	**106**	1.55
17	63.17	**47**	34.47	**77**	10.71	**107**	1.44
18	62.20	**48**	33.56	**78**	10.11	**108**	1.34
19	61.22	**49**	32.65	**79**	9.52	**109**	1.25
20	60.25	**50**	31.75	**80**	8.95	**110**	1.16
21	59.28	**51**	30.85	**81**	8.40	**111**	1.07
22	58.30	**52**	29.95	**82**	7.87	**112**	0.99
23	57.33	**53**	29.07	**83**	7.36	**113**	0.91

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
24	56.36	**54**	28.18	**84**	6.88	**114**	0.84
25	55.39	**55**	27.31	**85**	6.42	**115**	0.77
26	54.41	**56**	26.44	**86**	5.98	**116**	0.71
27	53.44	**57**	25.58	**87**	5.56	**117**	0.66
28	52.47	**58**	24.73	**88**	5.17	**118**	0.61
29	51.50	**59**	23.89	**89**	4.81	**119**	0.56