

Colorado Department Health Care Policy and Financing



Aged, Blind, and Disabled 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 the Aged, Blind and Disabled (ABD) categories of Medical Assistance. These procedures coincide with the rules pertaining to these categories which can be found in [10 CCR 2505-10 Volume 8](#) under 8.100.6.

There are different programs of ABD Medicaid. This section of the User Desk Reference Guide will cover the following programs:

- SSI-related Medicaid Programs
- Medicare Savings Programs (MSP)
- Breast and Cervical Cancer Program (BCCP)
- Low-Income Subsidy Program (LIS)

B. Income Guidelines for Determining Eligibility

SSI-related categories have income limits based on the SSI Federal Benefit Rate (FBR).

Medicare Savings Program income limits are based on the Federal Poverty Level (FPL).

Please refer to each individual category for the income limit applicable to that category.

In determining eligibility, gross earned, unearned and in-kind income types are counted. Please refer to the [General Medicaid User Desk Reference Guide](#) for a list of income types that are exempt.

1. Income disregards (8.100.5.H)

The income disregards listed below are **not** applicable to the HCBS or LTC programs. These disregards are only used for SSI, OAP and MSP programs.

- \$65 ½ earned income disregard-If a client receives earned income, subtract \$65 from the total gross household earned income. Then reduce the remainder by one half.
- \$20 unearned income disregard-If a client receives any unearned income, except SSI, reduce the total unearned income by \$20.

MSP exception- the \$20 disregard is incorporated within the FPL income limit- this disregard is not given to MSP clients (the income limit listed for MSP household size is shown as \$20 over the FPL)

- Disregards are given on a case level, and not on an individual level. If there is more than one person working in the household, the client still only receives one \$65 deduction. This also applies to unearned income disregards.
- The sum of the net earned and unearned income after allowable deductions is used to determine eligibility for the Adult Medicaid programs.

Examples:

Example #1

Client receives \$1025 earned income per month
-Disregard= $\$1025 - \$65 = \$960$
 $\$960 / 2 = \480
\$480 is countable on case

Example #2

Client receives \$1263 Rail Road retirement benefits per month
-Disregard= $\$1263 - 20 = \1243
\$1243 is countable on case

Example #3

Client receives \$964 earned income and \$346 Veterans Assistance per month
-Disregard= $\$964 - \$65 = \$899$
 $\$899 / 2 = \449.50
\$449.50 in earned income to count against case
 $\$346 - \$20 = \$326$
\$326 in unearned income to count against case
 $\$449.50 \text{ earned} + \$326 \text{ unearned} = \$775.50$
\$775.50 total to count against case

Example #4

Client receives \$1564 earned income per month, client's wife receives \$2004 earned income per month and \$206 in SSA benefits per month
-Disregard= $\$1564 + \$2004 = \$3568$
 $\$3568 - \$65 = \$3503$
 $\$3503 / 2 = \1752
\$1752 in earned income to count against case
 $\$206 - \$20 = \$186$
\$186 in unearned income to count against case
 $\$1752 + \$186 = \$1938$
\$1938 total to count against the case

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

The resource limit for OAP and SSI related categories is the same as SSI level

- \$2,000 for an individual
- \$3,000 for a couple

The resource limit for the MSP categories is adjusted yearly. 2012 amounts are-

- \$8,440 for an individual
- \$13,410 for a couple

The resource limit for the LIS program is adjusted yearly. 2012 amounts are-

- \$13,070 for an individual
- \$26,120 for a couple

Transfers without Fair Consideration rules do not apply to these categories of assistance, only to the LTC and HCBS programs. Please see the LTC User Desk Reference Guide for more information.

D. SSI Related Categories

There are five categories of eligibility related to SSI.

1. SSI Mandatory Categories

These categories are mandatory under the [1634 agreement](#) which allows states and SSA to enter an agreement for determining eligibility for SSI-related clients and are not a State Plan option. The categories are outlined in the [State Plan](#) under Attachment 2.2A-13.a

SSA performs the disability determination and the determination is binding upon the State. The State disability contractor (ARG) cannot overrule the disability determination of SSA.

All redeterminations and eligibility updates are performed by SSA, and should be interfaced into CBMS through SDX.

a. 1634 Medical Assistance [\(8.100.6.C\)](#)

Colorado has an agreement allowing SSA to determine Medicaid eligibility for the Aged, Blind and Disabled populations. [1634](#) is the specific section of the Social Security Act that allows for this agreement. Clients determined eligible by SSA can be referred to as 1634 SSI Mandatory.

This means:

- Colorado has agreed to make the eligibility criteria for the Aged, Blind and Disabled identical to eligibility for the SSI program with no additional requirements
- When a client is approved for SSI, financial payments begin the first of the month following their application date. SSI clients are deemed eligible for Medicaid as of their SSI application date. Medicaid coverage will remain active throughout the duration of their eligibility for SSI
- As with any other Medicaid category, the individual may submit a request for retroactive eligibility up to three months prior to their Medicaid application date (SSI application date). The client must meet all eligibility criteria in each month of the requested retroactive coverage and have a medical bill. For 2012, under the SSI category of Medicaid, the client

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must have income below \$698/month and assets under \$2,000. The client's disability onset date must be on or before the date eligibility is being determined

When SSA determines a client is eligible for SSI, the client is automatically deemed eligible for Medicaid. A client is not required to submit an application for this category. SSI eligibility is seen in the State Data Exchange (SDX) interface. When all demographic information in CBMS matches the SDX interface, the interface will automatically populate the applicable screens in CBMS to approve the client.

If demographic information does not match and the case does not interface, eligibility workers will need to manually enter and approve these cases. Eligibility workers must check and work the discrepancy report to determine what clients are not interfacing into the system. The SSI application date on the SDX interface screen should be used as the Medicaid Application date.

Medicaid eligibility under the SSI category is directly related to the date a client first receives an SSI payment. Since the date of application is generally prior to the SSI payment receipt, the date of application is considered to be the beginning date when determining the three month retroactive coverage. Therefore, the retroactive period shall begin from the individual's application date rather than their financial payment date. Please see the [ABD General User Desk Reference Guide](#) for more information on retroactive coverage for SSI recipients.

Example:

The individual's SSI application date is 1/20/11. SSI payments will begin effective 2/1/11. The SSI application date will be used as the AM application date. AM-SSI will begin effective 1/20/11. The individual requests three month retroactive coverage. The backdating period will begin from the date of application. The months of 10/2011, 11/2011, 12/2011, and 1/2011 are considered retroactive months.

b. 1619b Cases ([8.100.6.C.8](#))

Clients in this category are working and would be eligible for SSI except for their work income. SSA has determined that they are deemed eligible using a threshold calculation involving how much they have utilized Medicaid benefits in the past year and their impairment-related work expenses. If the income is below the threshold number, they are eligible as 1619b. SSA continues to redetermine these clients and they are kept on Medicaid as if they were a 1634 SSI Mandatory.

To determine the person's SSI status, check the SDX interface screens within CBMS. Within the SDX interface screen, there is a field that says 1619. In that box, if there is a "B" this is a 1619B case approved by SSA. These cases should interface into CBMS automatically, like 1634 Medicaid cases. Eligibility workers must check and work the discrepancy report to determine what clients are not interfacing into the system, and manually approve them using the same procedure as explained above. SSA determines Medicaid eligibility for these clients.

2. Pickle Amendment ([8.100.6.D](#))

The Pickle Amendment is a law enacted in April 1977 which established a separate category of Medicaid for those individuals who lost Supplemental Security Income (SSI) or Old Age Pension Medicaid (OAP) due to a Title II Cost Of Living Adjustment (COLA) or initial entitlement. Individuals who meet all eligibility criteria for this category of Medicaid will receive continuation of medical coverage. Program rules and regulations can found at 10 C.C.R. 2505-10 § 8.110.21-.24 and 42 C. F. R. Part 435.135-136.

The State is required to notify clients annually of their potential eligibility for Medicaid under the Pickle category. At this time, the State estimates approximately 21,000 individuals have lost their SSI Medicaid over the past 4 years (2005-2009) and may be eligible for Medicaid under the Pickle category if they would have been appropriately noticed and determined through Colorado Benefits Management System (CBMS).

In order to comply with state and federal regulations, an interim, manual process for noticing potential clients has been developed until an automated process can be implemented within CBMS.

The Social Security Administration (SSA) sends two “leads” files annually to the State of Colorado:

- 503 Leads
- Lynch vs. Rank

503 Leads-

Special files are created yearly by SSA following the computation of Title II COLA increases to identify individuals who may be eligible for Medicaid continuation under the provisions of Section 503, Title V of Public Law (P.L.) 94-566. Clients listed within the 503 file should have automatic continuation of medical coverage and will not receive a notice.

Lynch vs. Rank-

In 1985, SSA assisted Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, CMS) and the States to comply with the Lynch vs. Rank court ruling by identifying Title II beneficiaries who had lost SSI due to an increase in their Title II benefit through 1984. The States use the SSA furnished data to notify the individuals of their potential Pickle eligibility for continuation of Medicaid annually for three years. Since the States do not have current data on terminated SSI recipients, it has been decided that SSA will continue to assist the States by providing files on an annual basis containing address and benefit data for all current Title II beneficiaries who lost SSI due to an increase in their Title II benefit during the preceding three years. A sample of this Pickle Client letter can be found on the HCPF website under [Reference Documents](#).

The State will match the clients in the Lynch vs. Rank files against CBMS and will only notify clients of their potential Medicaid eligibility under the Pickle category if they are not currently receiving Medicaid within CBMS. The notice that will be sent to potential clients is called the Potential Pickle Eligibility Notification Letter (see attached).

To become eligible for Medicaid as a Pickle, the client must meet the following 4 criteria in addition to meeting all other requirements for Medicaid including income and resources:

- Is currently eligible for and receiving RSDI (Retirement, Survivors, or Disability Insurance); and
- Was simultaneously entitled to receive Title II SSA RSDI and SSI or OAP in at least one month since April 1977; and
- Is currently ineligible for SSI Medicaid or OAP Medicaid; and
- Had an initial entitlement from SSA that caused client to lose SSI or OAP benefits plus all other countable income is below the current SSI or OAP standard

Eligibility Site Responsibilities-

County departments of human/social services will receive applications for Adult Medical Assistance along with the Potential Pickle Eligibility Notification Letter. Follow normal processing guidelines for these applications including requesting required verifications (income, resources, etc.).

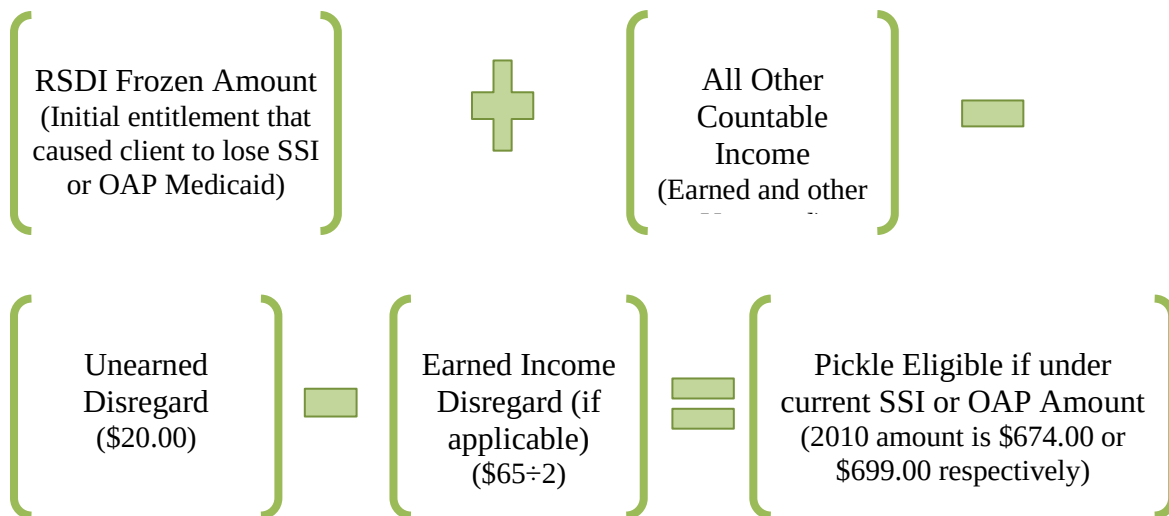
Verifications-

Do not request citizenship and identity verifications for this population since the client was previously exempt from these requirements due to receipt of SSI. Verification of initial RSDI entitlement is a required verification for this category. This letter is called a Social Security Pickle Amendment Letter. A sample of this Pickle SSA letter can be found on the HCPF website under [Reference Documents](#).

Pickle Income Calculation-

At application and redetermination, Medicaid eligibility shall be determined using the initial Title II/ Retirement, Survivors, or Disability Insurance (RSDI) entitlement that caused the individual to lose SSI or OAP.

Below is the calculation that shall be used when determining Medicaid eligibility under the Pickle Amendment rules. The following calculation must be manually calculated, as CBMS is not currently using this calculation. This system issue will be corrected in a future CBMS change. If you determine that an applicant/client is not eligible based on this calculation, do not authorize the case, please submit a [help desk ticket](#). If you determine that an applicant/client is eligible based on this calculation and CBMS is not passing, please submit a help desk ticket and request a Notice of Action (Medicaid Verification Letter).



Data Entry-

Refer to the Entering an Adult Medical Pickle Case Procedure document found in the CBMS Document Index on the CBMS Portal for instructions on how to data enter these applications into CBMS.

Examples:

Example #1

Client ineligible due to increase in earned income:

Mr. Mac is a 48 year old disabled individual who in March of 2004 is entitled to \$525.00 in RSDI. Less the \$20.00 disregard, their countable income is \$505.00. Because \$505.00 is below the 2004 SSI standard of \$564.00, Mr. Mac is eligible to receive \$59.00 in SSI to increase their income to the SSI standard for 2004.

Mr. Mac is able to work sporadically and begins a job in April of 2004. He earns \$255.00 in April and every month thereafter. To figure his countable earned income, \$65.00 is disregarded and the remainder is divided in half. His countable earned income is \$95.00. The countable RSDI of \$505.00 plus the countable earned income of \$95.00 totals \$600.00. This is over the SSI standard of \$564.00 so Mr. Mac is no longer eligible to receive SSI and therefore loses Medicaid eligibility.

Because Mr. Mac did not lose SSI eligibility due to COLA, there is nothing to disregard. The only way he may regain Medicaid eligibility as a Pickle is if the SSI standard eventually increases to an amount greater than the “frozen” RSDI amount plus countable earned income.

- In this example the “frozen” amount is \$525.00. If Mr. Mac’s monthly earned income remains at \$255.00/mo then he would regain Medicaid eligibility in 2006 when the COLA’s have raised the SSI standard to \$603.00 which is above their total countable income of \$600.00
- $525.00 - 20.00 = 505.00$ countable unearned income
- $255.00 - 65.00 / 2 = 95.00$ countable unearned income
- $600.00 (\text{Countable Income}) < 603.00 (\text{SSI Standard in 2006}) = \text{Pickle}$

Example #2

Client ineligible due to initial entitlement:

Mrs. Samee is a 40 year old disabled individual who currently receives the SSI standard for 2006 of \$603.00. She is approved SSDI effective 4/2006, in the amount of \$800.00 per month. This amount is over the 2006 SSI standard of \$603.00 so she is no longer eligible to receive SSI and therefore loses Medicaid eligibility.

Because Mrs. Samee lost SSI eligibility due to initial entitlement and not to COLA, there is nothing to disregard. The only way she may regain Medicaid eligibility as a Pickle is if the SSI standard eventually increases to an amount greater than the “frozen” RSDI amount plus all other countable income.

Mrs. Samee will be noticed for 3 years of his potential eligibility for Medicaid under the Pickle Amendment.

Example #3

Client ineligible due to COLA:

Ms. Puffs is a 40 year old who is disabled. In 2007, Ms. Puffs was entitled to SSDI in the amount of \$642.90. Because SSDI is rounded down to the nearest dollar, she is actually only receiving \$642.

After the \$20 disregard, she has \$622 in countable income which is below the 2007 SSI Federal Benefit Rate (FBR) of \$623 making the client eligible for \$1 in SSI.

The 2008 COLA of 2.3% is applied to both RSDI and SSI which is effective January 2008. The 2008 SSI FBR becomes \$637 and Ms. Puffs SSDI becomes \$657.68.

After rounding down to the nearest dollar and taking the \$20 unearned income disregard, her countable income is \$637. Because this is equal to the SSI FBR, Ms. Puffs is no longer eligible for the \$1 of SSI and has lost Medicaid.

However, under Pickle, the COLA is disregarded keeping the countable amount at \$622 which is below the FBR of \$637.

She will remain eligible for Medicaid as a Pickle. Going forward, the client's "frozen" amount from which all future COLAs will be disregarded is \$657, the amount of the SSDI that caused SSI to be lost.

3. Disabled Adult Children (DAC) [\(8.100.3.F.1.g\)](#)

Disabled Adult Children are adults who have been disabled before age 22 and who become entitled to [I. Definitions](#) based upon earnings from their parent(s). The amount of OASDI caused them to lose SSI eligibility. These clients can remain Medicaid eligible as long as they are still disabled and meet the SSI income and asset limits. When determining countable income, the OASDI is disregarded and all other countable income must be below the SSI income limit. Because these clients are no longer SSI eligible, SSA no longer determines their eligibility for Medicaid. The client must submit an application and must be redetermined each year.

The client must:

- Be at least age 18
- Have been determined disabled and SSI eligible prior to age 22
- Be identified by being OASDI eligible and having a BIC code of "C"
- Be determined as previously receiving SSI, but lost SSI eligibility because the OASDI (DAC) payment exceeded the SSI income limits.

Receipt of Railroad Retirement is not considered OASDI for this policy.

a. DAC Payment Disregard

When a Disabled Adult Child applies for Medicaid, all OASDI (DAC) payments which caused him/her to lose SSI eligibility are disregarded.

This disregard will be applied to a client's eligibility for the client's entire lifespan. If a client goes off of assistance for any period of time and comes back in at a later date to receive assistance, the initial OASDI payment that the client received when they initially became eligible is disregarded.

Examples:

Example #1

George is an SSI recipient. While his father worked, George received a monthly SSI payment of \$686.78.

When his father retired and began receiving \$1000 a month in SSA, George began receiving an OASDI (DAC) payment of \$500 a month (50% of his father's SSA payment).

His monthly check is \$706.78 (\$500 DAC + \$186.78 SSI + \$20 SSI unearned income disregard).

When George's father dies, George begins receiving a DAC payment of \$750 a month (75% of his father's SSA payment). This puts him over the SSI income limit (\$686.78 + \$20 unearned income disregard = \$706.78). He loses SSI.

When he applies for ABD Medicaid, the total increase of \$250 (\$750 - \$500 = \$250) is disregarded.

Example #2

Harvey is an SSI recipient. While his father works, Harvey receives a monthly SSI payment of \$686.78.

When his father retires and receives \$1800 per month in SSA, Harvey begins receiving an OASDI (DAC) payment of \$900 (50% of his father's SSA payment). This \$900 payment makes Harvey ineligible for SSI.

When Harvey applies for ABD Medicaid, the initial DAC payment of \$900 will be disregarded when his ABD Medicaid eligibility is determined.

4. Certain Disabled Widow(er)s [\(8.100.6.H.\)](#)

Medical Assistance shall be provide retroactive to July 1, 1986, to qualified disabled widow(er)s who lost SSI and/or OAP due to the 1983 change in the actuarial reduction formula prescribed in section 134 of P.L. No. 98 21.

In order for these widow(er)s to qualify, these individuals must have:

- Been continuously entitled to Title II benefits since December 1983;
- Been disabled widow(er)s in January 1984;
- Established entitlement to Title II benefits prior to age 60;
- Been eligible for SSI/SSP benefits prior to application for the revised actuarial reduction formula;
- Lost eligibility for SSI/SSP as a result of the change in the actuarial table; and
- Reapplied for assistance prior to July 1, 1987

5. Disabled Widow(er)s [\(8.100.6.I\)](#)

Effective January 1, 1991, Medical Assistance shall be provided to disabled widow(er)s who lost SSI and/or OAP due to the receipt of SSA benefits as a disabled widow(er). The individual shall remain eligible for Medical Assistance until they become eligible for Medicare Part A (hospital insurance).

To be eligible as a Disabled Widow(er) a client must:

- Be a widow(er);
- Have received SSI in the past;
- Be at least 50 years old but not 65 years old;
- No longer receive SSI payments because of SSA payments;

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- Not have hospital insurance under Medicare (Part A); and,
- Meet all other Medical Assistance requirements

E. Old Age Pension (OAP) (8.100.6.J)

OAP is also called the State Supplement to SSI. It is a state financial program that provides a small income to clients over age 60. If a client is eligible for OAP, they are also eligible for either Medicaid or the State Only Medical Assistance Program.

These clients are *not exempt* from citizenship and identity verification requirements. If an OAP client fails to submit DRA, they may be enrolled on OAP-HCP. OAP-HCP is a State funded program that does not provide full Medicaid coverage and is subject to House Bill (HB) 1023. HB 1023 is used in financial and state-only assistance programs to verify lawful presence and identification for applicants. This is completed by using the lawful presence affidavit and a form of identification. This process is done prior to a client receiving a favorable OAP-financial determination and should not need to be performed specifically for medical coverage.

OAP eligibility is broken down into 3 categories.

1. OAP-A

To be eligible for OAP-A, a client must:

- Be age 65 or over
- Be a U.S. citizen or a qualified alien
- Not be over the Medicaid resource limit due to a countable life insurance policy

2. OAP-B:

To be eligible for OAP-A, a client must:

- Be age 60-64
- Meet SSA disability criteria
- Be a U.S. citizen or a qualified alien
- Not be over the Medicaid resource limit due to a countable life insurance policy

3. OAP-HCP:

OAP-Health Care Plan (HCP) is not Medicaid. OAP-HCP has 2 sub categories OAP- HCP A and OAP-HCP B

To be eligible for OAP-HCP, a client must be ineligible for OAP-A or OAP-B because they:

- Do not comply with the citizenship and identity documentation requirements, and/or
- Are over the resource limit due to a countable life insurance policy

OAP-HCP A and B are divided by age. The OAP-HCP A program is for clients age 65 or over. The OAP-HCP B program is for clients age 60-64.

F. Medicare Beneficiaries Introduction

Medicare is the health insurance program administered by the federal Centers for Medicare & Medicaid Services for people over age 65 and for certain younger disabled people.

Medicare is divided into two types of health coverage. Hospitalization Insurance (Part A) pays hospital bills and certain skilled nursing facility expenses. Medical Insurance (Part B) pays doctors' bills and certain other charges.

Medicare charges premiums. Colorado Medicaid may pay some or all of the Medicare premiums for persons participating in the programs described below. These programs are referred to as Medicare Savings Programs (MSP).

Financial eligibility for the MSP categories is determined the same as for the other adult Medicaid categories. Please refer to the [1. Income disregards \(8.100.5.H\)](#) section of this guide for full details of how to calculate income.

Effective 1/1/2010, due to changes from The Medicare Improvements for Patients and Providers Act (MIPPA) the Estate Recovery Program is no longer applicable to MSP clients.

1. Medicare Savings Programs (MSP)

The Medicare Savings Programs are considered Medicaid programs, but only help pay for Medicare premiums, co-pays or deductibles. The income limits are based upon the Federal Poverty Level (FPL) and not SSI limits. When determining eligibility for these categories, the FPL is increased by \$20 to account for the \$20 unearned income disregard.

There are 4 different categories:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualified Individuals 1 (QI-1)
- Qualified Disabled and Working Individuals (QDWI)

a. Qualified Medicare Beneficiary (QMB) [\(8.100.6.K\)](#)

To be eligible for QMB, a client must have income below 100% of the FPL.

Eligibility begins the first of the month following application. This category cannot receive three month retroactive coverage.

A QMB client can be “dual” eligible and receive assistance from another Medicaid category.

QMB covers the Medicare Part A deductible and co-insurance and Part B premiums, deductible and co-insurance

Example:

Big Al is a QMB recipient. He has gross unearned income of \$680/month. The QMB income limit in December is \$686.67. In January, a COLA increase of \$11.17 increases Big Al's income to \$691.17. CBMS will automatically disregard the COLA increase in any determination of Big Al's continued QMB eligibility from January through March. Increased QMB income limits will be effective April 1. CBMS will not disregard the COLA increase from April forward when determining continued QMB eligibility for Big Al.

b. Special Low Income Medicare Beneficiary (SLMB) [\(8.100.6.L\)](#)

To be eligible for SLMB, a client must:

- Have income below 120% of the FPL
- Be entitled to Medicare Part A

A SLMB client can be “dual” eligible and receive assistance from another Medicaid category.

Eligibility begins the date of application and eligibility allows three month retroactive coverage.

SLMB pays Medicare Part B premium only.

c. Qualified Individual-1 (QI-1) [\(8.100.6.M\)](#)

To be eligible for QI-1 a client must:

- Have income below 135% of the FPL
- Not be eligible for another category of Medicaid

Eligibility begins the date of application and eligibility allows three month retroactive coverage.

QI-1 pays Medicare Part B premium only.

d. Qualified Disabled Working Individual (QDWI) [\(8.100.6.N\)](#)

To be eligible for QDWI a client must:

- Have income below 200% of the FPL
- Not be eligible for another category of Medicaid
- Be disabled, but have lost SSDI eligibility due to work income above the Substantial Gainful Activity (SGA). SGA is what SSA uses to determine whether or not a disabled individual remains eligible for a payment when they return to work. If an individual’s income is above the SGA limit, the individual is not be eligible for SSDI.
- Not be eligible for Medicare-paid Part A hospital coverage under SSDI

Eligibility begins the date of application and eligibility allows three month retroactive coverage.

QDWI pays Medicare Part A premiums only.

G. Other Programs

1. Breast and Cervical Cancer Program (BCCP) [\(8.715\)](#)

BCCP is a Medicaid program for women who have been screened and diagnosed with breast or cervical cancer at a Women's Wellness Connection (WWC) site.

BCCP offers the same coverage and benefits as regular Medicaid and also covers treatment for medical conditions that might lead to breast or cervical cancer if left untreated.

To apply, the client will submit the Presumptive Eligibility form to the WWC. The WWC will screen the client for BCCP eligibility. If the client appears eligible, the WWC will call the Department to obtain a State ID and to initiate Presumptive Eligibility Spans for the client. The WWC contractor completes all steps in the [WWC Step List](#).

BCCP Presumptive Eligibility (PE) is a temporary Medicaid coverage that allows the client to get treatment right away while the actual BCCP Medicaid application is reviewed and processed. The program allows for Presumptive Eligibility (PE) of no less than 45 days from the date of diagnosis.

The WWC will assist the client to complete an application, and will forward the completed application to the Department. Upon receipt, the Department shall forward the application to the county of residence.

In order to qualify for the BCCP program, a woman must be diagnosed at a WWC site. To be eligible for screening at a WWC site, the client:

- Is between 40 and 64 years old
- Has income less than 250% of the federal poverty level (FPL)
- Has not had a mammogram or Pap smear test in the last year
- Lives in Colorado
- Meets citizenship and identification rules
- Does not have medical insurance or has medical insurance that does not cover breast or cervical cancer treatment
- Is not already enrolled in Medicaid
- Is not eligible for Medicare

To be eligible for BCCP Medicaid, the client:

- Is a *woman* under age 65
- Is a U.S. citizen or qualified non-citizen
- Is a Colorado resident
- Has been screened at a WWC site
- Has been found to be in need of treatment for breast or cervical cancer
- Does not have any other creditable coverage including another category of Medicaid or Medicare

Coverage ends when women:

- Get other insurance that covers treatment for breast or cervical cancer
- Are found eligible for another Medicaid program
- Turn 65
- Do not send in the renewal packet on time
- Refuse treatment or do not start treatment within the first three months in the program
- Have completed active treatment for breast or cervical cancer

The eligibility site's responsibilities include:

- Requesting citizenship and identity verification from the client if it has not been provided by the Presumptive Eligibility Site
- Processing the application within 30 days of receipt
- Screening the client for all forms of Medicaid, not just BCCP. If the client is found eligible for another program of assistance, the eligibility worker will approve the client for the other program. The client can receive treatment under any Medicaid program
- Notifying the [BCCP program coordinator](#) of the approval or denial of a case

- Making any ongoing changes or updates to the case
- Completing the yearly redetermination.
- Informing the [BCCP program coordinator](#) when a client's eligibility changes

2. Low-Income Subsidy (LIS) [\(8.1000\)](#)

Low-Income Subsidy is a program that assists Medicare beneficiaries to pay for Medicare Part D prescription drug costs. LIS is not a category of Medicaid. LIS is administered through Social Security Administration (SSA).

People with Medicare and Medicaid, Medicare Savings Program (MSP) enrollment, or those receiving Supplemental Security Income (SSI) are automatically eligible for the extra help. People in these programs are considered to be deemed eligible. They do not need to apply for LIS.

Beneficiaries with limited income and resources who do not fall into one of the deemed subsidy groups must apply for LIS. Their eligibility for LIS can be determined by either SSA or the eligibility site. Applicants should contact SSA to ensure they are not already enrolled in LIS prior to applying. Beneficiaries can apply for LIS at SSA by mail, telephone, on the internet at www.ssa.gov or in person.

If a beneficiary insists on completing the application for LIS at an eligibility site, the eligibility site should comply and make the LIS determination. CBMS is programmed to make LIS determinations.

To be eligible for LIS, the beneficiary must:

- Have income at or below 150% of the FPL
- Have resources less than the federal limit. Resource levels are adjusted yearly. 2012 amounts are below \$13,070 for individual and \$26,120 for a married couple
- Be entitled to Medicare Part A and/or enrolled in Medicare Part B

[F. Med Spans](#)

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

Following authorization of an approval, medical spans should appear in CBMS the following day. The information from CBMS could take 48-72 hours to transmit to the MMIS, which means providers cannot see the eligibility for at least 2 days.

G. Benefits

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

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

If a client has questions regarding their benefits and whether or not a specific service is covered, please direct them to the [BCCP Program Coordinator](#)

Role

The BCCP Program Coordinator oversees overall program operations for BCCP.

When to Contact

Contact the BCCP Program Coordinator regarding program questions and client-related inquiries at Diane.Stayton@state.co.us.

Medicaid Customer Service.

H. Technical Assistance

Colorado Department of Human Services (CDHS) HelpDesk

Role

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

When to Contact

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

- CBMS password reset
- Data entry issues
- Help Desk Tickets
- Clearance
 - Choosing the correct client
 - Choosing the correct client or state ID
 - SIDMOD-**AFTER** the 24 hour period

Contact Info: Phone: 303-866-5204 or 1-877-487-4871

Email: PC.Helpdesk@state.co.us

After hours (OIT): 303-239-4357 or 1-877-632-2487

The hours of the CDHS Help Desk are 7 AM – 5 PM.

Please note: No password re-sets are done after hours, including weekends and State holidays.

ACS Provider Services

Role

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

When to Contact

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

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

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

Aged, Blind, and Disabled (ABD) Eligibility Specialist

Role

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

When to Contact

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

BCCP Program Coordinator

Role

The BCCP Program Coordinator oversees overall program operations for BCCP.

When to Contact

Contact the BCCP Program Coordinator regarding program questions and client-related inquiries at Diane.Stayton@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

HealthColorado provides assistance to Medicaid clients with selecting a Medicaid Managed Care Health Plan. **HealthColorado** 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.

Aged, Blind, and Disabled

I. Definitions

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

AND - AID to Needy Disabled is a program which provides financial assistance to low-income persons over age 18 who have a total disability which is expected to last six months or longer and prevents them from working.

AFDC - AID to Families with Dependent Children is the Title IV federal assistance program in effect from 1935 to 1997 which was administered by the United States Department of Health and Human Services. This program provided financial assistance to children whose families had low or no income.

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

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

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

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

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

Case management services are services provided by community mental health centers, clinics, community centered boards, and EPSDT case managers to assist in providing services to Medical Assistance clients in gaining access to needed medical, social, educational and other services.

CBMS - Colorado Benefits Management System is the computer system that determines an applicant's eligibility for public assistance in the state of Colorado.

CDHS -Colorado Department of Human Services is the state department responsible for administering the social service and financial assistance programs for Colorado.

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

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

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

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

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

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

Colorado State Plan is a written statement which describes the purpose, nature, and scope of the Colorado's Medical Assistance Program. The Plan is submitted to the CMS and assures that the program is administered consistently within specific requirements set forth in both the Social Security Act and the Code of Federal Regulations (CFR) in order for a state to be eligible for Federal Financial Participation (FFP).

Common Law Marriage is legally recognized as a marriage in the State of Colorado under certain circumstances even though no legally recognized marriage ceremony is performed or civil marriage contract is executed. Individuals declaring or publicly holding themselves out as a married couple through verbal or written methods may be recognized as legally married under state law. C.R.S. 14-2-104(3)

Complete application means an application in which all questions have been answered, which is signed, and for which all required verifications have been submitted.

The Department is defined in this volume as the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Child Health Plan Plus programs as well as other State-funded health care programs.

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

Disability means the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of 12 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.

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

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

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

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

Inpatient is an individual who has been admitted to a medical institution on recommendation of a physician or dentist and who receives room, board and professional services for 24 hours or longer, or is expected to receive these services for 24 hours or longer.

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

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

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

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

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

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

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

Qualified Alien is an individual who is one of the following:

1. Defined as a qualified alien under 8 United States Code section 1641.
2. Defined as a qualified alien by the attorney general of the United States under the authority of Public Law 104-208, section 501.

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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.