COLORADO RESOURCE GUIDE COLORADO RESOURCE GUIDE

Colorado
Resource Guide

2001

for People with Disabilities

FOR PEOPLE WITH DISABILITIES FOR PEOPLE WITH DISABILITIES

Welcome to the Colorado Disability Resource Guide

The Health Care Financing Administration, the Social Security Administration, and the State of Colorado are working together to provide important information to people with disabilities living in Colorado. Please keep this Guide with your important papers so you can find it when you need it.

This Guide will help you learn more about the kinds of disability and health benefits you may be able to get in the State of Colorado. It tells you:

- who can get benefits,
- how to apply,
- what is covered by the benefits you get, and
- who to call for help with the benefits you get.

For more information about benefits for people with disabilities, call the phone numbers or visit the websites listed below for more help with your questions:

Social Security Administration
1-800-772-1213
www.ssa.gov

Medicare Health Insurance
1-800-633-4227 (1-800-MEDICARE)
www.medicare.gov

Colorado Medicaid Health Insurance
1-800-221-3943
www.hcpf.state.co.us

This Guide is a pilot project (test) to see if you find the information in it useful. We want to hear from you. Send your comments to: HCFA, Attention Jill West, 1600 Broadway, Suite 700, Denver, CO 80202.

Alex E. Trujillo
Regional Administrator
Health Care Financing Administration

Richard Gonzalez
Regional Commissioner
Social Security Administration

Richard Allen
Director Colorado Medicaid

This Guide explains Social Security Disability Programs, Medicare, and Colorado Medicaid. It is not a legal document. The official Social Security, Medicare, and Colorado Medicaid program provisions are contained in the relevant laws, regulations, and rulings.

s In This Guide

Section 1: Social Security Disability Programs (continued)

Section 3: Colorado Medicaid (continued)

o Use This Guide

This Guide has 8 sections. You can tell which section you are reading by the heading at the top of each page. Terms in red are defined on pages 94-96.

If you:	**Read page(s) . . .**
Want to find a specific topic in this Guide.	98-103 – **Index**: An alphabetical list of all topics in this Guide and the page(s) where you will find the information you need.
Want to know what this Guide is about.	8
Want to know about Social Security Disability Insurance (SSDI).	16-20
Want to know about the Supplemental Security Income (SSI) Program.	20-23
Don’t agree with a decision about your disability case.	25
Want to know about Medicare.	31-52
Want to know about Colorado Medicaid.	53-66
Want to know about Medicaid Managed Care.	67-84
Want to know how your health benefits work together.	85-88
Want to know how to get other health care coverage.	89-92

This Guide gives you general information about 4 programs in Colorado that help people who are disabled or blind with their living expenses and with their health care costs. They are:

1. Social Security Disability Insurance (SSDI)
2. The Supplemental Security Income (SSI) Program
3. Medicare
4. Colorado Medicaid

The information in this Guide is not intended to cover all provisions of the law.

Note: The Social Security Administration (SSA) runs the SSDI and SSI programs. The Health Care Financing Administration (HCFA) runs the Medicare and Medicaid programs.

1. Social Security Disability Insurance (SSDI)

This program provides benefits to disabled or blind people who are "insured" by workers' contributions to the Social Security trust fund. These contributions are the Federal Insurance Contributions Act (FICA) social security tax paid on your earnings or those of your spouse or parents.

For more information about the SSDI program, see page 16.

2. The Supplemental Security Income (SSI) Program

This program makes cash assistance payments to aged, blind, and disabled people (including children under age 18) who have limited income and resources. The federal government funds SSI from general tax revenues.

The states pay benefits in different ways:

Some states pay benefits to some people to supplement their federal benefits. Some of these states combine the supplementary payment and the federal payment into one monthly check.

Other states manage their own programs and make their payments separately.

3. Medicare

Medicare is a health insurance program for:

- People 65 years of age and older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts, Part A (Hospital Insurance) and Part B (Medical Insurance).

For more information about Medicare, see page 31.

4. Colorado Medicaid

Medicaid is a joint federal and state program that helps pay health care costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid.

For more information about Medicaid, see page 53.

Abbreviations In This Guide

These are some of the abbreviations in this Guide:

DDS	Disability Determination Services
DSS	Department of Social Services
ESRD	End-Stage Renal Disease
FICA	Federal Insurance Contributions Act
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
OLTC	Options for Long-Term Care (Medicaid)
PCPP	Primary Care Physician Program
PACE	Programs of All-inclusive Care for the Elderly
SEP	Single Entry Point Agencies Medicaid
SGA	Substantial Gainful Activity
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income Program

Section 1: Social Security Disability Progams

Section 1: Social Security Disability Programs

Deciding If You Are Disabled

The Social Security Administration (SSA) uses a detailed process to decide if you can get benefits under the SSDI (Social Security Disability Insurance) and SSI (Supplemental Security Income) programs. This section walks you through this process and tells you how to file a claim.

Evaluating Work Activity

SSA evaluates your work activity when you claim benefits under both the SSDI and SSI programs. To qualify for Social Security disability benefits, you must have worked long enough under Social Security. You can earn up to a maximum of four work credits per year.

The number of work credits you need for disability benefits depends on your age when you become disabled. Generally, you need 20 credits earned in the last 10 years ending with the year you become disabled. However, younger workers may qualify with fewer credits.

You can receive Social Security disability benefits until age 65. When you reach 65, your disability benefits automatically convert to retirement benefits and the amount remains the same.

Both SSDI and SSI programs use earnings guidelines (a measure of how much money you made when you were working) to decide whether your work activity is substantial gainful activity (SGA).

What Is Substantial Gainful Activity (SGA)?

In order to be considered disabled under the law, SSA decides whether your medical condition prevents you from substantial gainful activity (SGA).

Evaluating Work Activity (continued)

SGA is when:

- You earn over $740 a month and you have a condition other than blindness (starting January 2001), or
- You earn over $1,240 a month and you are blind (for any work performed in 2000).

How Is SGA Used?

The **SSDI** program uses the SGA as one important factor in these processes:

- Deciding if you have a disability (other than blindness).
- Deciding if your disability continues when you are already receiving benefits, except during the trial work period.

The **SSI** program uses the same SGA levels as SSDI for applicants with impairments other than blindness.

- Your SSI eligibility continues until you recover medically or it ends for a non-disability-related reason.

The SGA is not a factor for SSI applicants who are blind.

The Process of Deciding If You Are Disabled

SSA uses a five-question process to decide if you are disabled:

1. Are you working?
2. Is your condition severe?
3. Is your condition on SSA's list of disabilities?
4. Are you able to do the work of your previous job?
5. Can you do any other type of work?

The Process of Deciding If You Are Disabled (continued)

1. Are You Working?

If you are working and your monthly income is at or above the SGA level (see page 13), SSA may not consider you disabled in spite of your condition.

If your monthly income is less than the SGA level, see question 2.

2. Is Your Condition Severe?

In order for SSA to consider you disabled, your condition must be severe enough to limit you from basic work activities, like walking, seeing, and remembering.

If you can do basic work activities, SSA does not consider you disabled.

If you can't do basic work activities, see question 3.

3. Is Your Condition on SSA's List of Disabilities?

SSA has an estabalished list of conditions that are considered severe enough to prevent a person from doing any SGA. If your condition is not on the list, SSA will decide if your condition is as severe as a condition on the list.

If your condition is on the list, SSA approves your claim.

If your condition is not on the list, see question 4.

4. Are you able to do the work of your previous job?

If your condition is severe, but not as severe as a condition on SSA's list, then SSA will decide if you can do all the duties of your previous job.

If you can do all the duties, SSA will deny your claim.

If you can't do the duties, see question 5.

The Process of Deciding If You Are Disabled (continued)

5. Can you do any other type of work?

SSA looks at your age, education, past work experience, and skills in deciding if you can do any other type of work.

If you can't do any other kind of work, SSA will approve your claim.

If you can do another type of work, SSA will deny your claim.

Other Government and Private Programs

SSA rules for deciding disability differ from those in other government and private programs. However, medical evidence from their files may be considered in SSA's decision.

What Medical Evidence SSA Needs From You

To process your claim quickly, SSA needs copies of all your medical reports. The medical evidence is the same for SSDI and SSI benefits. You also need to contact your doctors and other treatment sources to let them know that SSA will be asking for information from them, such as:

- ☑ When your medical condition began.
- ☑ How your condition limits your activities.
- ☑ What your medical tests have shown.
- ☑ What treatment or tests have been provided, and when doctor has prescribed for you.
- ☑ Names, addresses, and telephone numbers of doctors, hospitals, clinics, and institutions that have treated you—and the dates of treatment.
- ☑ Names of all prescription drugs you are taking and the prescribed dosage.

What SSA Needs From You (continued)

Note: If you do not have medical reports and test results, SSA will secure them from your treatment sources at no cost to you. SSA does not ask your doctors and treatment centers to decide if you are disabled.

For more information about what you will need to file a claim, see specific sections on SSDI (see below) and SSI (page 20).

Who Makes the Final Decision?

Once SSA goes through the process on pages 14-15 and you meet the basic requirements, your application will be sent to the Disability Determination Services (DDS) office in Colorado.

In the DDS office, a doctor (or psychologist) and a disability examiner will review your case and decide if you are disabled.

If the DDS office needs more medical information to decide your case, SSA may ask you to have a special exam called a consultative exam. You can get this exam from your doctor or the medical facility where you were treated. SSA will pay for the exam, other medical tests you may need, and related travel costs.

How Will I Know the Final Decision?

- Once a final decision has been made on your claim, SSA will send you a letter.
- If they approve your claim, the letter shows your benefit amount and when payments will start.
- If they don't approve your claim, the letter explains why and tells you how to appeal the decision.

Social Security Disability Insurance (SSDI)

Social Security Disability Insurance (SSDI) provides monthly cash benefits to disabled or blind people who are "insured" by workers' contributions to the Social Security trust fund. These contributions are the Federal Insurance Contributions Act (FICA) social security tax paid on your earnings or those of your spouse or parents.

Section 1: Social Security Disability Programs

Who is Eligible For SSDI?

To be eligible for SSDI, you must:

1. Have worked and paid Social Security taxes for enough years to be covered under Social Security insurance. Some of the taxes must have been paid in recent years.

2. You must be at least **ONE** of these:

   - The worker, the worker's adult child, widow, or widower

   or

   - Considered medically disabled and not working

   or

   - Working, but earning less than the substantial gainful activity (SGA) level

What You Need to File For Benefits

The Social Security office will help you. You can speed things up by bringing certain documents with you when you apply. You can also help SSA get any other information you need to show that you are disabled, including:

- ☑ Your Social Security number and birth certificate or other proof of age.
- ☑ A summary of where you worked the past 15 years (company names, addresses, supervisors' telephone numbers) and the kind of work you did.
- ☑ A copy of your W-2 Form (Wage and Tax Statement) if self-employed, and your federal tax return for the past year.
- ☑ The dates of any previous marriages.

Do not wait to file for benefits just because you don't have all the information you need.

If you have a bank account, bring something from your bank that shows your account number so SSA can deposit your benefits directly into your account. You may choose to have the check mailed to you.

How to File For SSDI Benefits

As soon as you believe you are eligible, file for benefits. There is no waiting period for filing, and waiting may make it more difficult to collect the records you need to support your claim. To file, follow these steps:

1. Call the SSA toll-free number: **1-800-772-1213.** SSA may be able to answer your questions over the telephone. But, you may have to go to their office to give information about your claim.

2. SSA arranges to take your claim either over the telephone or at their office. If you have to go to the office, SSA will send you a confirmation of appointment.

3. SSA sends you a form to get your claim started. You will need to fill out this form if you give your claim over the phone or at an SSA office.

4. Fill out the form as completely and accurately as you can.

5. Ask the claims representative how to send the form back. If you visit the SSA office before then, bring the form with you.

How Much Will My Payment Be?

The amount of the SSDI payment is based on the worker's lifetime average earnings covered by Social Security. The payment amount may change each year due to cost-of-living increases. SSA may reduce the payment amount by:

- Workers' compensation payments (including Black Lung payments)

- Public disability benefits (state, civil service)

Other income or resources do not affect the benefit amount.

When SSDI Benefits Start

Generally, you must wait 5 full calendar months from the month SSA has determined that you are disabled before you receive SSDI benefits. If your disability benefits end but you later refile with the same or a related condition within 5 years, SSA does not require a new waiting period.

Note: SSA does not require a waiting period for disabled adult children filing for disability benefits based on their parent's earnings record.

SSA Reviews Your Disability Case

Periodically, SSA reviews your disability case to see if your condition has improved or if you can perform SGA.

- If your original disabling condition is expected to improve, SSA will review your case on or about the date the improvement is expected.
- If medical improvement is possible, SSA will review your case at least once every 3 years.
- If medical improvement is not expected, SSA will review your case every 5-7 years.
- If SSA is informed by a credible source that you may have returned to work or appear to have improved, they review your case when they receive the information.

The Supplemental Security Income (SSI) Program

The Supplemental Security Income (SSI) Program makes cash assistance payments to aged, blind, and disabled people (including children under age 18) who have limited income and resources. The federal government funds SSI from general tax revenues.

Some states pay benefits to some people to supplement their federal benefits. Colorado does not provide a supplement for people who receive a full SSI benefit. People who receive only a partial benefit, however, may be eligible for a supplement.

Who is Eligible for SSI?

To be eligible for SSI based on a medical condition you must:

1. Have little or no income or resources.
2. Be a U.S. citizen or meet the requirements for non-citizens.
3. Be considered medically disabled.
4. Be a resident of one of the 50 States, District of Columbia, or Northern Mariana Islands.
5. File an application.
6. File for any and all other benefits for which you are eligible.
7. Not be working, but if you are working, earning less than the SGA level if your impairment is other than blindness.

If you are blind, only the first six requirements apply to you.

Once you are enrolled, your eligibility continues until you medically recover or no longer meet a requirement that is not related to your disability.

What You Need To File for Benefits

Do not wait to file for benefits just because you don't have all the information you need. The Social Security office will help you. You can speed things up by bringing certain documents with you when you apply and helping SSA get any other information or medical evidence you need to show that you are disabled, including:

- ☑ Your Social Security number and birth certificate or other proof of age.
- ☑ X-rays, and laboratory and test results.
- ☑ A summary of where you worked in the past 15 years (company names, addresses, supervisors' telephone numbers) and the kind of work you did.
- ☑ A copy of your W-2 Form (Wage and Tax Statement); if self-employed, your federal tax return for the past year.
- ☑ Dates of any previous marriages.
- ☑ Information about the home where you live, such as your mortgage or your lease and landlord's name.
- ☑ Payroll slips, bank books, insurance policies, car registration, burial fund records, and other information about your income and the things you own (loan notes, stocks, bonds, other investments, etc.).
- ☑ Proof of U.S. citizenship or non-citizen status.

How to File for SSI Benefits

If you have a bank account, bring something from your bank that shows your account number so SSA can have your benefits deposited directly into your account. You may choose to have the check mailed to you.

As soon as you believe that you might be eligible, file for benefits. There is no waiting period for filing, and waiting may make it more difficult to collect the records that you need to support your claim. To file, follow these steps:

1. Call the SSA toll-free number 1-800-772-1213 or call your local Social Security office (see pages 29-30). SSA may be able to answer your questions over the telephone.

2. SSA arranges to take your claim either over the telephone or at the office.

3. SSA sends you a confirmation of this appointment. SSA also sends you a form to get your claim started.

4. Fill out the form as completely and accurately as you can.

5. Ask the claims representative to tell you how to send the form back. If you visit the SSA office before then, bring the form with you.

When SSI Benefits Start

There is no waiting period required before receiving SSI benefits. Your payments will start as soon as it is determined that you meet the eligibility requirements.

Getting Help to Manage Your Money

More than six million people who receive monthly Social Security, Supplemental Security Income (SSI) benefits, or both need someone to help them manage their money. After a careful investigation, the Social Security Administration appoints a relative, friend, or other interested party to serve as your representative payee, or "payee".

Your Social Security or SSI benefits are then paid in the representative payee's name on your behalf.

- About 25% of people who get SSI have a payee.
- About 10% of people who get Social Security have a payee.
- Almost all children under 18 have a payee, usually a parent.
- Adults who are unable to manage their finances because of severe physical or mental illness also need payees.

All payees will get a guide booklet that tells what they have to do and how to keep track of what is spent on your behalf.

Ticket to Work and Work Incentives Improvement Act of 1999

In December 1999, President Clinton signed the Ticket to Work and Work Incentives Improvement Act of 1999, which does the following:

- Increases choice in rehabilitation and vocational services.
- Removes barriers that require people with disabilities to choose between health care coverage and work.
- Ensures that more Americans with disabilities have the opportunity to work and lessens their need for public benefits.

Some of the key provisions of the law (which become effective at various times):

- Expands the availability of health care services to people who work and earn more than SGA.
- Establishes the ticket to work and self-sufficiency program.
- Expedites reinstatement of benefits.
- Postpones disability reviews.

For more information on this new law, call your Social Security office (see pages 29-30). In Denver, contact Chris Johnson at 303-844-6766, extention 3011, in Pueblo County call JoAnn Russ at 719-545-3052, extention 217. Or, visit their website at www.ssa.gov for more information on this new law.

*See page 12 for more information about SGA.

Appealing Decisions About Disability

Social Security wants to be sure that every disability decision made about your Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) claim is correct. Before we make any decision that affects your eligibility or your benefit amount, we carefully consider all the information in your case.

When SSA decides whether you are eligible for benefits, they will send you a letter explaining their decision. If you don't agree with their decision, you can ask SSA to look at your case again. This is called an appeal.

When you ask for an appeal, SSA will look at the entire decision, even those parts that were in your favor. If the decision was wrong, they will change it.

If you want to appeal, you must make your request in writing within 60 days from the date that you receive a letter from SSA. SSA will assume you received the letter five days after the date on it, unless you can show them you received it later.

There are three levels of appeals:

1. Hearing by an administrative law judge
2. Review by the Appeals Council
3. Federal Court review

When SSA sends you a letter about a decision on your claim, they will tell you how to appeal the decision. If you need help with your appeal, call your Social Security office (see pages 29-30).

SSA has many booklets about disability benefits and the SSI program. See the list of booklets on pages 27-28.

Where to Get More Information

Free SSA Booklets (see pages 27-28)

How to Get These Booklets

To get these booklets, you can:

1. Call SSA at 1-800-772-1213 and ask for a copy using the order numbers when you call.

2. Go to the SSA website at www.ssa.gov on the Internet. This website also has booklets about:

   - Retirement benefits
   - Survivors benefits
   - The appeals process
   - Work and earnings
   - Subjects of special interest

Booklets About Disability Benefits

Title	Order Number
Disability	05-10029
Appeals Process	05-10141
Desktop Guide to Social Security and SSI Work Incentives	05-11002
Guide to Social Security and SSI Disability Benefits for People with HIV Infection	05-10020
How Social Security Can Help With Vocational Rehabilitation	05-10050
How We Decide If You Are Still Disabled	05-10053
How Worker's Compensation and Other Disability Payments May Affect Your Benefits	05-10018
Project ABLE: Able Beneficiaries' Link To Employers	05-10056
Receive Your Benefits By Direct Deposit	05-10123
Reviewing Your Disability	05-10068
Social Security: Benefits for Children with Disabilities	05-10026
Social Security: If You Are Blind How We Can Help	05-10052
Social Security: What You Need To Know When You Get Disability Benefits	05-10153
Social Security Benefits for People Living With HIV/AIDS	05-10019
Social Security Disability Programs Can Help	05-10057
Redbook on Work Incentives For People With Disabilities	64-030
Working While Disabled…How We Can Help	05-10095

Booklets About the Supplemental Security Income Program (SSI)

Title	Order Number
Supplemental Security Income	05-11000
Desktop Guide To Social Security & SSI Work Incentives	05-11002
Desktop Guide to SSI Eligibility Requirements	05-11001
Food Stamps and Other Nutrition Programs	05-10100
Food Stamp Facts	05-10101
A Guide to Social Security and SSI Disability Benefits for People with HIV Infection	05-10020
How Worker's Compensation and Other Disability Payments May Affect Your Benefits	05-10018
The Definition of Disability for Children	05-11053
Receiving Your Benefits By Direct Deposit	05-10123
Reviewing Your Disability	05-10068
Social Security: What You Need To Know When You Get SSI	05-11011
Social Security: Working While Disabled…A Guide to Plans for Achieving Self-Support (PASS)	05-11017
Social Security: You May Be Able To Get SSI	05-11069
Special Benefits for Certain World War II Veterans	05-10157
Supplemental Security Income for Noncitizens	05-11051

Social Security Offices in Colorado

Call 1-800-772-1213 or visit any of the following SSA District Offices if you want to apply for Social Security Disability Insurance or the Supplemental Security Income Program.

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call the Social Security Administration at 1-800-772-1213.

Alamosa
511 Main Street
Alamosa, CO 81101-2664
(719) 589-2953

Aurora
501 Sable Boulevard
Aurora, CO 80011
(303) 361-0434

Boulder
665 South Broadway
Suite A
Boulder, CO 80303
(303) 543-9492

Canon City
115 N 10th Street
Canon City, CO 81212
(719) 275-7848

Colorado Springs
1049 N. Academy Blvd.
Colorado Springs, CO 80909
(719) 574-9279

Cortez
(Residence Station)
925 S. Broadway
Room 220
Cortez, CO 81321
(970) 565-4534

Denver
1616 Champa Street,
4th Floor
Denver, CO 80202-9771
(303) 844-6766

Durango
103 Sheppard Drive,
Room 120
Durango, CO 81301
(970) 247-3128

Englewood
888 W. Ithaca Ave.
Englewood, CO 80110
(303) 762-7200

Social Security Offices in Colorado

Call 1-800-772-1213 or visit any of the following SSA District Offices if you want to apply for Social Security Disability Insurance or the Supplemental Security Income Program.

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call the Social Security Administration at 1-800-772-1213.

Ft. Collins
301 South Howes,
Room 212
Ft. Collins, CO 80521
(970) 482-7354

Glenwood Springs
2425 Grand Avenue,
Room 101
Glenwood Springs, CO 81601
(970) 945-8609

Grand Junction
774 Horizon Court, Room 120
Grand Junction, CO 81506
(970) 245-2627

Greeley
800 8th Avenue, Suite 330
Greeley, CO 80631
(970) 395-2192

La Junta
1420 E. 3rd Street
La Junta, CO 81050-3699
(719) 384-8887

Lakewood
8585 W. 14th Avenue
Lakewood, CO 80215
(303) 234-1008

Montrose
30 N. Uncompaghre
Montrose, CO 81401
(970) 249-1072

Pueblo
201 W. 8th
Suite 700,
Norwest Bank Bldg.
Pueblo, CO 81003
(719) 542-9248

Ft. Morgan
(Residence Station)
625 W. Platte Ave.
Ft. Morgan, CO 80701
(970) 353-2192

Trinidad
207 East Main St.
Trinidad, CO 81082
(719) 846-6556

Section 2: Medicare

Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older
- Some disabled people under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

To get more details about what Medicare covers, look at the Medicare Part A and Part B coverage charts on pages 34-36.

The Two Parts of Medicare

Medicare has two parts:

1. **Part A (Hospital Insurance)** helps pay for:
   - Inpatient hospital care
   - Some skilled nursing facility care
   - Hospice care
   - Some home health care

   Most people get Part A automatically when they turn 65. They do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working.

2. **Part B (Medical Insurance)** helps pay for:
   - Doctors' services
   - Outpatient hospital care
   - Some other medical services that Part A doesn't cover (like some home health care)

   Part B helps pay for these covered services and supplies when they are medically necessary.

2. **Part B (Medical Insurance)** (continued)

You pay the Medicare Part B premium of $50.00 per month in 2001. Rates can change yearly. In some cases, this amount may be higher if you did not choose Part B when you first became eligible at age 65. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it, except in special cases. You will have to pay this extra 10% for the rest of your life.

If you have general questions about your Medicare Part B coverage, call 1-800-332-6681.

Medicare Part A (Hospital Insurance) Helps Pay For:	What YOU Pay in 2001* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, a private room unless **medically necessary**, or a television or telephone in your room. Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.	**For each** benefit period **YOU pay**: • A total of $792 for a hospital stay of 1-60 days. • $198 per day for days 61-90 of a hospital stay. • $396 per day for days 91-150 of a hospital stay. • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: ** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay).	**For each benefit period YOU pay**: • Nothing for the first 20 days. • Up to $99 per day for days 21-100. • All costs beyond the 100th day in the benefit period.
Home Health Care: ** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	**YOU pay**: • Nothing for home health care services. • 20% of the Medicare-approved amount for durable medical equipment.
Hospice Care: ** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	**YOU pay**: • A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year.
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	**YOU pay**: For the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2002.

** You must meet certain conditions in order for Medicare to cover these services.

If you have general questions about Medicare Part A, call your Fiscal Intermediary (see page 49).

Medicare Part B (Medical Insurance) Helps Pay For:	What YOU Pay in 2001* in the Original Medicare Plan (see Note below)
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions.	**YOU pay:** • $100 deductible (pay once per calendar year). • 20% of Medicare-approved amount after the deductible, except in the outpatient setting.
Also covers outpatient physical and occupational therapy including speech-language therapy.	• 20% for all outpatient physical, occupational, and speech-language therapy services.
Outpatient mental health care.	• 50% for outpatient mental health care.
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**YOU pay:** • Nothing for Medicare-approved services.
Home Health Care: ** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.	**YOU pay:** • Nothing for Medicare-approved services. • 20% of Medicare-approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**YOU pay:** • A coinsurance or fixed copayment amount which may vary according to the service.
Blood: Pints of blood you get as an outpatient, or as part of a Part B covered service.	**YOU pay:** For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2002.
** You must meet certain conditions in order for Medicare to cover these services or equipment.

Note: Actual amounts you must pay are higher if the doctor or supplier does not accept assignment, and you may have to pay the entire cost. Medicare will then send you its share of the costs. If you have general questions about Medicare Part B, call your Medicare Carrier (see page 49). If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC) (see page 49).

Medicare Part B Covered Preventive Services	Who is covered...	What YOU pay in the Original Medicare Plan...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount (or a set copayment amount) after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every 12 months. • Flexible Sigmoidoscopy* - Once every 48 months. • Colonoscopy* - Once every 24 months if you are at high risk for colon cancer. Starting July 1, 2001, once every 10 years for people who are not at high risk for cancer. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. (*25% if performed in an ambulatory surgical center or hospital outpatient department.)
Diabetes Services: • Coverage for glucose monitors, test strips, and lancets.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the yearly Part B deductible.
• Diabetes self-management training.	If requested by your doctor or other provider.	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months. (You can also get one baseline mammogram between ages 35 and 39.)	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 36 months. Starting July 1, 2001, once every 24 months. Once every 12 months if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months.	All women with Medicare.	Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Shots (vaccinations): • Flu Shot - Once a year in the fall or winter. • Pneumonia Shot - One shot may be all you ever need. Ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	Nothing for flu and pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible.

How to Get Medicare

The Social Security Administration (SSA) decides who is eligible for Medicare. If you think you are eligible for Medicare, call SSA at 1-800-772-1213.

When Medicare Benefits Start (For People With Disabilities)

If you have End-Stage Renal Disease (ESRD), permanent kidney failure requiring regular dialysis or a transplant, you may qualify for Medicare almost immediately.

For everyone else, there is a 24-month waiting period for Medicare coverage based on disability. During this 24-month period, you may be eligible for health insurance through a former employer. Contact the employer for information about health insurance coverage.

If you disenroll from the disability benefit and return with the same or a related condition within 5 years (7 years for widows, widowers, and disabled adult children), a new waiting period is not required.

Medicare Health Plan Choices

Depending on where you live, you may have three choices:

1. **The Original Medicare Plan** (also known as fee-for-service),

2. **A Medicare managed care plan** (like an HMO), or

3. **A Private Fee-for-Service plan** (a new health care choice that is available in some areas of the country. However, in 2001, this plan is not available in Colorado.)

Medicare Health Plan Choices (continued)

1. The Original Medicare Plan

A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance).

2. A Medicare Managed Care Plan

These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

3. A Private Fee-for-Service Plan

This is a new health care choice in some areas of the country. It is a Medicare health plan offered by a private insurance company. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits that the Original Medicare Plan does not cover.

For more information about your Medicare health plan choices, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the **"Medicare & You"** handbook. You can also read or print a copy of this handbook at www.medicare.gov on the Internet. Select "Publications."

Medicare Health Plans In Colorado

In addition to the Original Medicare plan, Medicare managed care plans are the only other Medicare health plan available in Colorado at the time this Guide was printed. But, that may change. For the most up-to-date information on the health plans available in Colorado, call 1-800-MEDICARE (1-800-633-4227) or look at www.medicare.gov on the Internet.

The chart on pages 42-44 is a listing of Medicare managed care plans available in Colorado. Some plans may be open to current members only. Please call 1-800-MEDICARE (1-800-633-4227) or the health plan to ask if the plan you are interested in is currently accepting new members.

Who Can Join a Medicare Managed Care Plan?

If you have Medicare, you can join a Medicare managed care plan if:

- You have both Part A (Hospital Insurance) and Part B (Medical Insurance).
- You live in the service area of the plan. The service area is where the plan accepts members. In the case of a managed care plan, it's also where you get services from the plan.
- You don't have End-Stage Renal Disease (ESRD), permanent kidney failure requiring dialysis or a kidney transplant. ESRD patients can stay in the plan they are in or join another plan offered by the same company. If you've had a successful kidney transplant, you may be able to join a plan. Call 1-800-MEDICARE (1-800-633-4227) for more information about ESRD and Medicare health plans.

Medicare Health Plans In Colorado (continued)

What will I see on the following pages?

On pages 42-44, you will see a chart of basic information about Medicare health plans in Colorado. Each company that has a contract with Medicare can offer one or more plans. Companies decide where to do business and may not be available everywhere. Remember to check with the company and ask if the plan you are interested in is offered in your zip code.

How do I read the chart?

Health plan descriptions and costs are listed by company name on pages 42-44. Please read this example before turning to those pages.

Note: See page 41 for the description of the numbered items in the example below.

Example

Colorado

Company Information	Plan Name	Plan Service Area	Monthly Premium	Prescription Drug Coverage
(1) ABC Health Plan (H4567) (2) 1(888)333-3127 (3) Approved by Medicare (4) Managed Care Plan (5) Available to current members only	(6) Medicare Gold (001)	(7) Howard & Anne Arundel Counties	(8) $40	(9) Yes
	Medicare Silver (002)	Prince Georges County	$25	Yes
	Medicare Bronze (003)	Baltimore City and County	$15	Yes, for an extra cost

Description of numbered items in example on page 40:

1. Name of company that contracts with **Medicare** to offer a managed care or Private Fee-for-Service plan. (The number next to the name is for Medicare's use only.)

2. Customer service number to call for information about the plan(s) offered.

3. Tells you if Medicare has approved the benefits and costs offered by the company for the year 2001. If "As submitted by organization" appears, the company has a current contract with Medicare, but Medicare is still discussing the benefits and costs offered by the company for the year 2001.

4. Tells you if this is a Private Fee-for-Service plan or a managed care plan.

5. Tells you if there are special rules for joining this plan.

6. Name of the Medicare health plan. (The number next to the name is for Medicare's use only.)

7. Local area where the plan is being offered. You must live in this area to join this plan. Check to make sure your zip code is in the service area.

8. Amount you pay each month, in addition to your monthly Medicare Part B premium, when you join the plan. In a few cases, a note will tell you "Under Review" instead of a premium amount. This means that Medicare and the company are still discussing the amount.

9. Tells you if the plan covers prescription drugs. If "Yes, for an extra cost" appears, that means you can choose to have prescription drug coverage with this plan, but it will cost you extra. Some plans cover only certain drugs or pay up to a set dollar limit. Call the plan to get all the details of prescription drug coverage so you understand any conditions or limits. If "Under Review" appears, it means that the prescription drug coverage is still being discussed.

Year 2001 Medicare Health Plans Available in Parts of Colorado

Some plans may be open to current members only. Please call 1-800-MEDICARE or the health plan to ask if the plan you are interested in is currently accepting new members.

Company Information	Plan Name	Plan Service Area	Monthly Premium*	Prescription Drug Coverage**
Rocky Mountain HMO (H0602) 1-800-346-4643 Approved by Medicare Managed Care Plan	RMHMO Medicare Standard Plan (001)	Specified Colorado counties	$74	No
	RMHMO Medicare Gold Plan (002)	Specified Colorado counties	$134	Yes
	RMHMO Medicare Plus Plan (003)	Specified Colorado counties	$134	Yes
HMO Colorado, Inc. (H0603) 1-303-831-7046 Approved by Medicare Managed Care Plan	Blue Advantage for Seniors — Base (006)	Adams/ Arapahoe/ Denver/ Douglas/ Jefferson Counties	$0	Yes, for an extra cost

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or look on the Internet at www.medicare.gov for more detailed information, including costs and benefits, about these health plans.

* This is the amount you must pay each month to belong to the plan. You must continue to pay the monthly Part B premium ($50.00 in 2001). Some companies may offer extra benefits for an additional cost. New Part B premium amounts will be available in January for the year 2002.

** Some plans cover only certain drugs or pay up to a set dollar limit. Call the plan to get all the details of prescription drug coverage so you understand any conditions or limits.

Year 2001 Medicare Health Plans Available in Parts of Colorado (continued)

Colorado

Company Information	Plan Name	Plan Service Area	Monthly Premium*	Prescription Drug Coverage**
PacifiCare of Colorado, Inc. (H0609) 1-800-308-2160 Approved by Medicare Managed Care Plan	Secure Horizons Basic Plan (002)	Colorado Springs	$74	Yes
	Secure Horizons Preferred Plan (006)	Denver Metro	$41	Yes
	Secure Horizons Basic Plan (007)	Denver Metro	$19	Yes
	Secure Horizons Basic Plan (003)	Larimer	$74	Yes
	Secure Horizons Basic Plan (001)	Pueblo	$99	Yes
Kaiser Foundation Health Plan of Colorado (H0630) 1-303-338-3800 Approved by Medicare Managed Care Plan	Senior Advantage Silver (004)	Denver Metropolitan Area	$10	Yes
	Senior Advantage Silver Plus (005)	Denver Metropolitan Area	$29	Yes
	Senior Advantage Gold (006)	Denver Metropolitan Area	$55	Yes

Year 2001 Medicare Health Plans Available in Parts of Colorado (continued)

Colorado

Company Information	Plan Name	Plan Service Area	Monthly Premium*	Prescription Drug Coverage**
HMO Health Plans, Inc. (H0657) 719-852-4055 800-475-8466 Approved by Medicare Managed Care Plan	San Luis Valley HMO Preferred	Not Available	$65	Not Available
	San Luis Valley HMO Select	Not Available	$55	Not Available
United Healthcare Insurance Company (H0662) 1-800-393-0993 Approved by Medicare Managed Care Plan	EverCare Colorado (001)	EverCare	$0	No
TRICARE Senior Prime (Military Retirees) (H0667) 1-719-266-7000 Approved by Medicare Managed Care Plan	TRICARE Senior Prime (001)	TRICARE Central	$0	Yes

How to Join a Medicare Managed Care Plan

To join a plan:

1. Call the plan and ask for an enrollment form. Fill out the form and mail it to the plan, **or**

2. Get an enrollment form from a plan representative. Fill out the form and give it to the plan representative.

You will get a letter from the plan telling you when your coverage begins.

Insurance That Supplements Medicare

There are many types of health coverage that may cover some or all of the health care costs that Medicare does not cover. They include:

1. Employee or Retiree Coverage from an Employer or Union (see below)

2. A Medigap Insurance Policy (see page 46)

3. Medicaid (see page 46)

1. Employee or Retiree Coverage From an Employer or Union

This type of group health coverage is for current employees or retirees. Generally, employer plans have better rates than you can get if you buy a policy yourself, and employers pay part of the cost. Call your benefits administrator to find out if you have or can get health coverage based on your or your spouse's past or current employment, or your parents' current employment.

2. A Medigap Insurance Policy

A "Medigap" insurance policy fills gaps in Original Medicare Plan coverage only. Medigap insurance must follow federal and state laws. These laws protect you. All Medigap policies are clearly marked "Medicare Supplement Insurance."

Some insurance companies will sell Medigap policies to people with Medicare under age 65. However, these policies may cost you more. Call the Colorado State Health Insurance Assistance Program at 1-888-696-7213 for information about buying a Medigap policy if you are disabled or have ESRD.

For more detailed information about Medigap policies:

✓ Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the **"Guide to Health Insurance for People with Medicare."** To read or print this booklet, visit www.medicare.gov and select "Publications."

✓ Visit www.medicare.gov on the Internet to get information on Medigap policies in your state. Select **"Medigap Compare."** This website has information on:

- Which Medigap policies are sold in your state.
- Shopping for a Medigap policy.
- What these policies must cover.
- How insurance companies decide what to charge you for a Medigap policy premium.
- Your Medigap rights and protections.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

3. Medicaid

This is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid.

3. Medicaid (continued)

States also have Medicare Savings Programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurances for certain people who have Medicare and a low income.

To qualify for these Medicare Savings Programs, you must:

- Have Medicare Part A (hospital insurance). If you're not sure if you have Part A, look on your red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.
- Have a monthly income of less than $1,273 for an individual or $1,714 for a couple in 2001.*
- Have savings of $4,000 or less for an individual or $6,000 or less for a couple. Savings include money in a checking or savings account, stocks, or bonds.

* Income limits will go up slightly in 2002, and new limits will be available by April 1, 2002.

To get more information on these programs, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for information on "Savings for Medicare Beneficiaries."

For information about Colorado Medicaid, see Section 3 on page 53.

Appealing Medicare Decisions

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or another Medicare health plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Appealing Medicare Decisions (continued)

Appeal Rights in The Original Medicare Plan

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. This notice will also tell you why Medicare didn't pay your bill and how you can appeal.

Appeal Rights in a Medicare managed care plan or Private Fee-for-Service plan

If you are in a Medicare managed care plan or a Private Fee-for-Service plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. You may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about your rights during an appeal.

Where to Get More Information

1-800-MEDICARE Helpline

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to:

- Get help with your Medicare questions.
- Order information about the Medicare health plans in your area.
- Listen to recorded questions and answers on topics such as Medicare health plan choices.
- Order Medicare booklets. (Some are available in audiotape, Braille, large print, and Spanish.)

Where to Get More Information (continued)

1-800-MEDICARE Helpline (continued)

You can hear a recording with answers to frequently asked questions, and can order Medicare booklets 24 hours a day, 7 days a week. You can also talk with a Customer Service Representative between 8 a.m. and 4:30 p.m. in your time zone, Monday through Friday.

Colorado Phone Numbers to Call for Help

Below are phone numbers you may call for help with your questions about Medicare. At the time of printing, these numbers were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can also go on the Internet at www.medicare.gov and select "Helpful Contacts."

Medicare Part A Claims
1-800-442-2620

Medicare Part B Claims
1-800-332-6681

Durable Medical Equipment Claims
1-800-213-5452

Home Health and Hospice Claims
1-515-471-7200

End-Stage Renal Disease
1-800-783-8818

Quality of Care Complaints (Peer Review Organization)
1-800-727-7086

Information on How to Save Money
1-800-221-3943

The Colorado State Health Insurance Assistance Program
1-888-696-7213

Where to Get More Information (continued)

Colorado Phone Numbers to Call for Help (continued)

Call 1-800-659-3656 for TTY/TDD assistance from Colorado Relay for any of the phone numbers listed on page 48-49.

FREE Medicare Booklets

Medicare has many booklets to help you learn about the program (see below). To get these booklets, you can:

1. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the booklet you want.

2. Look on the Internet at www.medicare.gov and select "Publications." You can read or print out these booklets.

About Basic Medicare Information:

- Medicare & You 2001

  You can get free copies of this handbook in:
  - English print
  - Spanish print
  - English large print
  - Spanish large print
  - English audiotape
  - Spanish audiotape
  - Braille

About Services Medicare Covers:

- Medicare and Your Mental Health Benefits **New!**
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services **New!**
- Medicare Coverage of Skilled Nursing Facility Care **New!**
- Getting a Second Opinion Before Surgery
- Medicare Home Health Care Services
- Medicare Hospice Benefits
- Medicare Preventive Services

FREE Medicare Booklets (continued)

About Health Care Choices:
- Choosing a Doctor **New!**
- Choosing a Hospital **New!**
- Choosing Treatments **New!**
- Your Guide to Choosing a Nursing Home
- Private Contracts Fact Sheet
- Nursing Homes Fact Sheet

About Medicare Health Plan Choices and Supplemental Coverage:
- Health Plan Comparison Information (with quality data)
- Understanding Your Medicare Choices
- 2000 Guide to Health Insurance for People with Medicare
- Your Guide to Private Fee-for-Service Plans
- Your Guide to Medicare Medical Savings Accounts
- Worksheet for Comparing Medicare Health Plans

About Your Rights and Protections:
- Medicare Appeals and Grievances (Complaints)
- Medicare Fraud and Abuse
- Medicare Patient Rights
- Medigap Policies and Protections

About Costs and Payment:
- Do You Need Help to Pay Health Care Costs?
- Does Your Doctor or Supplier Accept Assignment?
- Medicare and Other Health Benefits: Your Guide to Who Pays First **New!**
- Your Guide to the Outpatient Prospective Payment System **New!**

Note: Many of these booklets are available in audiotape (English and Spanish), Braille, large print (English and Spanish), and Spanish. Some booklets are also available in Chinese.

NOTES

Section 3: Colorado Medicaid

Section 3: Colorado Medicaid

What is Medicaid?

Medicaid is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid.

Who is Eligible for Colorado Medicaid?

If you have a disability, you may be eligible for Medicaid. To qualify for the program, you must meet specific income, disability, and other criteria under the Supplemental Security Income (SSI) program (see page 20).

How to Apply for Colorado Medicaid

For people with disabilities, there are two ways to apply for Medicaid:

1. Through the Social Security Administration (SSA)
2. Through your county Department of Social Services (DSS) or Human Services Office

1. Applying for Medicaid through the Social Security Administration (SSA)

To apply through the SSA for SSI, call 1-800-772-1213.

- State clearly that you are applying for the SSI program, not just asking for information.
- Tell the SSA worker if you're going to be out of your home for a long period of time, or if you are currently out of your home. This is because different income standards may apply.

1. Applying for Medicaid through the Social Security Administration (SSA) (continued)

It may take several months to become approved for the SSI program. If you are eligible for SSI, you will receive Medicaid and may receive cash as a benefit of the SSI program.

The Process for Deciding if You are Eligible For SSI Benefits

1. SSA reviews your financial and other information that applies.

2. If SSA finds that you meet the financial and other criteria, Disability Determination Services (DDS) will review your disability information to decide if you also qualify under the disability criteria.

If you are found to be eligible for SSI, you will get Medicaid in addition to your cash benefit.

If you are found not eligible for SSI, you have the right to appeal the decision.

When Will I Know if I am Eligible for SSI?

The Social Security Administration will send you a notice that you are eligible. However, it may take several weeks for your Medicaid information to become available to providers.

Will Medicaid Pay the Doctor Bills I Already Had Before I Became Eligible?

If you have medical bills up to three months before your Medicaid coverage began, you may be able to get those bills paid through Medicaid. Call your county DSS to see if you were Medicaid eligible during that time.

2. Applying for Medicaid through Your County Department of Social Services (DSS) Office

Call your county Department of Social Services (DSS) Office to apply for Medicaid. Your county DSS office will decide if you meet specific eligibility criteria, such as income. They will also direct you to the appropriate agency for a disabililty determination.

If you are found eligible, you will receive only the Medicaid benefit, not the SSI cash benefit.

If you are found not eligible for the Medicaid program, you have the right to appeal the decision.

Why Should I Apply for Medicaid Through My County DSS Office?

You should apply through your county DSS office if:

- You applied for SSI but would also like to apply through the county in case the SSI decision takes longer.
- You have been institutionalized (like in a nursing home or hospital) for at least 30 days and your income is a little more than the SSI limit.
- You are an undocumented resident and you need emergency services.
- You want to have your Medicaid eligibility backdated up to 3 months because you have medical bills.

When Medicaid Benefits Start

For Medicaid in Colorado, your SSI application is also your Medicaid application, and your Medicaid eligibility starts the same month as your SSI eligibility.

If you are not receiving SSI, the Department of Social Services will let you know when your benefits will start.

Medicaid Covered Programs

Medicaid covers the following federally mandated programs:

1. Qualified Disabled and Working Individual Program

If you have a disability and you have lost Social Security Disability Insurance (SSDI) and Medicare Part A (hospital insurance) because you returned to work, you may still buy Medicare Part A. If you have limited income and resources, and you are not eligible under another assistance category, Medicaid will pay the Part A premiums for you. To receive this benefit, you must apply at your local county Human Services office.

2. Baby Care Kids Care Program

This program is for certain pregnant women and young children. It is available to pregnant women of all ages who are married or single. Children can get services from the time they are born until they are 6 years old. In some cases, help is also given to older children.

One goal of this program is to help women have healthy babies. Another goal is to make sure that those babies grow into healthy children. Pregnant women can get prenatal care and help with family planning. Medicaid will also pay for all of the medical care needed during labor, delivery, and care for the mother up to 6 weeks after the birth of the child. The newborn will also receive full medical care until the child is one year old. Children in the Baby Care Kids Care program get complete health care.

3. Medicare Buy-In and Medicare Savings Programs

If you are eligible for Medicaid and entitled to Medicare, Medicaid will pay your monthly Medicare Part B premiums under Medicare Buy-In.

If you are entitled to Medicare Part A and have limited income and resources, Medicaid may help pay some of your Medicare out-of-pocket health care costs (some or all of your Medicare premiums, and in some cases deductibles and coinsurance).

Medicaid Covered Services

After the county Department of Social Services (DSS) finds you eligible for Medicaid, you are entitled to all Medicaid covered health care services if they are medically necessary. These services include:

1. Inpatient and Outpatient Services (see page 59)
2. Laboratory and X-ray Services (see page 59)
3. Doctors' Services (see page 59)
4. Adult Dental Services (see page 59)
5. Nursing Facility Services (see page 60)
6. Home Health Services (see page 60)
7. Medical Equipment and Supplies (see page 60)
8. Emergency Medical Assistance to Non-citizens, Undocumented Aliens, Unqualified Aliens, and Qualified Aliens (see page 60)
9. Family Planning Services and Supplies (see page 60)
10. Nurse-midwife and Family and Pediatric Nurse Practitioner Services (see page 61)
11. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, see page 61)
12. Rural health services (see page 61)
13. Federally qualified health centers (see page 61)

These services are discussed in detail on the following pages.

Medicaid Covered Services (continued)

You can get these services whether you are in the Medicaid Primary Care Physician Program or in a Health Maintenance Organization (HMO). Some Medicaid benefits may be provided outside of what your HMO covers. These benefits are called "wrap-around" benefits.

Your doctor must prescribe all Medicaid covered services. Before you can get any of these services you may also need pre-approval from Colorado's Medicaid peer review organization (see page 49).

1. Inpatient and Outpatient Services

Inpatient and outpatient hospital services include those items and services provided by hospitals for your care and treatment. These services are provided under the direction of your doctor. Non-emergency services in an emergency room setting are not covered.

2. Laboratory and X-ray Services

X-ray services, and lab services and materials are benefits when approved by your primary care doctor.

3. Doctors' Services

Doctors' services for medically necessary diagnostic and treatment services are a benefit of the Medicaid program. Medical and surgical services of a dentist are a benefit for people under age 21 and may be covered for people over 21 if medically necessary.

4. Adult Dental Services

Doctors' services in dental care are a benefit when provided for:

- Surgery related to the jaw or any structure close to the jaw, including treatment for tumors or cysts in the mouth

or

- Reduction of fracture of the jaw or facial bones, including dental splints or other devices.

Routine and preventive dental services are not a Medicaid benefit for adults.

Medicaid Covered Services (continued)

5. Nursing Facility Services

Skilled nursing facility services and alternative long-term care facilities are a covered benefit of the Medicaid program, when the person has a need for a certain level of care.

6. Home Health Services

These are services provided in your home by a certified home health care agency for the treatment of an illness, injury, or disability. Medicaid also covers physical therapy, occupational therapy, and speech therapy in the home.

7. Medical Equipment and Supplies

These services include disposable medical supplies and medically necessary durable medical equipment (like prosthetic devices, wheelchairs and oxygen).

8. Emergency Medical Assistance to Non-citizens, Undocumented Aliens, Unqualified Aliens, and Qualified Aliens

Emergency medical services, including labor and delivery, are covered services under Medicaid for undocumented aliens.

9. Family Planning Services and Supplies

Medicaid covers family planning, counseling, treatment and follow-up, information on birth control, including:

- Insertion and removal of approved contraceptive devices
- Measurement for contraceptive diaphragms
- Male/female surgical sterilization
- Birth control medications

Medicaid Covered Services (continued)

10. Nurse-midwife and Family and Pediatric Nurse Practitioner Services

Nurse-midwife services (as allowed under state law) are provided for the management and care of mothers and babies throughout the pregnancy. Family and Pediatric nurse practitioners provide direct services for families and children.

11. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is a special health program within Medicaid for people up to age 21 that is designed help find and treat health problems early. The program gives you:

- Medical, dental, vision, and hearing screenings
- Medically necessary tests and examinations
- Diagnosis of problems found through screenings
- Treatment of medical problems and other hearing, eye or dental problems
- Health education and risk counseling

12. Rural Health Clinics

Rural Health Clinics are located in rural areas. These clinics do not have rehabilitation facilities, nor are they a facility for the care and treatment of mental diseases. Clinic staff may include physicians, physician assistants, nurse-midwives or nurse practitioners.

13. Federally Qualified Health Centers (FQHC)

FQHCs are certified by the U.S. Department of Health and Human Services. FQHCs may either be free-standing or part of a hospital. They include the services of physicians, physician assistants, nurse-midwives or nurse practitioners.

Optional Services Provided by Colorado Medicaid

Colorado Medicaid provides the following optional services:

1. Vision Services (see below)
2. Prosthetic devices (see below)
3. Transportation (see page 63)
4. Mental Health Services (see page 63)
5. Private-Duty Nursing (see page 63)
6. Foot Care (see page 63)
7. Hospice Care (see page 63)
8. Program of All-inclusive Care for the Elderly (PACE) (see page 63)
9. Health Insurance Buy-In Program (see page 63)
10. Prescribed Drugs (see page 64)
11. Nursing Home Vaccine Program (see page 64)
12. Durable Medical equipment and supplies (see page 64)
13. Home and Community Based Services (see page 64)
14. Therapies under home health (see page 64)
15. Alcohol and Drug Counseling for pregnant women (see page 65)

1. Vision Services

Vision exams are only covered if they are medically necessary. A Medicaid doctor may help you decide if a vision exam is medically necessary in your case. However, you don't need a referral. Medicaid HMO's cover vision exams for all their members regardless of age.

- Eyeglasses or contact lenses are not covered unless you have had eye surgery or belong to a Medicaid HMO.
- Medical procedures to correct refractive errors (vision problems) are not covered under Medicaid.

Eyeglasses may be provided for children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

2. Prosthetic Devices

Medicaid covers prosthetic devices (like breast prostheses after a mastectomy) including medically necessary communication devices (augmentative).

Optional Services Provided by Colorado Medicaid (continued)

3. Transportation

Both emergency and non-emergency transportation are generally covered.

Transportation to and from Medicaid-covered medical appointments is available to all people with Medicaid. This service must be pre-approved by contacting your county Department of Social Services.

4. Mental Health Services

Mental Health Assessment and Service Agencies (MHASAs) provide all mental health care to people with Medicaid in their area.

5. Private-Duty Nursing

Private-duty nursing services are available in the home for those meeting special eligibility and medical criteria.

6. Foot Care

Medicaid covers foot care services given by a doctor or licensed podiatrist (foot doctor).

7. Hospice Care

Hospice is a program that provides medical and support services to people who are terminally ill and for their family. These services may be provided in the home in a hospice facility or in a nursing home.

8. Programs of All-inclusive Care for the Elderly (PACE)

PACE is a special program that combines both outpatient and inpatient medical and long-term care services to frail elderly persons 55 years of age and older.

9. Health Insurance Buy-In Program

The purpose of the Colorado Health Insurance Buy-In (HIBI) program is to reduce or shift Medicaid costs by paying the cost of your private health insurance premiums and out-of-pocket costs when it is cost-effective for Medicaid to do so.

Optional Services Provided by Colorado Medicaid (continued)

9. Health Insurance Buy-In Program (continued)

This program is in addition to your regular Medicaid benefits. Medicaid is the payer of last resort.

10. Prescribed Drug Benefit

Medicaid will pay for prescribed drugs. There are some restrictions and some drugs require prior approval. For example, this benefit does not include injectable drugs given in your doctor's office or for emergency drugs.

11. Nursing Home Vaccine Program

Vaccines provided in nursing homes are covered only as part of an immunization program conducted by the Department of Social Services.

12. Durable Medical Equipment and Supplies

Included are disposable medical supplies and medically necessary durable medical equipment (like prosthetic devices, wheelchairs and oxygen).

13. Home and Community Based Services (HCBS)

HCBS may be provided in the home to help you avoid nursing home placement. You must qualify for the HCBS Program to get these services. Some of these services, which may require prior authorization through an agency or a case manager, include: adult day services, alternative care facility services (including homemaker and personal care services in a residential setting), electronic monitoring, home modification, homemaker services, non-medical transportation, personal care, assistive equipment, and respite care. Other services may be available, depending on the waiver for which you are eligible.

14. Therapies Under Home Health

Physical, occupational and speech therapy may be provided in the home setting through a home health agency if you qualify for such services, based on a plan of care.

15. Alcohol and Drug Counseling for Pregnant Women

Drug and alcohol treatment, which includes counseling, is provided for pregnant women who are at risk of poor birth outcome due to substance abuse. This is through a program called “Special Connections”.

Waivered Programs

Waivered programs provide other Medicaid benefits to people who are:

- At risk of institutional placement in a nursing facility, hospital, or an intermediate care facility for the mentally retarded.
- Willing to get services in their homes or communities.
- Eligible for all basic Medicaid services except nursing facility, long-term hospital care, and intermediate care facilities for the mentally retarded.

Waivered services must be provided by certified Medicaid providers. The cost of the waivered services can’t be more than the cost of nursing facility or hospital care.

There is a limit to the number of people who can be enrolled in each waivered program. There may be a waiting list for any particular waiver. Special waivered programs and their services include:

- **Children’s Home and Community Based Service (HCBS)**
  - Case Management
- **Children’s Medical Waiver Case Management**
- **Children’s Extensive Support Waiver**
  - Home modification services
  - Specialized medical equipment and supplies
  - Professional services
  - Community connection services
  - Personal assistance services

Waivered Programs (continued)

- **Children's Habilitation Residential Program Waiver**
  - Self advocacy training
  - Cognitive services
  - Communication services
  - Counseling and therapeutic services
  - Professional care services
  - Emergency assistance training
  - Community connection services
  - Travel services
  - Supervision services

- **Brain Injury Waiver**
  - Day care and day treatment
  - Home modifications
  - Special equipment
  - Counseling
  - Behavioral management
  - Skills training
  - Respite care
  - Personal care
  - Non-medical transportation

- **Mentally Ill Waiver**
  - Adult day care
  - Alternative care facilities
  - Electronic monitoring
  - Home modifications
  - Non-medical transportation
  - Respite care
  - Personal care
  - Homemaker

- **Persons Living with AIDS Waiver**
  - Adult day care
  - Homemaker
  - Personal care

- **Persons Living with AIDS Waiver (cont'd)**
  - Private duty nursing
  - Non-medical transportation
  - Electronic monitoring

- **Elderly, Blind, and Disabled Waiver**
  - Adult day care
  - Alternative care facilities
  - Electronic monitoring
  - Home modifications
  - Non-medical transportation
  - Respite care
  - Personal care
  - Homemaker

- **Supported Living Services Waiver**
  - Personal assistant services
  - Home modifications
  - Assistive technology
  - Counseling and therapeutic services
  - Dental services
  - Habilitation services (specialized day, prevocational and supported employment)

- **Developmentally Disabled Waiver**
  - Habilitation (specialized day, prevocational and supported employment)
  - Residential habilitation (individual or group residential services and supports)
  - Transportation

Section 4: Medicaid Managed Care

Section 4: Medicaid Managed Care

What is Medicaid Managed Care?

Medicaid Managed Care is a system of providing health care benefits to people with Medicaid through one doctor, organization, or clinic that is either:

1. A Health Maintenance Organization (HMO, see below)
2. The Primary Care Physician Program (PCPP, see below)
3. The Program of All-inclusive Care for the Elderly (PACE, see page 69)

1. Health Maintenance Organization (HMO)

An HMO is a health plan that offers health care by specific providers for most kinds of services that you may need. Generally, you can only see a specialist (like a cardiologist) when you receive a referral from your Primary Care Physician.

HMO benefits include:

- Coordinating your health care, including preventative care exams and 24-hour access to medical care
- Wellness services and walk-in care
- Vision and hearing tests and eyeglasses
- No copayments
- Health education classes on childbirth, parenting, weight loss, smoking cessation, and other topics offered by many plans

2. Primary Care Physician Program (PCPP)

Under the PCPP, you have one primary care provider who serves as your medical case manager. The PCPP can be a doctor or a clinic (community health clinic, rural health clinic, or federally qualified health center).

2. Primary Care Physician Program (PCPP) (continued)

This provider is responsible for coordinating and monitoring all health care services received under Medicaid, except for those that do not require a PCP referral.

3. Program of All-inclusive Care for the Elderly (PACE)

PACE provides a comprehensive umbrella of outpatient, inpatient, and long-term care services to frail elderly persons 55 years old and over who are eligible for care in a nursing facility.

Joining a Medicaid Managed Care Plan

In most cases, you **must** select a Medicaid managed care plan within 65 days of being found eligible for Medicaid. Until your managed care plan coverage starts, you can get services from any provider who accepts Medicaid.

Most people have the choice of enrolling in a Medicaid Health Maintenance Organization (HMO) or choosing a doctor who participates in the Primary Care Physician Program (PCPP).

When you choose a Medicaid HMO you will also be asked to choose a primary care doctor from the HMO's list of providers. HealthColorado can tell you what doctors belong to each Medicaid HMO.

When you become eligible for Colorado Medicaid, information will be sent to you listing the managed care plans available to you.

Joining a Medicaid Managed Care Plan (continued)

After you have picked a managed care plan, the name and telephone number of the PCPP or Medicaid HMO you have selected will be printed on your Colorado Medicaid card.

- You must go to providers within the HMO's network and have your primary care doctor's approval to get care.
- If you have chosen the PCPP, you will need to go to the doctor listed on your card for all of your care. If you need to see another Medicaid provider for specialty care, you will need to have approval from your PCPP. You do not need a referral for mental health, vision care, or for an emergency.

To learn more about Colorado Medicaid, including the options available to you and to pick a managed care plan, call HealthColorado at 1-888-367-6557 (1-888-ENROLLS).

Leaving a Medicaid Managed Care Plan

You may leave for any reason during the first 90 days after enrollment in an HMO or PCPP. After that, you are locked-in and may not leave without good cause except during open enrollment, which occurs once every twelve months of enrollment. At the beginning of your open enrollment period, the HMO will notify you of your option to change health plans. If you leave a health plan, you must choose another HMO or PCPP at the time you leave.

You don't have to choose another plan if you have other insurance or Medicare, you're a foster child, or you have less than two managed care options in the county you live in.

If you want to leave the plan and you are locked-in (you are not in an open enrollment period), you should try to work out the issue with the HMO. Call the member services number in your member handbook. If you are enrolled in the PCPP, you should call the provider directly. If the problem can't be resolved, you can:

- Call Medicaid Customer Service at 1-800-221-3943 for questions and help with issues.

Leaving a Medicaid Managed Care Plan (continued)

- Call the Colorado Managed Care Ombudsman at 303-744-7667 or 1-877-HELP-123. The Ombudsman can help you file an appeal.
- File an appeal, at any time, through the Division of Hearings at 303-894-2500.
- Call the Health Plan Manager at the Colorado Department of Health Care Policy and Financing, who will help you remain in the HMO and help resolve benefit issues or approve your leaving the plan for good cause.

Medicaid Managed Care Plans in Colorado

The available managed care plans vary by the county. Enrolling in the Medicaid Primary Care Physician Program is an option in most counties in Colorado. Colorado Medicaid has also contracted with 5 HMOs across the state. They are:

- **Colorado Access:** available to the Metro Denver area, El Paso County, Pueblo County, many of the Front Range and San Luis Valley area counties and on the Western slope.
- **Community Health Plan of the Rockies:** available to the Metro Denver area, Boulder, El Paso, Jefferson, and Pueblo counties.
- **Kaiser Permanente:** available in the Metro Denver counties.
- **Rocky Mountain HMO:** available in much of the Metro Denver area and Western Colorado.
- **United Healthcare:** available in Adams, Arapahoe, Denver, Douglas, and Jefferson Counties.

Colorado also has the **Program of All-inclusive Care for the Elderly (PACE)** which is available in certain areas in Denver, Adams, Arapahoe, Boulder, and Jefferson Counties.

Limitations may apply with some of these HMOs. For details about the benefits offered through each HMO or to enroll in one of the managed care plans, call 1-888-367-6557.

When an HMO Stops Providing Services

If you are enrolled in an HMO that ends its contract with the State, the plan or the State will notify you that the plan is leaving. You will have at least 65 days from the mailing of the first notice to choose another managed care plan. Whenever possible, you will not be disenrolled from the plan until the full 65-day choice period has ended.

HMO contracts can run up to five years but may be changed as needed to reflect changes in the laws and regulations.

If an HMO stops providing services, you are still in the Medicaid program. You may be required to select a new HMO or PCP if you wish to stay in a Medicaid managed care plan.

When you are enrolled in Medicaid, you are automatically enrolled for mental health services based on the county where you live.

Where to Get More Information

Colorado Medicaid Toll-Free Help Line and Internet Site

Colorado Medicaid toll-free customer service information line, 1-800-221-3943.

- Denver metro area residents, (303) 866-3513.
- **TDD/TTY:** Call (303) 866-3305 or 1-800-221-3943. Press 1 for English, and enter extension 3305.
- **Language Line Services:** Provides language translation in over 140 different languages. Call 303-866-4008 or 1-800-221-3943. Press 1, and enter extension 4008.
- **Teletips:** Pre-recorded information on Colorado Medicaid programs is available 24 hours a day, 7 days a week. Call 303-866-3513 and follow the prompts.

Where to Get More Information (continued)

Colorado Medicaid Toll-Free Help Line and Internet Site (continued)

People from customer service are available to answer questions and help resolve problems Monday through Friday, from 6:00 a.m. - 5:45 p.m. except holidays. If you have been wrongfully billed for Medicaid covered services, staff is also available to help.

Internet

Colorado Medicaid information is available at http://www.hcpf.state.co.us on the Internet.

Single Entry Point (SEP) Agencies - Options for Long-Term Care (OLTC)

The single entry point (SEP) agencies, also known as Options for Long-Term Care (OLTC), provide case management for Medicaid long-term care programs in 25 agencies statewide. Agencies are responsible for:

- Information and referral
- Conducting client assessments
- Developing care plans
- Arranging for services
- Monitoring services
- Assisting with eligibility determination when appropriate

Also, agencies take a leadership role in developing long-term care resources at the local level. See pages 74-82 for a list of the SEP or OLTC agencies in Colorado.

Colorado Single Entry Point Districts - Options for Long-Term Care

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-221-3943 or TTY/TDD: 1-800-221-3943.

Adams

Donald M. Cassatas, Ph.D., Director
Adams County Dept of Social Services
Mary Dwyer, OLTC Supervisor
7190 Colorado Boulevard, 4th Floor
Commerce City, CO 80022
Contact: Edie Wright (303) 227-2283
David Rodgers (303) 227-2308
Mary Dwyer (303) 227-2284
(303) 287-8831 FAX: (303) 227-2326

Alamosa, Saguache

Julie Geiser, Agency Director
Alamosa County Nursing Service
403 Santa Fe Avenue
Alamosa, CO 81101
Contact: Kim Canty
(719) 589-6639 FAX: (719) 589-1103

Arapahoe, Douglas, Elbert

Florence Jones, Director
Home Care Management, Inc.
5601 South Broadway, Suite 401
Littleton, CO 80121
Contact: Colleen Foster
(303) 738-0720 FAX: (303) 738-1949

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Bent, Kiowa

Debbie Six, RN, Director
Bent County Nursing Service
701 Park Avenue
Las Animas, CO 81054
Contact: Lynn Lewis
(719) 456-0517 FAX: (719) 456-0518

Boulder, Gilpin, Clear Creek

Barbara Wilkins-Crowder, Contract Manager
Adult Care Management, Inc., Tri-County Office
12 Garden Center, #220
Broomfield, CO 80020-1700 (303-473-8495- pager)
(303) 439-7011 FAX: (303) 439-7726

J.C. Lodge, Executive Director (303)964-2440
Adult Care Management, Inc.
2460 W 26th Ave, #260C
Denver, CO 80211
(303) 561-3666 FAX: (303) 561-3634

Conejos, Costilla

Debora Gabbel RN, Administrator
Conejos County Nursing Service
PO Box 78
La Jara, CO 81140

Location:
19023 State Highway 285 South
La Jara, CO 81140
Contact: Darleen Hawkins
(719) 274-4307 FAX: (719) 274-4309

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Delta, Gunnison, Hinsdale

William C. Lemoine, Director
Delta County Dept of Social Services
Courthouse Annex
560 Dodge Street
Delta, CO 81416
Contact: **Ruth Trumpfheller**
(970) 874-2030, Extension 2048 FAX: (970) 874-2068

Denver

Director of Adult Services
Denver County Dept of Human Services
1200 Federal Boulevard
Denver, CO 80204-3221
Contact: Donald J. Burt (720) 944-2901
(720) 944-2993 FAX: (720) 944-3094

Subcontractor: Home Care Management, Inc.
Florence Jones, Executive Director
1900 Grant, #400
Denver, CO 80203
Contact: Amy Hayes (303) 832-0553
(303) 863-1665 FAX: (303) 863-1688

El Paso, Teller

Laurie Tebo, Executive Director
Home and Health Care OLTC
2812 E Bijou
Colorado Springs, CO 80909
Contacts: Kris Abbott x122
Bregitta Hughes x102
(719) 457-0660 FAX: (719) 457-0762

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Fremont, Park, Chaffee, Lake, Custer

Mary Elin Stratton, M.A.
Central Mountain OLTC
172 Justice Center Road
Canon City, CO 81212
Contact: Jehnell Giganti
(719) 275-2318, Extension 3032 FAX: (719) 275-5206

Garfield, Grand, Jackson, Summit, Moffat, Rio Blanco, Routt, Eagle, Pitkin

Margaret Long, Director
Garfield County Dept of Social Services
PO Box 580
Glenwood Springs, CO 81602-0580

Location:
2014 Blake Street
Glenwood Springs, CO 81601
(970) 945-9191 FAX: (970) 928-0465
Contact: Linda Byers
Rifle Office: (800)494-9474
FAX: (970)963-8731, or (970)625-0927

Jefferson

Larry McDowell, Deputy Director (Administrator)
Jefferson Cty Dept of Human Services
900 Jefferson County Parkway
Golden, CO 80401
Contact: Tom Hitpas (303)271-4255
(303)271-4448 FAX: (303)271-4444

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Kit Carson, Lincoln, Cheyenne

Kindra Mulch, RN, Nursing Supervisor
Kit Carson County Public Health
PO Box 70
Burlington, CO 80807

Location:
252 S 14th St
Burlington, CO 80807
Contact: Angela Berry
(719) 346-7158 FAX: (719) 346-8066

Larimer

Ruth Coberly, Administrator
Larimer County Dept of Human Services
1629 Blue Spruce Drive, #209
Fort Collins, CO 80524
Contact: Cheryl Smith (970) 498-6456
(970) 498-6329 FAX: (970) 498-6455

Las Animas, Huerfano

Bill Aragon, Director
Las Animas County Dept of Social Services
204 South Chestnut
Trinidad, CO 81082
Contact: Robert Bertolino
(719) 846-2276 FAX: (719) 846-4269

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Mesa

Thomas Papin, Executive Director
Mesa County Dept of Human Services
Diann Rice/Ron Danekas
PO Box 20,000
Grand Junction, CO 81502-5035

Location:
2952 North Avenue
Grand Junction, CO 81501
Contacts: Dyann Walt (970) 248-2799
Vickie Clark (970) 248-2802
(970) 241-8480 (Main Number) FAX: (970) 248-2849

Montezuma, Dolores

Lori Cooper, RN, Director of Nursing
Montezuma County Health Department
County Annex Building
106 West North St
Cortez, CO 81321-3189
Contact: Jane Duncan
(970) 565-3056, Extension 37 FAX: (970) 565-0647

Montrose, San Miguel, Ouray

Mary Sawicki
Montrose County Dept of Social Services
PO Box 216
Montrose, Colorado 81402

Location:
107 S. Cascade
Montrose, CO 81402
Contact: Mabel Risch, Supervisor
Mike Shaver
(970) 249-3401, Extension 133 FAX: (970) 249-3402

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Morgan, Logan, Sedgwick, Phillips, Yuma, Washington

Sandra Baker, Executive Director
Northeastern Colorado Area Agency on Aging
231 Main Street, Suite 211
Fort Morgan, CO 80701
(970) 867-9409 FAX: (970)867-9053
Contact: Jan Binkley
(970) 867-1840 FAX: (970) 867-1850

Otero, Crowley

Joseph Carrica, Director
Otero County Dept of Human Services
PO Box 494
La Junta, CO 81050

Location:
Courthouse, 122 San Juan
La Junta, CO 81050
Contact: Donna Rohde
(719) 383-3166 FAX: (719) 383-3150

Prowers, Baca

Linda Fairbairn, Director
Prowers County Dept of Social Services
PO Box 1157
Lamar, CO 81052

Location:
1001 S. Main
Lamar, CO 81052
Contact: Cheryl Tague
(719) 336-7486, Extension 126 FAX: (719) 336-7198

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Pueblo

Del Olivas, Director
Pueblo County Dept of Social Services
212 W. 12th Street
Pueblo, CO 81003
Contact: Judy Barnard
(719) 583-6845 FAX: (719) 583-6348

Rio Grande, Mineral

James Broadfoot, Director
Rio Grande County Dept of Social Services
1015 6th St
PO Box B
Del Norte, CO 81132
(719) 657-2138 FAX: (719) 657-4013

Rio Grande County OLTC Address: (12/7/1999)
925 6th St.
Del Norte, CO 81132
Contact: Jackie Stephens
(719) 657-4208 FAX: (719) 657-4211

San Juan, La Plata, Archuleta

Lynn Westberg, Director
San Juan Basin Health Department
P.O. Box 140
Durango, CO 81302

Location:
281 Sawyer Dr
Durango, CO 81301
Contact: Rita Fowler, RN
(970) 247-5702, Extension 237 FAX: (970) 247-9126

Colorado Single Entry Point Districts - Options for Long-Term Care (continued)

Weld

Linda Piper, Director
Weld County Area Agency on Aging
PO Box 1805 (send to PO Box)
Greeley, CO 80632

Location:
1551 North 17th Avenue
Contact: Eva Jewell
(970) 353-3800, Extension 3331 FAX: (970) 356-3975

Where to Get More Information

FREE Colorado Medicaid Booklets

- A Medicaid Client's Guide to Filing Complaints (in English and Spanish)
- Colorado Medicaid (in English and Spanish)
- Are You Having Trouble Accessing Health Care Services, Treatment, or Providers? (in English and Spanish)
- Health Insurance Buy-In (HIBI) (in English and Spanish)
- Should you enroll in an HMO if you are covered by both Medicare and Medicaid?
- A Guide for Medicaid Clients Who Have Other Health Insurance

For free copies of these Colorado Medicaid booklets, call 1-800-221-3943.

NOTES

Section 5: Having More Than One Benefit

Section 5: Having More Than One Benefit

This section tells you how different types of insurance that you may have work together. It specifically focuses on:

- Medicare,
- Medicaid, and
- An Employer (or Union) Group Health Plan.

Note: You should always make sure that your provider will accept your coverage; otherwise, you may be held responsible for some or all of the payment.

Medicare and Medicaid

If you have both Medicare and Medicaid, Medicare pays your claims first. Remaining claims are sent to Medicaid for payment.

Medicare and an Employer (or Union) Group Health Plan

For People With End-Stage Renal Disease (ESRD)

If you have Medicare, an Employer (or Union) Group Health Plan and permanent kidney failure, Medicare is the secondary payer to the Employer (or Union) Group Health Plan for 30 months. This applies both to:

- People with permanent kidney failure who have their own coverage under a Group Health Plan.

- People covered under a Group Health Plan as dependents.

The period during which the Group Health Plan is the primary payer begins with:

- The first month of your entitlement to Medicare Part A based on permanent kidney failure.

- The first month in which you would have been entitled to Medicare Part A if you had filed an application based on permanent kidney failure.

Medicare and an Employer (or Union) Group Health Plan (continued)

For People With Disabilities

Medicare is the secondary payer for people under age 65 who have Medicare because of a disability. This means that you have received 24 months of Social Security disability benefits and you are covered under a large group health plan because of your current employment or the employment of a family member.

A large group health plan is a plan sponsored or contributed to by an employer or employee organization (such as a union). The plan must meet these criteria:

- Provide health care to employees, former employees, the employer, business associates of the employer or their families.
- Has 100 or more employees.

For more information about Medicare and Employer (or Union) Group Health Plans, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of "**Medicare and Other Health Benefits: Your Guide to Who Pays First**." You can also read or print a copy of this handbook at www.medicare.gov on the Internet. Select "Publications."

Medicaid and an Employer (or Union) Group Health Plan

If you have Medicaid and an Employer (or Union) Group Health Plan, the Employer (or Union) Group health plan would pay your claims first. The claims might not automatically be sent to Medicaid for additional payment. Therefore, it is the responsibility of the provider to bill Medicaid after the Employer (or Union) Group Health Plan pays its part.

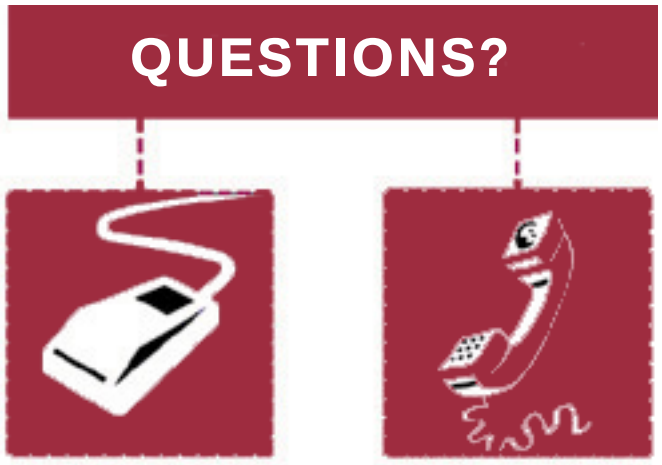
Section 5: Having More Than One Benefit

Medicare, Medicaid, and an Employer Group Health Plan

If you are covered by Medicare, Medicaid, and an Employer (or Union) Group Health Plan, the Employer (or Union) Group Health Plan is the first payer if it meets the criteria under "Medicare and Employer (or Union) Group Health Plan" listed on the page 89. Medicare is the second payer and Medicaid is **always** the payer of last resort.

If the Employer (or Union) Group Health Plan does not meet the criteria, Medicare is the first payer, the Employer (or Union) Group Health Plan is the second payer, and Medicaid is the last payer.

Section 6: Where to Get More Information



- Internet Websites to Visit
- Phone Numbers To Call For Help With Your Questions

Section 6: Where to Get More Information

Phone Numbers To Call For Help With Your Questions

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers call:

- 1-800-221-3943 for listings 1 through 4, and
- 1-800-MEDICARE (1-800-633-4227 or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for listings 5 through 10.

If you do not qualify for Medicaid, you may be able to get health care coverage through one of the following organizations:

1. Child Health Plan Plus (CHP+): 1-800-359-1991
2. Colorado Indigent Care Program: 303-866-2580
3. Colorado Uninsurable Health Insurance Program: 303-863-1960 or 1-800-672-8441
4. Medicaid and CHP+ Ombudsman for Managed Care: 1-877-HELP123 or (1-877-435-7123) 303-744-7667
5. Long-Term Care Ombudsman: 303-722-0300
6. Colorado Division of Insurance: 303-894-7499
7. Home Health Information: 1-800-221-3943, Extension 5619, or 303-866-5619
8. State Health Insurance Assistance Program: 1-800-544-9181
9. Health Care Financing Administration: 303-844-4024
10. Colorado Office for Civil Rights: 1-800-368-1019

Section 6: Where to Get More Information

You can also call:

- First Help (a medical information resource): 1-800-283-3221
- Office of the Inspector General (for reporting fraud): 1-800-447-8477 or TTY/TDD: 1-800-377-4950
- U.S. Department of Veteran Affairs (if you are a veteran): 1-800-827-1000. If you or your spouse retired from the military, call the Department of Defense at 1-800-538-9552.

Internet Websites to Visit

Social Security Administration: www.ssa.gov

Health Care Financing Administration: www.hcfa.gov

Medicare: www.medicare.gov

You can also access hundreds of links to community organizations serving people with disabilities through the Colorado Medicaid webpage at:

www.hcpf.state.co.us

NOTES

Section 7: Definitions of Important Words

Section 7: Definitions of Important Words

Appeal – A special kind of complaint you make if you disagree with any decision about your health care services.

Assignment – In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor visit.

Benefit Period – The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance – The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service, such as 20%.

Copayment – In some Medicare health plans, the amount that you pay for each medical service you get, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible –The amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Durable Medical Equipment Regional Carrier (DMERC) – Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Medicare Part B, and you pay 20% coinsurance in the Original Medicare Plan.

Earnings Guidelines – A measure of how much money you made when you were working.

End-Stage Renal Disease (ESRD) – Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Fiscal Intermediary – A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Health Maintenance Organization (HMO) – A group of doctors, hospitals, and other health care providers who agree to give health care to Medicare (or Medicaid) beneficiaries for a set amount of money from Medicare (or Medicaid) every month. In an HMO, you usually must get all your care from the providers that are part of the plan.

Home Health Care – Skilled nursing care and certain other health care you get in your home for treatment of an illness or injury.

Section 7: Definitions of Important Words

Hospice Care – A special way of caring for people who are terminally ill and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (hospital insurance).

Locked-in – After you are enrolled in a managed care plan, you are required to remain in that plan for a certain period of time. Therefore, you are locked in to receiving services from that plan. You may also be locked-in to a provider and pharmacy if you are found to be overusing Medicaid services.

Long-term Care – Custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses. Long-term care is not covered by Medicare.

Medicaid – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare – A federal health insurance program for:

- People 65 years of age or older,
- Some people with disabilities under age 65, and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare Carrier – A private company that contracts with Medicare to pay Part B bills.

Peer Review Organization – Groups of practicing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Premium – What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Primary Care Doctor – A doctor who is trained to give you basic care. This includes being the first one to check on health problems and coordinating your preventive health care with doctors, specialists, and therapists. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care provider.

Primary Care Physician Program (PCPP) – This provider is responsible for coordinating and monitoring all health care services received under Medicaid, except for those that do not require a PCP referral.

(continued on page 98)

Section 7: Definitions of Important Words

Programs of All-Inclusive Care for the Elderly (PACE) – A special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Representative Payee – A relative, friend, or other interested party appointed by the Social Security Administration to help a person who gets Social Security, Supplemental Security Income benefits, or both manage their money.

Reserve Days – Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs, except for a daily coinsurance amount.

Secondary Payer – The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

Single Entry Point Agencies (SEP) – These agencies form a geographically based system for accessing publicly funded long-term care services. SEP agencies are also called "Options for Long-Term Care (OLTC)."

Skilled Nursing Facility Care – A level of care that must be given or managed by licensed health care professionals and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including getting direct services. As long as you need skilled care, it makes no difference whether your illness is acute, chronic, or terminal. Medicare does not cover unskilled (custodial) care, except when it is given in addition to Medicare-covered skilled care.

Social Security Disability Insurance (SSDI) – Provides monthly cash benefits to disabled or blind people who are "insured" by workers' contributions to the Social Security trust fund.

State Health Insurance Assistance Program – A state organization that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

Substantial Gainful Activity (SGA) – When you earn over $700 a month and you have a condition other than blindness (starting July 1999), or you earn over $1,170 a month and you are blind (starting January 2000).

Supplemental Security Income (SSI) Program – Makes cash assistance payments to aged, blind, and disabled people (including children under age 18) who have limited income and resources.

Index

Index

E

F

H

Index

I

L

M

M (continued)

M (continued)

N

O

P

P (continued)

Q

R

S

S (continued)

T

V

U.S. DEPARTMENT OF
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