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0342 MEDICAID COVERAGE FOR CHILDREN AND FAMILIES

0346 MEDICALLY NEEDY AFDC-RELATED COVERAGE GROUP

0350 RITE SMILES DENTAL PLAN

Repealed 0351 OVERVIEW OF MA (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0352 CHARACTERISTIC REQUIREMENTS (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0354 RESOURCES GENERALLY (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0356 EVALUATION OF RESOURCES (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0358 SSI-RELATED DEEMING OF RESOURCED (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

0360 RESOURCE TRANSFER

Repealed 0362 INCOME GENERALLY (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0364 TREATMENT OF INCOME (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0366 SSI-RELATED DEEMING OF INCOME (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0368 FLEXIBLE TEST OF INCOME (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0370 SSI-RELATED COVERAGE GROUPS (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0372 SPECIAL TREATMENT COVERAGE GROUPS (SEE NEWLY ADOPTED SECTION #1400 “Medicaid Integrated Health Care Coverage”)

Repealed 0374 AND 0375 COMMUNITY SUPPORTED LIVING ARRANGEMENTS AND INTEGRATED CARE PROGRAM (SEE NEWLY ADOPTED MCAR SECTION #1475 “MANAGED CARE SERVICE DELIVERY OPTIONS FOR ELDERS, ADULTS WITH DISABILITIES, AND LONG-TERM CARE BENEFICIARIES”)

0376 OVERVIEW OF MA

0378 INSTITUTIONAL CARE

0380 RESOURCES GENERALLY

0382 EVALUATION OF RESOURCES

0384 RESOURCE TRANSFERS

0386 INCOME GENERALLY

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1475 MCAR MANAGED CARE SERVICE DELIVERY OPTIONS FOR ELDERS, ADULTS WITH DISABILITIES, AND LONG-TERM CARE BENEFICIARIES

0102 Confidentiality of Information

0102.05 Criteria for Use of Confidential Information

REV: 08/2013

The use and disclosure of information concerning applicants and recipients will be limited to purposes directly connected with the following:

- The administration of the program. Such purpose includes establishing eligibility, determining the amount of assistance, and providing services for applicants and recipients.

- Any investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the programs.

- The administration of any other federal or state assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need. The disclosure to any committee or legislative body (federal, state or local) of any information that identifies, by name and address, any applicant or recipient is prohibited.

- All information, such as federal tax information, shall remain confidential.

0108 Equal Access to Justice

0108.05 Purpose Scope and Authority

REV: 08/2013

The purpose of 42-92-1 of the General Laws of Rhode Island, 1993, is to provide equal access to justice for small businesses and individuals.

The rules and regulations of this law govern the application and award of reasonable litigation expenses to qualified parties in adjudicatory proceedings conducted by the state agency.

The rules and regulations herein contained are promulgated pursuant to Chapters 35 and 92 of Title 42 of the Rhode Island General Laws. They are applicable to all agencies currently administered under the auspices of the EOHHS.

It is hereby declared to be the official policy of the EOHHS that individuals and small businesses should be encouraged to contest unjust administrative actions in order to further the public interest, and toward that end, such parties should be entitled to state reimbursement of reasonable litigation expenses when they prevail in contesting an agency action which is, in fact, without substantial justification.

0108.15 Application/Awards of Litigation Expenses

REV: 08/2013

All claims for an award of reasonable litigation expenses shall be made on an application form to be supplied by the agency and shall be filed with the hearing office within thirty (30) to forty-five (45) days of the date of the conclusion of the adjudicatory proceeding which gives rise to the right

to recover such an award. The proceeding shall be deemed to be concluded when the agency or adjudicative officer renders a ruling or decision.

The adjudicative officer may, at his or her discretion, permit a party to file a claim out of time upon a showing of proof and finding by such administrative officer that good and sufficient cause exists for allowing a claim to be so filed.

All claims shall be filed on a state agency form which is obtained from the hearing office. All claims must be postmarked or delivered to the hearing office no later than thirty (30) days from the date of the conclusion of the adjudicatory proceeding. These claims must contain:

- A summary of the legal and factual basis for filing the claim;
- A detailed breakdown of the reasonable litigation expenses incurred by the party in the adjudicatory proceedings, including copies of invoices, bills, affidavits, or other documents, all of which may be supplemented or modified at any time prior to the issuance of a final decision on the claim by the adjudicative officer;
- A notarized statement swearing to the accuracy and truthfulness of the statements and information contained in the claim, and/or filed in support thereof. In this statement the claimant must also certify that legal fee time amounts were contemporaneously kept.

0108.15.05 Allowance of Awards

REV: 08/2013

Whenever a party which has provided the state agency with timely notice of the intention to seek an award of litigation expenses as provided in these rules, prevails in contesting an agency action, and the adjudicative officer finds that the state agency was not substantially justified in: (1) the actions leading to the proceeding; or (2) in the proceeding itself, an award shall be made of reasonable litigation expenses actually incurred.

In accordance with section 42-92-2 of the Rhode Island General Laws, as amended, "reasonable litigation expenses" means those expenses which were reasonably incurred by a party in adjudicatory proceedings, including, but not limited to, attorney's fees, witness fees of all necessary witnesses, and other costs and expenses as were reasonably incurred, except that: (i) The award of attorney's fees may not exceed one hundred and twenty-five dollars ($125) per hour, unless the court determines that special factors justify a higher fee; (ii) No expert witness may be compensated at a rate in excess of the highest rate of compensation for experts paid by this state.

The decision of the adjudicative officer to make an award shall be made a part of the record, shall include written findings and conclusions with respect to the award, and shall be sent to the claimant, unless the same is represented by an attorney, in which case the decision shall be sent to the attorney of record.

0108.15.10 Disallowance of Awards

REV: 08/2013

No award of fees or expenses may be made if the adjudicative officer finds that the state agency was substantially justified in the actions leading to the proceeding and in the proceeding itself.

There should be disallowance of fees or expenses if the party is not actually the prevailing party.

The adjudicative officer may, at his/her discretion, deny fees or expenses if special circumstances make an award unjust.

The adjudicative officer may deny, in whole or in part, any application for award of fees and expenses where justice so requires or which is considered to be excessive.

Whenever substantially justified, the adjudicative officer may recalculate the amount to be awarded to the prevailing party, without regard to the amount claimed to be due on the application, for an award.

Notice of the decision disallowing an application for an award of fees and expenses shall be sent to the party by the agency via regular mail provided however, that if the party is represented by an attorney, said notice shall be sent by regular mail to the attorney of record.

0108.20 Appeals and Severability

REV: 08/2013

Any party aggrieved by the decision to award reasonable litigation expenses may bring an appeal to the Superior Court in the manner provided by the Administrative Procedures Act, Rhode Island General Laws, Section 42-35-1, et seq.

If any provision of these rules and regulations, or the application thereof, to any person or circumstances are held invalid, such invalidity shall not affect the provisions of application of the rules and regulations which can be given effect, and to this end the provisions of these rules and regulations are declared to be severable.

0110 Complaints and Hearings

0110.05 Administrative Authorization

REV: 08/2013

The Executive Office of Health and Human Services (EOHHS), through federal/state programs established by the Social Security Act of 1935, as amended, the Rehabilitation Act of 1973, as amended, and through state/local programs established by Chapter 42-7.2, of the General Laws of Rhode Island, as amended, is the Department in the Rhode Island State Government authorized by law and designation to hold hearings on a statewide basis, the following public financial, medical, vocational and social services programs:

- RIW: Rhode Island Works
- CCAP: Child Care Assistance Program
- SNAP: Supplemental Nutrition Assistance Program
- SSI-SSP: Supplemental Security Income and State Supplemental Payment Program
- Medicaid
- MAGI Medicaid: The portion of the Medicaid program with eligibility subject to Modified Adjusted Gross Income ("MAGI"), pursuant to 42 C.F.R. 435.119
- OCSS: Office of Child Support Services
- GPA: General Public Assistance Program
- SS: Social Services Program
- ORS: Office of Rehabilitation Services' Vocational Rehabilitation (VR) Program and Services for the Blind and Visually Impaired (SBVI) Program
- VA: Veterans' Affairs (VA) Program
- DCYF: Department of Children, Youth, and Families programs and services
- DOH: Department of Health (DOH) programs and services
- BHDDH: Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals programs and services
- DEA: Division of Elderly Affairs programs and services.

The Rhode Island Health Benefits Exchange ("RIHBE" or "Exchange") has designated EOHHS to serve as the Exchange appeals entity for all Exchange appeals other than large employer appeals (hereinafter "Exchange Appeals"). EOHHS accepts that designation and thus is the Department authorized and designated hereinafter to hear and decide such Exchange Appeals.

Exchange Appeals include the following categories of appeals: Basic QHP Eligibility; APTC/CSR Eligibility or Calculation; Exemption; SHOP – Employer; SHOP – Employee; and Large Employer.

These specific policies and procedures are set forth under the law to provide equitable treatment for all applicants and recipients.

0110.10 Expressions of Dissatisfaction

REV: 08/2013

Expressions of dissatisfaction may arise in the administration of DHS, RIHBE, or OHHS programs for a variety of reasons. The state agency provides a method for receiving expressions of dissatisfaction that include but are not limited to:

- Complaints from certain applicants/recipients or their designated representatives questioning the application of policy with respect to such applicants/recipients;

- Appeals by an applicant/recipient or his/her designated representatives concerning:

  - A particular decision or delay in a decision rendered by an agency representative;
  - The manner in which agency services have been delivered; and/or
  - Some aspect of the financial, medical, social services, or food assistance programs;

- Requests for a hearing by an individual claimant or a group, relating to more general issues of agency policy and/or the adequacy of agency standards.

In compliance with state and federal statutes and regulations, the agency shall have interpreters available for individuals needing such services, such as a telephonic interpreter service/language line.

0110.15 Definition of a Complaint

REV: 08/2013

A "complaint" means any verbal or written expression of dissatisfaction made to state agency personnel responsible for receiving such complaints that includes: staff workers either in the field or office; and Central Office personnel by an applicant/recipient or his/her authorized representative questioning the administration of agency policies and programs with respect to the treatment and/or eligibility of said claimant to receive an assistance payment, medical assistance, social services, child support services and/or food assistance.

Complaints related to RIHBE-administered programs shall be referred to the RIHBE directly or to the RIHBE contact center for appropriate follow up and resolution.

0110.15.05 The Complaint Process

REV: 08/2013

Complaints received from an applicant/recipient or his/her designated representative, either in any DHS field office or at the EOHHS Central Office, are referred to the appropriate supervisor for follow-up as below.

If the complaint involves a question of eligibility or need:

- The complaint is referred to the appropriate state agency representative;

- The state agency representative has the responsibility to contact the individual to discuss with him/her the details of the complaint.

If the complaint relates to social services:

- The complaint is referred by the service supervisor to the appropriate state agency social worker;
- The state agency social worker then contacts the individual in order to discuss the complaint.

When the issue cannot be resolved by the state agency representative, the claimant is informed of his/her right to the following three options while the appeals process is proceeding:

- Discuss the issue with the assigned state agency supervisor;
- Have an adjustment conference, as described in section 0110.20.05;
- Proceed with a hearing.

If the complaint relates to Child Support:

- The complaint is referred by the state agency supervisor to the appropriate child support agent.
- The child support agent then contacts the individual to discuss the complaint.

If the complaint relates to a program administered by the RIHBE:

- The complaint is referred to the contact center administered by the RIHBE for appropriate follow up.

If further information/documentation is required concerning the situation from alternate sources, the claimant may obtain the necessary information or may request the state agency representative to obtain this information.

0110.20 Definition of an Appeal

REV: 08/2013

An "appeal" means a request by a claimant (or his/her authorized representative) for an opportunity to present his/her case to the appropriate state agency authority for resolution of the pertinent matter. The appeal must be filed within:

- Ten (10) days from the mail date if it pertains to General Public Assistance;
- Ninety (90) days from the mail date related to SNAP benefits;
- Forty-five (45) days from the mail date related to Office of Rehabilitation Services matters;
- Thirty (30) days from the mail date related to child support services;
- Thirty (30) days from the mail date related to the State Medical Assistance (Medicaid) Program;
- DCYF: Thirty (30) days from the mail date for any DCYF-related matter;
- BHDDH: Thirty (30) days from the mail date for any BHDDH-related matter;
- Thirty (30) days from the mail date for any other DHS program;
- Thirty (30) days from the mail date for any RIHBE-administered program.

Appeal requests for any of the programs listed above may be submitted:

- In person to any DHS/DCYF/BHDDH field office/appeals office, as appropriate; and

- By U.S. Mail to any DHS/DCYF/BHDDH field office/appeals office, as appropriate.

Appeal requests related to the MAGI Medicaid Program or related to any program administered by the RIHBE may, in addition to the submission methods listed above, be submitted:

- by telephone to the RIHBE contact center;
- by fax to the RIHBE contact center/appeals office;
- by U.S. Mail to the address indicated on the appeals request form; or
- online by accessing the user's account through the website made available by the RIHBE allowing for the electronic submission of appeals.

0110.20.05 The Appeal Process

REV: 08/2013

The intent of the appeal process is to protect a person or family's right to assistance, social services, child support services, health insurance benefits, or food assistance.

While the appeals process is proceeding, an appeal generally can be resolved through a discussion with the staff member who made the decision or, for MAGI Medicaid or programs administered by the RIHBE, through a discussion with a representative of the contact center administered by the RIHBE. If a claimant determines it is necessary to go beyond that staff member or representative to be assured that s/he is receiving equitable treatment, s/he must be informed of the following alternative provisions for expressing his/her complaint:

- A discussion of the disputed issue(s) can be arranged for the individual with the appropriate agency representative and his/her supervisor in the district or regional office("supervisory conference"); or
- If the individual prefers, and the issue relates to programs other than those administered by the RIHBE, then instead of the supervisory conference, or following it, an 'Adjustment Conference' can be arranged with the regional manager while the appeals process is proceeding. This is an informal hearing in which an individual has an opportunity to state his/her dissatisfaction with agency action. The state agency representative presents the facts upon which action was based. The regional manager determines whether or not the staff decision was made in accordance with state agency policy; or
- Since the individual has a right to request and receive a hearing unconditionally, s/he can proceed directly to a full hearing review of his/her complaint.

If the complaint or appeal relates to the MAGI Medicaid or any program administered by the RIHBE, then, in addition to the informal channels discussed above, an appellant shall have the opportunity to request informal resolution of the appeal prior to a hearing by contacting the contact center administered by the RIHBE, or a representative of the contact center administered by the RIHBE may contact the appellant and offer to discuss the issue if the appellant agrees.

- The appellant's right to a hearing shall be preserved if the appellant is dissatisfied with the outcome of the informal resolution process.

- The informal resolution process is voluntary and neither an appellant's participation nor nonparticipation in the informal resolution process shall affect the right to a hearing.

- The informal resolution process shall not delay the timeline for a hearing.

- During the informal resolution process, the representative shall try to resolve the issue through a review of case documents, allowing the appellant to submit further documentation, and submitting updated information or providing further explanation of previously submitted documents.

If an appellant is dissatisfied with the informal resolution, all additional submitted documentation shall be included in the documentation sent to hearing.

For programs administered by BHDDH, the informal resolution process shall be as contained in the *Rules and Regulations Governing the Practices and Procedures before the Rhode Island Department of Mental Health, Retardation, and Hospitals* last amended in February 2002.

For programs administered by DCYF, the informal resolution process shall be as contained in *Complaints and Hearings* last amended in January 2000.

0110.25 Legal Basis for Appeals and/or Hearings

REV: 08/2013

Procedures are available for applicants and/or recipients who are aggrieved because of a state agency decision or delay in making such a decision. Entitlements to appeals, reasonable notice and opportunity for a fair hearing, are provided by:

- Title 40 of the General Laws of Rhode Island, as amended;
- Rhode Island Works Program (RIW, as authorized under Title IV-A of the Social Security Act;
- Medicaid Program, as authorized under Title XIX of the Social Security Act and 42 C.F.R. 431.200 et seq.;
- Supplemental Security Income (SSI) Program, as authorized under Title XVI of the Social Security Act;
- Social Services Program, as authorized under Title XX of the Social Security Act;
- The Vocational Rehabilitation Act of 1972, as amended; and
- The Food Stamp Act of 1977, as amended.
- Title 15 of the R.I. General Laws;
- Chapter 42-7.2 of the Rhode Island General Laws
- Section 1411 of the ACA and 45 C.F.R. Part 155 Subpart F and section 155.740 of Subpart H;
- Chapter 42-35 of the Rhode Island General Laws, as amended.

0110.30 Definition of a Hearing

REV: 08/1987

A hearing is an opportunity provided by the agency for responding to an appeal. It is an instrument by which a dissatisfied individual may assert his/her right to financial assistance, medical assistance, health insurance, social services, and/or food assistance; and, to secure in an

administrative proceeding before an impartial appeals officer, equity of treatment under state law and policy and the agency's standards and procedures.

An opportunity for a hearing is granted to an applicant/recipient or his/her designated representative, when:

- His/Her claim for assistance, social services, or access to a program administered by the RIHBE is denied,
- Is not acted upon with reasonable promptness, or
- S/He is aggrieved by any other agency action resulting in suspension, reduction, discontinuance, or termination of assistance, social services, or access to a program administered by the RIHBE.

A hearing need not be granted:

- If a change in benefits is due to an automatic adjustment required by either state or federal law for classes of recipients, unless the reason for an individual appeal is a challenge of the correctness of the computation of his/her assistance payment or another aspect of the application of the automatic adjustment.

0110.30.05 The Right to Request a Hearing

REV: 08/2013

Assistance, social services, child support services and food assistance application forms shall include a statement regarding the right to request a hearing.

An individual shall be fully informed of the opportunity for a hearing. At the time of application, and at the time of any action affecting his/her claim for assistance, social services, or health insurance, the individual shall be informed, in writing, of:

- His/Her right to request and receive a hearing;
- The method of obtaining it; and
- His/Her right to be represented by others or to represent himself/herself.

Where applicable, at the time of any action affecting his/her claim for assistance, social services, or health insurance, the individual shall be informed, in writing:

- Of the circumstances under which the applicant's or enrollee's eligibility may be maintained while the appeal is pending; and
- That advance payments of the premium tax credit paid while awaiting a hearing are subject to reconciliation under 26 C.F.R. § 1.36B-4.

A hearing request remains valid until:

- The claimant voluntarily withdraws it and such withdrawal is confirmed without undue delay by the EOHHS Central Appeals Office in writing (For SNAP benefit hearing requests, upon receipt of a verbal request to withdraw a hearing, the appeals officer shall send written notice within ten (10) days confirming such withdrawal and providing the household with an opportunity to request or reinstate the hearing within ten (10) days of the confirmation notice.); or

- The claimant or his/her representative fails to appear at a scheduled hearing, without good cause (abandonment) as described in section 0110.40 ("Abandonment of the Hearing Request"); or

- A hearing has been held and a decision made.

0110.30.10 Method of Processing Hearing Requests

REV: 08/2013

The hearing process begins when a request is received through any of the methods described in section 0110.20 above. When a request is received, it shall be referred to the appropriate state agency representative. The following requirements shall be met by said agency:

- The decision at issue shall be reviewed with the individual to help him/her understand the provisions in state law and/or agency policy on which the decision was based.

- The individual shall be informed of the complete complaint procedure, including informal "adjustment conference" opportunities available with the appropriate supervisor while the appeals process is proceeding.

- If the individual decides to continue the appeal, the hearing process shall be reviewed with him/her to help the individual understand what s/he might expect and what is to be expected of him/her.

None of the forgoing prevents any State agency or department from employing other supplementary procedures (e.g., mediation) to attempt to explain decisions to appellants and/or seek informal resolutions of disputes.

0110.30.15 The Request for Hearing Form and Agency Response

REV: 08/2013

The individual is requested to submit his/her appeal to the appropriate office through any of the methods described in section 0110.20 above. If the appeal is submitted in writing, the OHHS-121 (Request for Hearing), the DHS-l2l (Request for Hearing) or DHS-121F (Request for Hearing-Child Support) forms may be used, and the appellant shall be provided any needed assistance to complete this form.

When the individual appeals to any office other than the DHS field office, a copy or description of the appeal shall also be sent, electronically or manually, to the hearing office at EOHHS Central Appeals Office. A copy or a description of the appeal shall also be sent, electronically or manually, to the appropriate office for that office to supply the state agency's response to the

appeal (e.g., through completion of section III of DHS-121, or through some other method of documenting the agency response).

The state agency's response shall be returned, electronically or manually, to the EOHHS Central Appeals Office within seven (7) days. If the field office determines during this period that the individual does not wish to proceed with the hearing, the hearing office shall be notified. An appellant's decision not to proceed with a hearing shall be documented, either in writing from the appellant, or recorded through other available recording means (e.g., voice recording of a phone call).

For Exchange Appeals or appeals related to MAGI Medicaid, all appeals submitted on paper, in person, or over the phone (to the contact centered administered by the RIHBE) shall be documented within the available electronic appeals database.

For appeals other than Exchange appeals or appeals related to MAGI –Medicaid, when an individual who has submitted a written request for a hearing does not submit the required information on a form provided by the state within a seven (7) day period, the state agency representative shall complete, all applicable sections of the appeal form, attach the written request to the form and submit it to the appeals officer, electronically or manually. All applicable sections of the state agency form shall be prepared by the state agency representative and shall be transmitted to the EOHHS Central Appeals Office, setting forth clearly and concisely the policy on which the decision at issue was based.

The Appeals office, in consultation with DHS, EOHHS and the RIHBE, will determine the appropriate office responsible for responding to the appeal.

For all Exchange Appeals, an appropriate representative of the Exchange shall be informed of the appeal and given the opportunity to respond and appear at the hearing, even for appeals for which DHS is the primary agency responsible for responding to the appeal.

0110.30.20 Advance Notice Period

REV: 08/2013

If a request for a fair hearing is made within the 10-day advance notice period the appropriate state agency shall assist the individual understanding the implications of continuing to receive the current amount of cash assistance, Medical Assistance, and/or food assistance until a hearing decision is made. Only at the applicant/recipient’s specific request shall the agency representative discontinue such assistance.

The date on which the notice is received is considered to be five (5) days after the date on the notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day period.

The applicant/recipient may indicate the request for discontinuance of RIW, Medicaid, and/or SNAP or continuance of GPA, as appropriate, in either Section II of the DHS-121 or Section I of the INRHODES Request for Hearing together with the recipient’s statement of complaint. This section must be signed by the recipient.

When an individual requests a hearing via the DHS-121F to contest an administrative lien, the lien on the bank account, insurance settlement or real property shall remain in full force and effect until the hearing decision is rendered.

When a hearing is requested after the advance notice period, the agency action being challenged is completed and remains in force until the decision is altered or reversed at the hearing, or is changed by another change in circumstances relating to the individual's assistance or services.

Unless the recipient requests the discontinuance of his/her assistance, such assistance shall be continued until a hearing decision is rendered, unless:

- A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law and not one of incorrect computation of the assistance payment; or

- Another change affecting the individual's assistance or services occurs while the hearing decision is pending and the individual fails to request a hearing on the second issue after notice of that change;

- The individual withdrawals his or her appeal; or

- The assistance affected by the aggrieved action is Supportive Services and/or Child Care Services.

Hearing Requests Related to General Public Assistance

For fair hearing requests pertaining to General Public Assistance, a written request for hearing shall be made within the 10 day advance notice period and shall be accompanied by or include a written request for continuation of GPA to stay the reduction, suspension, or discontinuance until the fair hearing decision is issued. Only at the applicant/recipient's specific written request shall the state agency representative continue GPA benefits.

If the recipient requests the continuance of his/her GPA, such assistance may be continued, except in the following instances:

- A determination is made at the hearing that the sole issue is one of state law or policy or change in state law and not one of incorrect computation of the assistance payment; or

- Another change affecting the individual's assistance occurs while the hearing decision is pending and the individual fails to request a hearing on the second issue after notice of that change.

0110.30.25 Rights of the Individual

REV: 08/2013

The individual shall be informed of his/her right to be represented by legal counsel and/or such witnesses as s/he may deem necessary to support the appeal. The state agency representative shall assist the individual to obtain legal services, if desired, by helping him/her to arrange an appointment with available community resources, such as Rhode Island Legal Services.

- The individual shall be informed that s/he is given opportunity and time to examine documents and records used at the hearing, at a reasonable time before the hearing, and during the hearing.

- The individual shall be informed of his/her right to: present his/her own case or enlist the aid of an authorized representative to present a case on his or her behalf; to bring witnesses; to establish pertinent facts and circumstances; to advance arguments without undue interference; and, during the hearing, to question or refute any testimony or evidence including opportunity to confront and cross-examine adverse witnesses.

- The individual shall be informed of his/her right to judicial review if dissatisfied with the hearing decision.

For appeals related to programs administered by the RIHBE, the individual shall be informed of his/her right to appeal to the federal Department of Health and Human Services, if dissatisfied with the hearing decision.

For appeals related to MAGI Medicaid and to programs administered by the RIHBE, the individual shall be informed that an appeal decision for one household member may result in eligibility re-determination for other household members.

0110.30.30 Expedited Appeals
REV: 08/2013

For appeals relating to Medicaid benefits or benefits for RIHBE-administered programs relating to health insurance coverage, the appellant may request an expedited appeals process in circumstances where there is immediate need for health services such that a routine appeal could seriously jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.

If an expedited appeal is granted by the EOHHS appeals office in its reasonable discretion, the hearing shall be expeditiously scheduled and the decision shall be issued without undue delay, taking into account the circumstances of appellant's medical condition and the extent to which a favorable hearing outcome may impact treatment and/or the favorable outcome such treatment.

If an expedited appeal is denied, the EOHHS appeals office shall notify the appellant without undue delay by telephone or other commonly available electronic media as provided by the applicant/recipient, to be followed in writing, of the denial of the request to expedite the appeal. If a request to expedite an appeal is denied, such an outcome shall not delay the timeline for a hearing and the appeal shall be handled through the standard appeal process.

0110.30.35 Special Procedures for SHOP Appeals
08/2013

For appeals related to the SHOP Exchange in accordance with 45 C.F.R. 155.740, whether filed by an employer or employee, the appellant shall have the right to request a "desk review" by the hearing officer in lieu of an in-person hearing. A "desk review" means the hearing officer reviews

written submissions and evidence from the appellant and any appropriate state agency representative(s) and issues a decision based on same.

In order to request a desk review, the appellant shall notify the EOHHS appeals office or the RIHBE call center in advance and as follows:

- If the hearing has already been scheduled, this advance notice shall be given no less than five business days before the scheduled hearing. In such cases, the written submissions shall be due on the day the hearing would have occurred.

- If the hearing has not yet been scheduled, the appellant may request the desk review at any time, and the written submissions shall be due within ten (10) days of such request or at such other deadline to be agreed between the appellant and the EOHHS Central Appeals Office.

Upon requesting a desk review, the appellant forfeits his/her opportunity for an in-person hearing.

0110.35 Hearing Office Action

REV: 08/2013

When an appeal is submitted through any of the methods described in 0110.20 above, the EOHHS Central Appeals Office schedules the date, time, and place of the hearing. A hearing is generally held at the central, regional or field office, in an individual's home, or telephonically when circumstances require. Hearings related to programs administered by the RIHBE shall be held at either the central EOHHS office or the offices of the Rhode Island Department of Administration.

Official notice of the hearing shall be sent to all parties involved at least ten (10) days before the scheduled hearing date.

The individual shall be notified in writing at their last known address of the hearing date, time, and location, and the written notice shall include basic information about the hearing process.

If an individual chooses to have legal representation at the hearing (e.g., be represented by an attorney, paralegal, or legal assistant) the representative shall file a written Entry of Appearance with the EOHHS Central Appeals Office at or before the hearing. The Entry of Appearance shall act as a release of confidential information, allowing the legal representative access to the agency case record. (See DHS Manual Section 0102 regarding confidentiality of information.) The Entry of Appearance is also needed for the EOHHS Appeals Office to confirm the representation for purposes of follow-up, review, requests for continuances, etc.

The state agency representative whose decision is being appealed shall receive information about the appeal in advance, including a copy of the Form DHS-l2lB, Form OHHS-121, and/or the completed Form DHS-l2l if available.

Evidence submitted at hearings shall be made available to all parties, including agency representatives. Final hearing decisions, with confidential contents redacted, shall be made available to the public.

All participants shall be promptly notified if the demands of the state agency and/or the convenience of the individual make a postponement or other adjustment in the date, time, and/or place of a hearing necessary.

0110.40 Continuances and/or Abandonment of the Hearing Request

REV: 08/2013

If an individual wishes to **continue** the request for a hearing and reschedule, s/he must call the EOHHS Central Appeals Office or, for appeals related to MAGI Medicaid or programs administered by the RIHBE, call the RIHBE contact center before the time of the hearing. No more than three (3) requests for continuances shall be permitted, unless the EOHHS Appeals Office exercises its discretion to allow more than three continuances after a demonstration of good cause. A SNAP household may request and receive a postponement in accordance with the Department of Human Services' Food Stamp Manual, Section 1032.10.05,"Household Request for Postponement."

A hearing request may be denied or dismissed when it is determined that it has been abandoned. Abandonment may occur when, without good cause, an individual or her/his authorized representative fails to appear at a hearing.

If the individual (or authorized representative) does not appear and has not notified the EOHHS Central Appeals Office (or the contact center administered by the RIHBE, for Exchange Appeals or appeals related to MAGI Medicaid) prior to the hearing to request a continuance or report that s/he is unable to appear, the individual shall be notified, in writing, that the hearing request is considered abandoned.

The written notice shall advise the claimant/legal representative to contact the EOHHS Central Appeals Office within ten (10) days if s/he wishes to reschedule the hearing and can demonstrate good cause (as described in Section 0110.40.05 as below) for failing to keep the appointment.

0110.40.05 Good Cause for Failure to Appear at Hearing

REV: 08/2013

A hearing shall not be considered abandoned as long as the individual has either: 1) requested a postponement or continuance before the time of the hearing, or 2) notified the EOHHS Central Appeals Office (or the contact center administered by the RIHBE, for Exchange Appeals or appeals related to MAGI Medicaid) prior to the hearing that s/he is unable to keep the appointment and still wishes a hearing.

Staff should assist the claimant in the establishment of good cause, and when necessary, forward determining information to the hearing officer.

Good cause for failure to attend a hearing shall be liberally interpreted in the claimant's favor and shall include, but shall not be limited to:

- Sudden and unexpected event (such as loss or breakdown of transportation, illness or injury, or other events beyond the individual's control) which prevents the individual's appearance at the hearing at the designated time and place; or appearance at the wrong office.

- Disabilities, such as linguistic and behavioral health limitations, that may impact the claimant's ability to attend.

- Injury or illness of claimant or household member that reasonably prohibits the individual from attending the hearing.

- Death in family.

If the hearing officer determines that good cause exists, the hearing shall be rescheduled. The benefit shall be reinstated without undue delay in the event it was terminated because of the abandonment.

0110.45 Time Limits in the Hearing Process

REV: 08/2013

It is the intention of the state agency to meet requests for hearings promptly. The hearing process, therefore, is subject to the following time schedule:

- A hearing regarding Long Term Care Medicaid, requested pursuant to section 0380.40.35, shall be scheduled within thirty (30) days of receipt by the agency of a written request for a hearing.

- The claimant and all interested parties shall be given at least ten days notice, in writing, of the date, time, and place of the hearing (e.g., through the DHS-l2lB or other scheduling notice).

- The entire hearing process, including the reporting of an action required to make the decision effective, shall be completed, whenever possible, within thirty (30) days of the receipt of a request, but in no case shall exceed a maximum of ninety (90) days, unless the individual requests in writing a delay to prepare his/her case.

- In food assistance hearings, final administrative action shall not be any later than sixty (60) days from the date of the hearing request.

0110.50 The Appeals Officer

REV: 08/2013

The hearing shall be convened by an impartial designee of the Secretary of EOHHS. No person who has participated in the pertinent matter under review shall be eligible to serve as an appeals officer.

The appeals officer shall endeavor to bring out all relevant facts bearing on the individual's situation at the time of the questioned state agency action or inaction and on state agency policies pertinent to the issue. The hearing shall not be closed until the appeals officer is satisfied that all interested parties have had the opportunity to present the facts needed for a decision.

0110.55 The Hearing Procedure

REV: 08/2013

The hearing shall be recorded. Any person who testifies at the hearing shall be sworn in by the appeals officer. An orderly procedure shall be followed that includes no less than the following:

- A statement by the appeals officer reviewing the state agency's purpose relative to the hearing; the reason for the hearing; the hearing procedures; the basis upon which the decision will be made, and the manner in which the individual is informed of the decision.

- A statement by the claimant (or his/her authorized representative) outlining his/her understanding of the problem at issue.

- A statement by the state agency representative, setting forth the state agency's policies under which action was taken or denied.

- A full and open discussion of all facts and policies at issue by participants under the active leadership of the appeals officer.

The hearing may be adjourned from day to day or to a designated day when either the appeals officer and/or the individual needs time to obtain further information.

0110.55.05 Admissible Information

REV: 08/2013

Only information bearing directly on the issue under review and the supporting policy may be introduced from agency records. The appeals officer shall not review any information that is not made available to all interested parties.

Ex Parte Communications

"***Ex Parte"*** communications means a discussion, correspondence or contact regarding a contested case between the administrative hearing officer and a party to a contested case, or a non-party who has an interest in the outcome of the case, without all parties being present to such communication. Communications for the purpose of scheduling and other administrative functions shall not be considered *ex parte.*

No person who is a party to or a participant in any proceeding before the state agency, or the party's counsel, employee, agent, or any other individual, acting on the party's or their own or another's behalf, shall communicate *ex parte* with the administrative hearing officer about or in any way related to the proceeding; and the administrative hearing officer shall not request or entertain any such *ex parte* communications. The prohibitions contained above do not apply to those communications which relate solely to general matters of procedure and scheduling.

Evidence after Completion. No evidence shall be admitted after completion of a hearing or after a case submitted on the record, unless the administrative hearing officer reopens the hearing or the parties agree to the submission, and all the parties have been notified of said reopening.

The administrative hearing officer shall not review any records or evidence that has not been introduced at the hearing.

0110.55.10 Hearing Attendance

REV: 08/2013

Attendance at hearings shall be restricted to individuals directly concerned with the issue(s), including the appellant's chosen representative, if any, and the appeals officer. If, at any time, the appeals officer finds that the number or the conduct of persons in attendance limits or prevents an orderly process to the hearing of the complaint, s/he may adjourn the hearing and reschedule it at a later date and time.

A representative of DHS or the RIHBE, or one from each agency, as appropriate in accordance with Section 0110.30.15 above, shall attend the hearing prepared to answer questions pertinent to the appropriate agency's decision. With respect to DHS representatives, an appropriate supervisory person shall endorse the findings. The state agency representative(s) shall have the obligation to secure, if possible, the attendance of all persons who were involved in the relevant action under appeal.

0110.55.15 Right to Legal Counsel

REV: 08/2013

The individual shall be informed at all times of his/her right to legal counsel in the preparation and/or presentation of his/her complaint, and the accessibility of such counsel through Rhode Island Legal Services and other community resources, as applicable.

If the individual chooses to have legal representation, e.g., be represented by an attorney, paralegal, or legal assistant, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the agency case record. (See DHS Manual Section 0102 General Provisions and all applicable federal and state statutes and regulations regarding confidentiality of information.) The Entry of Appearance is also needed for the Appeals Office for purposes of follow-up, review, requests for continuances, etc.

0110.55.20 Medical Assessment

REV: 08/2013

When the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, a medical assessment from someone other than the person or persons involved in the original decision, shall be obtained, at state agency expense, and made part of the hearing record, if the appeals officer considers it necessary.

0110.55.25 The Hearing Record

REV: 08/2013

The recording, together with all papers and documents introduced, shall constitute the complete and exclusive record for the decision. This record shall be available to the individual or his/her representative(s), within a reasonable time.

0110.60 The Hearing Decision

REV: 08/2013

The full responsibility of the state agency in the hearing process shall be discharged only when a definite decision has been made, in writing, by the EOHHS appeals officer and the required action,

if any, is carried out. No adjournment for further information limits the EOHHS appeals officer's responsibility to make such a final decision.

Any decision in favor of the individual shall apply retroactively to the date of the incorrect action, except as provided below. All decisions made in the hearing process shall be binding upon all state agency personnel who have responsibility for carrying them out.

In the case of appeals decisions where retroactive application could lead to financial liability for the appellant, for example if the appellant would owe premiums for the retroactive months of health insurance, the appeals office shall allow the appellant to elect whether the decision shall be effective retroactively or prospectively.

0110.60.05 Discharge of the Hearing Responsibility

REV: 08/2013

The hearing responsibility shall not be considered discharged until the following steps have been taken:

- A written decision, based exclusively on evidence and other material introduced at the hearing, has been rendered, on behalf of the state agency, by the person who conducted the hearing.

- Copies of the decision, setting forth the issue, the relevant facts brought out at the hearing, the pertinent provisions in the law and state agency policy, and the reasoning which led to the decision, have been sent to the individual, the staff member involved, and the appropriate supervisor, and other agencies as appropriate (for Exchange Appeals, a copy of the decision must be sent to a representative of the Exchange); and

- Action required by the decision, if any, has been completed by the state agency representative and confirmed in writing to the EOHHS Central Appeals Office.

For appeals relating to programs administered by the RIHBE, the individual shall be notified of his or right to make an appeal request to the federal Department of Health and Human Services within thirty (30) days of the notice of decision.

The individual shall also be notified of the right to seek judicial review. Appeal to the federal Department of Health and Human Services shall not be a prerequisite for seeking judicial review unless or until a court with appropriate jurisdiction finds otherwise.

Decisions related to an award or level of advance premium tax credits shall include a plain-language statement that the final calculation of tax credits is conducted by the federal Internal Revenue Service (IRS) through the reconciliation process, in accordance with section 36B(f) of the Internal Revenue Code, and that decisions or interpretations of the EOHHS appeals office are not binding against the IRS during that process.

0110.70 Public Access to Hearing Decisions

REV: 08/2013

EOHHS hearing decisions rendered in accordance with its record retention schedule are available for examination at the Hearing Office, Hazard Building, 74 West Road, Cranston, Rhode Island,

between the hours of 9:00 A.M. to 11:00 A.M. and l:00 P.M. to 3:00 P.M., Monday through Friday. An index of decisions is available to facilitate this examination. EOHHS may, at their discretion, make hearing decisions available on a publicly accessible website in lieu of or in addition to making them available at their offices.

0110.75 OCSS Quarterly Notice and Hearing Procedures

REV: 08/2013

The Office of Child Support Services (OCSS) shall provide a quarterly notice (computer generated) to RIW recipients and non-recipients for whom a child support obligation has been established and for whom a child support collection has been made.

The quarterly notice shall specify, at a minimum, the amount of support paid, the date such payment was made, the date such payment was received by DHS or R.I. Family Court, the date and amount of pass-through and/or child support paid to the, applicant/recipient, and an explanation of the recipient's rights to a hearing which shall be requested within 30 days of the date of the notice. When a pass-through payment is not sent to a recipient in a particular month, the quarterly notice shall include an explanation as to why it was not made. A hearing request form shall be enclosed with the quarterly notice.

The following shall constitute the OCSS hearing procedure:

- The recipient of the quarterly notice will mail the request form to the OCSS Accounting office, 77 Dorrance Street, Providence, RI 02903. The form will be date stamped and logged in a central location by the business office. The Business Agent shall research the records to determine all pass-through payments made for the months the recipient was on RIW (if applicable). In most cases it will not be necessary to refer the matter to obtain the RIW payroll card because the recent RIW on/off dates are on the IV-A system to which the agents have access. The agent shall refer the hearing request form packet to the legal unit for scheduling of a hearing indicating in their log the date the matter was so referred.

- Clerical staff shall date stamp the packet, log the case in a central log and schedule the matter for hearing. A notice shall be mailed to the applicant/recipient advising him/her of the hearing date. Notice of scheduled hearings shall be given to the business office on a weekly schedule.

The hearing shall be conducted in the same manner as the income tax intercept hearings. The business officer or other OCSS representative shall be present and shall be available to answer the applicant/recipient's relevant questions relating to the information provided to the applicant/recipient in the quarterly notice. The applicant/recipient shall then have an opportunity to present why s/he believes s/he should have received a child support payment and/or pass-through in a given month. The business officer or other OCSS representative shall then be given an opportunity to respond by presenting testimony and/or evidence with respect to the child support and/or pass-through payments and periods contested by the applicant/recipient.

The hearing officer may, in his or her discretion, grant a continuance to any party for good cause shown, including, but not limited to, a party's reasonable request to obtain, review, and present additional relevant evidence. The applicant/recipient shall be advised s/he will receive a written decision by mail within 30 days following the close of the hearing.

The hearing officer shall prepare a decision letter. The original shall be sent to the applicant/recipient, with copies to his/her representative, masterfile, hearing file, and business office.

Any person who has exhausted all available administrative remedies and who is aggrieved by a final order of the state agency shall be entitled to judicial review pursuant to Section 42-35-15 of the R.I. General Laws, as amended.

If an applicant/recipient appeals the decision of the hearing officer to the Family Court, the hearing officer shall be responsible to obtain a transcript of the hearing, assemble the evidence (Exhibits) and forward the material to the Chief Legal Counsel, OCSS.

September 10, 2015
0110techseptember2015

0300 Overview of the Rhode Island Medicaid and Children's Health Insurance Programs

REV: June 2014

0300. 01 A. Statutory Authority of the State Agency

Rhode Island General Laws Section 42-7.2-2 created the Rhode Island Executive Office of Health and Human Services (EOHHS) in 2006. EOHHS serves "as the principal agency of the executive branch of state government for managing the departments of children, youth and families, health, human services, and behavioral healthcare, developmental disabilities and hospitals." Toward this end, the EOHHS possesses, among others, the following duties and responsibilities:

Lead the state's four (4) health and human services departments in order to:

- Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting, and financing;
- Design strategies and implement best practices that foster service access, consumer safety, and positive outcomes;
- Maximize and leverage funds from all available public and private sources, including federal financial participation, grants, and awards;
- Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments;
- Ensure that state health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf. (See Rhode Island General Laws section 42-7.2-2 *et seq*.).

In addition, the EOHHS is responsible for administering the State's Medicaid program, which provides health care services and supports to a significant number of Rhode Islanders on an annual basis.

The statutory foundations of the Rhode Island Medicaid program are Title XIX of the Social Security Act (42 U.S.C. § 1396a *et seq*.), Rhode Island General Laws 40-8, and Rhode Island General Laws 42-7.2. Statutory authority for health care coverage funded in whole or in part by the federal Children's Health Insurance Program (CHIP) is derived from 42 U.S.C. § 1397aa *et seq*., of the U. S. Social Security Act which establishes that program and provides the legal basis for providing health coverage, services and supports to certain targeted low-income children and pregnant women through Medicaid.

EOHHS is designated as the "single state agency", authorized under Title XIX and, as such, is legally responsible for the fiscal management and administration of the Medicaid program. As health care coverage funded by CHIP is administered through the State's Medicaid program, the EOHHS also serves as the CHIP State Agency under federal and State laws and regulations.

The Medicaid and CHIP state plans and the Rhode Island's Medicaid Section 1115 demonstration waiver provide the necessary authorities for the health care administered through the Medicaid program and establish the respective roles and responsibilities of beneficiaries, providers, and the State.

The four state agencies under EOHHS maintain the legal authority to execute their respective powers and duties in accordance with applicable laws except as otherwise provided in §42-7.2.

Unless otherwise noted, the "state agency" referenced herein means EOHHS.

B. Purposes and Scope of the Medicaid Program
REV: June 2014

The Rhode Island Medicaid program is the joint federal/state health care program that provides publicly funded health coverage to low-income individuals and families, adults without dependent children age nineteen (19) to sixty-four (64), elders, and persons with disabilities who otherwise cannot afford or obtain the services and supports they need to live safe and healthy lives.

(1) **Eligibility -- Coverage Groups.** A coverage group is a classification of individuals eligible to receive Medicaid benefits based on a shared characteristic such as age, income, health status, and level of need criteria. Pursuant to the authority provided under the Medicaid and CHIP state plans and the State's Section 1115 demonstration waiver, health coverage, services, and supports are available to individuals and families who meet the eligibility requirements for the following coverage groups:

(a) **Medicaid Affordable Care Coverage (MACC) Groups** – To implement the federal Affordable Care Act (ACA 2010), the federal government has assisted the states in building state-of-the-art eligibility systems with the capacity to evaluate whether a consumer qualifies for affordable coverage funded in whole or in part through Medicaid, tax credits, and/or other subsidies. To ensure these eligibility systems function in the most efficient and consumer friendly manner possible, a single income standard – Modified Adjusted Gross Income or "MAGI" – must be used to determine the eligibility of all applicants for affordable coverage without respect to payer – that is, including Medicaid. Accordingly, the federal government has eliminated distinctions in the financial criteria and standardized the eligibility requirements to the extent feasible for the Medicaid populations subject to the MAGI. This, in turn, made it possible for the states to reorganize the MAGI-eligible populations with similar characteristics into distinct, easily identifiable, Medicaid affordable care coverage groups. The Rhode Island MACC groups are as follows:

(i) Families with children including children and young adults, pregnant women, infants and parents/caretakers with income up to the levels sets forth in Section 1303;

(ii) Adults between the ages of nineteen (19) and sixty-four (64) without dependent children who are otherwise ineligible for Medicaid and meet the income limits set forth Section 1303, including any persons in this age group who are awaiting a determination of eligibility for Medicaid for persons who are aged, blind, or living with disabilities pursuant to Sections 0356 and 0376 or Supplemental Security Income (SSI) pursuant to Section 0394;

(b) **Integrated Health Care Coverage (IHCC) Groups –** All applicants for Medicaid who must meet both clinical and financial eligibility requirements or who are eligible based on their participation in another needs-based, federally funded health and human services program are not subject to the MAGI. The State has reclassified these categorically and medically needy populations into coverage groups based on shared eligibility characteristics, level of need, and/or access to integrated care options as follows:

(i) Adults between the ages the ages of nineteen (19) and sixty-four (64) who are blind or disabled and elders age sixty-five (65) and older who meet the financial and clinical eligibility for Medicaid-funded coverage established pursuant to Section 0352;

(ii) Persons of any age who require long-term services and supports in an institutional or home and community-based setting who meet the financial and clinical criteria established pursuant to Section 0376 or in the case of children eligible under the Katie Beckett provision, who meet the criteria in Section 0394.35;

(iii) Individuals eligible for Medicaid-funded health coverage on the basis of their participation in another publicly funded program including children and young adults receiving services authorized by the Department of Children, Youth and Families and persons of any age who are eligible on the basis of receipt of SSI benefits.

(iv) Medically needy individuals who meet all the eligibility criteria for coverage in subparagraph (b)(i) or (ii) above except for excess income. Individuals in this coverage group achieve eligibility by applying a flexible test of income which applies excess income to certain allowable medical expenses thereby enabling the individual to "spend down" to within a medically needy income limit (MNIL) established by the Medicaid agency.

(v) Low-income elders and persons with disabilities who qualify for the Medicare Premium Payment Program (MPPP) authorized by the Title XIX. Medicaid pays the Medicare Part A and/or Part B premiums for MPPP beneficiaries.

(2) **Benefits.** Medicaid beneficiaries are eligible for the full scope of services and supports authorized by the Medicaid State Plan and the Section 1115 demonstration waiver.

(a) *General scope of coverage*. Although there is variation in benefits by coverage group, in general Medicaid health coverage includes the following:

• Doctor's office visits	• Home health care
• Immunizations	• Skilled nursing care
• Prescription and over-the-counter medications	• Nutrition services
• Lab tests	• Interpreter services
• Residential treatment	• Childbirth education programs
• Behavioral health services	• Prenatal and post-partum care

• Drug or alcohol treatment • Early and Periodic, Screening, Detection and Treatment (EPSDT)* • Referral to specialists • Hospital care • Emergency care • Urgent Care • Long-term Services and Supports (LTSS) in home and community-based and health care institution settings such as nursing homes	• Parenting classes • Smoking cessation programs • Transportation services • Dental care • Expedited LTSS • Organ transplants • Durable Medical Equipment

(b) *EPSDT*. Title XIX authorizes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for all Medicaid beneficiaries who are under age twenty-one (21) for the purposes of identifying and treating behavioral health illnesses and conditions. Medically necessary EPSDT services must be provided irrespective of whether they are within the scope of Medicaid State Plan covered services.

(c) *Limits.* Certain benefits covered by the Medicaid State Plan or the State's Section 1115 waiver are subject to limits under federal and/or State law. Program-wide benefit limits are set forth in section 0300.10(D) of this rule. Limits and restrictions applicable to specific coverage groups are located in the rules describing the coverage group and service delivery.

0300.01 C. Program Administration
REV: June 2014

(1) **Applications and Eligibility**. The EOHHS implements a "no wrong door" policy to ensure persons seeking eligibility for Medicaid health care coverage have the option to apply at multiple locations throughout the State and in a manner that is best suited to their needs including, but not limited to, in-person, on-line, by telephone, or by U.S. mail. Application and eligibility information for the MACC groups is located in MCAR Section 1303. An overview of the application process for the IHCC groups is located section 0302.

(a) *Determinations***.** The EOHHS must make timely and efficient eligibility, enrollment, and renewal decisions. Accordingly, the EOHHS or an entity designated by the secretary for such purposes must review and make eligibility and renewal determinations for Medicaid health care coverage in accordance with applicable State and federal laws, rules, and regulations.

(b) *Timeliness*. In general, determinations must be made in no more than thirty (30) days from the date a completed application is received by the EOHHS or its designee unless clinical eligibility factors must be considered. In instances in which both clinical and financial eligibility factors are material to the application process, as for eligibility for Medicaid-funded LTSS or coverage for persons with disabilities, determinations must be made in ninety (90) days. Applicable time-limits and other eligibility requirements are set forth in the Medicaid

Code of Administrative Rules in the sections and chapters related to each population Medicaid serves by eligibility coverage groups.

(c) *Cooperation***.** As a condition of eligibility, the Medicaid applicant/recipient must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial or termination of eligibility.

(2) **Eligibility Agent -- DHS.** The Medicaid State Agency is authorized under Title XIX and federal implementing regulations to enter into agreements with other State agencies for the purposes of determining Medicaid eligibility. The EOHHS has entered into a cooperative agreement with the Rhode Island Department of Human Services (DHS) that authorizes the DHS to conduct certain eligibility functions. In accordance with the Code of Federal Regulations (CFR) at 42§ 431.10 (e)(3), the DHS has agreed to carry out these functions in accordance with the Medicaid State Plan, the State's Section 1115 demonstration waiver, and the rules promulgated by the EOHHS.

(3) **Written Notice**. The executive office is responsible for notifying an applicant, in writing, of an eligibility determination. If eligibility has been denied, the notice to the applicant sets forth the reasons for the denial along with the applicable legal citations and the right to appeal and request a fair hearing. Section 0110 describes in greater detail the appeal and hearing process.

(4) **Mandatory Managed Care Service Delivery**. To ensure that all Medicaid beneficiaries have access to quality and affordable health care, the EOHHS is authorized to implement mandatory managed care delivery systems. Managed care is a health care delivery system that integrates an efficient financing mechanism with quality service delivery, provides a medical home to assure appropriate care and deter unnecessary services, and places emphasis on preventive and primary care. Managed care systems also include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the Medicaid agency. Managed care systems include the Medicaid program's integrated care options such as long-term services and supports and primary care health coverage for eligible beneficiaries. The managed care options for Medicaid beneficiaries vary on the basis of eligibility as follows:

(a) Families with children eligible under Section 1305 are enrolled in a RIte Care managed care plan in accordance with Section 1310 or, as applicable, an employer health plan approved by the executive office for the RIte Share premium assistance program in accordance with Section 1312 unless specifically exempted;

(b) Adults ages nineteen (19) to sixty-four (64) eligible in accordance with Section 1305 are enrolled in a Rhody Health Partners managed care plan in accordance with Section 1309 or, as applicable, an employer health plan approved by the executive office for the RIte Share premium assistance program in accordance with Section 1312 unless specifically exempted;

(c) Elders and adults who are blind or living with a disability and between the ages of nineteen (19) and sixty-four (64) eligible pursuant to Section 0352 are enrolled in a Rhody Health Partners plan or Connect Care Choice primary care case management practices in accordance with Section 0374 and/or 0375.

(d) Persons eligible for Medicaid-funded long-term services and supports in accordance with Sections 0376 *et seq*. have the choice of self-directed care, fee-for-service or enrolling for services in PACE, Rhody Health Options, or Connect Care Choice Community Partners in accordance with Section 0375.

(e) Persons eligible as medically needy or as a result of participation in another publicly funded health and human services program may be enrolled in fee-for-service or a managed care plan depending on the basis of eligibility. See exemptions in Sections 1310, 1312, and 0374-0375 related to coverage group.

(5) **Waiver eligibility and services**. Until 2009, the Medicaid program utilized authorities provided through its RIte Care Section 1115 and multiple Title 1915(c) waivers to expand eligibility and access to benefits beyond the scope provided for in the Medicaid State Plan. At that time, the State received approval from the Secretary of the U.S. Department of Health and Human Services (DHHS) to operate the Rhode Island Medicaid program under a single Section 1115 demonstration waiver. All Medicaid existing Section 1115 and Section 1915(c) waiver authorities have been incorporated into the Medicaid program-wide Section 1115 demonstration waiver, as it has been renewed and extended, since it was initially approved in 2009.

D. Program-wide Limits and Restrictions

Both federal and State law impose certain limits and restrictions on the scope, amount, and duration of the health care coverage, services, and supports financed and administered through the Medicaid program.

(1) Benefits authorized under the Medicaid State Plan and the State's Sections 1115 demonstration waiver are limited as follows:

(a) Termination of pregnancy. The deliberate termination of a pregnancy – or an abortion – is only a paid Medicaid service when the pregnancy is the result of an act of rape or incest or the termination is necessary to preserve the life of the woman. The treating physician performing the procedure must submit to EOHHS along with a request for payment a sworn, written statement certifying that: (1) the woman's pregnancy was the result of rape or incest or (2) the termination was necessary to save the life of the mother. A copy of this letter must be maintained in the woman's patient record for a period of no less than three (3) years. In cases of rape or incest, the woman receiving the termination procedure must also submit a sworn statement to EOHHS attesting that her pregnancy was the result of rape or incest. This requirement may be waived if a treating physician certifies that the woman is unable for physical or psychological reasons to comply. The procedure must be performed by a Rhode Island licensed physician in an appropriately licensed hospital-setting or out-patient facility.

(b) Organ Transplant Operations. Medicaid provides coverage for organ transplant operations deemed to be medically necessary upon prior approval by the EOHHS.

(i) *Medical necessity* for an organ transplant operation is determined on a case-by-case basis upon consideration of the medical indications and contra-indications, progressive nature of the disease, existence of alternative therapies, life threatening nature of the disease, general

state of health of the patient apart from the particular organ disease, any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

(ii) *Prior Written Approval* of the Secretary or his/her designee is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are available through the provider portal on the EOHHS website at: www.eohhs.ri.gov/providers.

(iii) *Authorized Transplant Operations* provided as Medicaid services, upon prior approval, when certified by a medical specialist as medically necessary and proper evaluation is completed, as indicated, by the transplant facility are as follows:

- Certification by medical specialist required -- kidney transplants, liver transplants, cornea transplants, and bone marrow transplants.

- Certification by an appropriate medical specialist and evaluation at the transplant facility - pancreas transplants, lung transplants, heart transplants, heart/lung transplant.

(iv) *Other Organ Transplant Operation**s*** as may be designated by the Secretary of the Executive Office of Health and Human Services after consultation with medical advisory staff or medical consultants.

(c) **Pharmacy Services for Dual Eligible Beneficiaries.** Under federal law, states providing a Medicaid-funded pharmacy benefit must extend or restrict coverage and co-pays to beneficiaries eligible for both Medicaid and Medicare as follows:

(i) Medicare Part D Wrap. Medicaid beneficiaries who receive Medicare Part A and/or Part B, qualify for Part D and must receive their pharmacy services through a Medicare-approved prescription drug plan. Therefore, these dually eligible Medicaid-Medicare beneficiaries are not eligible for the Medicaid pharmacy benefits. There are, however, certain classes of drugs that are not covered by Medicare Part D plans. Medicaid coverage is available to those receiving Medicare for these classes of drugs. The classes of drugs covered by Medicaid are: vitamins and minerals (with the exception of prenatal vitamins and fluoride treatment), Medicaid-approved over-the-counter medications, cough and cold medications, smoking cessation medications, and covered weight loss medications (with prior authorization). When purchasing these classes of drugs, Medicaid beneficiaries are required to pay a co-payment of one dollar ($1.00) for generic drug and three dollars ($3.00) for a brand name drug prescription.

(ii) Medicare Part D Cost-sharing Exemption. There is no Medicare Part D cost-sharing for full benefit Medicaid-Medicare dual eligible beneficiaries who would require the level of services provided in a long-term health facility if they were not receiving Medicaid-funded home and community-based services under Title XIX waiver authority, the Medicaid State Plan, or through enrollment in a Medicaid managed care organization. To obtain the cost-sharing exemption, the Medicare Part D plan sponsor must receive proof of participation in one of the following Medicaid-funded home and community-based services programs: Preventive/Core Services, Personal Choice, Habilitation, Shared Living, and Assisted

Living as well as the co-pay program administered by the Division of Elderly Affairs (DEA).

(2) Federal law and regulations authorize the Medicaid agency or its authorized contractual agent (managed care plan/organization) to place appropriate restrictions on a Medicaid-funded benefit or service based on such criteria as medical necessity or on utilization control (42 CFR§ 440.230(d)). The Medicaid *Pharmacy Lock-In Program* was established under this authority to restrict access to full pharmacy services in instances in which there is documented excessive use by a beneficiary. Beneficiaries are "Locked-In" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medicaid beneficiaries from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

(a) *Enrollment.* Whenever Medicaid records indicate that beneficiary utilization is excessive or inappropriate given actual medical need, the Medicaid agency or its authorized contractual agent, may require an individual to designate a physician and pharmacy of choice for exclusive service to:

- Protect the individual's health and safety;
- Provide continuity of medical care;
- Avoid duplication of service by providers;
- Avoid inappropriate or unnecessary utilization of Medicaid as defined by community practices and standards; and
- Avoid excessive utilization of prescription medications.

The determination of whether utilization is “excessive” must be based on current evidence-based practices and appropriate medical and pharmacological references.

(b) *Notice*. Beneficiaries determined to have excessive utilization are provided with written notice at least thirty (30) days prior to the imposition of the pharmacy lock-in restriction. Upon notification, beneficiaries are asked to choose a primary pharmacy/physician as a single source for all Medicaid health care. The notification will also advise the beneficiary that failure to cooperate will result in the Medicaid agency designating a physician/pharmacy to serve in this capacity based on other factors such utilization patterns and location. The notification includes a statement of the right to request a fair hearing within thirty (30) days if the beneficiary disagrees with the findings and the Medicaid agency’s action.

(3) Primary Pharmacy of Choice
REV: June 2014

The Primary Pharmacy of Choice must monitor the drug utilization of each restricted recipient and must exercise sound professional judgment when dispensing drugs in order to prevent inappropriate drug utilization by the recipient. When the pharmacist reasonably believes that the recipient is attempting to obtain excessive drugs through duplicate prescriptions or other inappropriate means, the pharmacist must contact the providing physician to verify the authenticity and accuracy of the

prescription presented. Primary pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to administrative action by EOHHS or its contracted Managed Care Organization(s), including the recovery of payments.

(4) Primary Care Physician
REV: June 2014

(a) The Primary Care Physician is delegated the responsibility of overseeing the health care needs of the restricted recipient and providing all medically necessary care for which the recipient is eligible. The provider should be knowledgeable about the recipient's health care problems and aware of the care and services the recipient is receiving.

(b) A recipient may change his/her primary pharmacy/physician for reasonable cause by notifying the Medicaid Pharmacy Lock-In Program or its contracted Managed Care Organization(s) and choosing a new primary pharmacy/physician.

(5) Change in Recipient Status
REV: June 2014

If, after review of the recipient's drug-usage profile, it is determined by the Medicaid Pharmacy Lock-In Program that restriction is no longer appropriate, the restriction will be removed. Such review will not take place prior to fifteen (15) months from the date of enrollment.

0300.01.E Cooperation Requirements
REV: June 2014

As a condition of eligibility, the Medicaid applicant/recipient must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial of eligibility or case closure.

F . Direct Reimbursement to Beneficiaries
REV: June 2014

(1) Some individuals, while appealing a determination of Medicaid ineligibility, incur and pay for covered services. Direct reimbursement may be available to beneficiaries in certain circumstances. Direct reimbursement is available to such individuals if, and only if, all of the following requirements are met:

1. A written request to appeal a denial or discontinuance of Medicaid coverage is received by the State within the time frame specified in Section 0110.20.

2. The original decision to deny or discontinue Medicaid coverage is reversed on appeal by the Appeals Officer (hearing decision) or by the Regional Manager or Chief Supervisor/Supervisor (adjustment conference decision).

Reimbursement is only available if the original decision was reversed. Reimbursement is not made, for example, if the original decision is reversed because information or documentation, not provided during the application period, is provided at the time of the appeal.

3. The recipient submits the following:

- A completed Application for Reimbursement form;
- A copy of the medical provider's bill or a written statement from the provider which includes the date and type of service;
- Proof of the date and amount of payment made to the provider by the recipient or a person legally responsible for the recipient. A cash receipt, a copy of a canceled check or bank debit statement, a copy of a paid medical bill, or a written statement from the medical provider may be used as proof of payment provided the document includes the date and amount of the payment and indicates that payment was made to the medical provider by the recipient or a person legally responsible for the recipient.

4. Payment for the medical service was made during the period between a denial of Medicaid eligibility and a successful appeal of that denial. That is, payment was made on or after the date of the written notice of denial (or the effective date of Medicaid termination, if later) and before the date of the written decision issued by the EOHHS Appeal Office, or decision by the Regional Manager/Chief Casework Supervisor after adjustment conference, reversing such denial is implemented (or the date Medicaid eligibility is approved, if earlier).

(2) **Procedure and Notification**

(a) Notices of Medicaid ineligibility provide applicants and recipients with information about their rights to appeal the agency's decision. These notices also contain specific information about the availability of direct reimbursement if a written appeal is filed and the State's initial decision is overturned as incorrect. The rules governing appeals and hearings are located in DHS and EOHHS rule section #0110.

(b) The EOHHS Appeals Office must provide individuals who may qualify with an Application for Reimbursement form to request repayment for medical expenses which they incurred and paid while their appeal was pending.

(c) The individual must complete and sign the Application for Reimbursement form and include: a) a copy of the provider's bill showing date and type of service; and b) proof that payment was made by the recipient or a person legally responsible for the recipient between the date of the erroneous denial and the date of the successful appeal decision. The completed form and required documentation is returned to the appropriate department representative.

(d) If either the bill or proof of payment is not included with the Application form, the Medicaid agency representative offers to assist the recipient in obtaining the required documentation, and sends a reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the Application for Reimbursement form. If all documents are not received within thirty (30) days, or if the documentation provided indicates that

medical service or payment was not made between the date of Medicaid denial (or termination) and the date of Medicaid acceptance (or reinstatement), the agency representative denies the request for reimbursement.

(e) Otherwise, the agency representative forwards a referral form, attaching the recipient's written request for reimbursement and all supporting documentation to the Medicaid agency for a decision on payment. The Medicaid agency is responsible for providing the individual with written notification of the agency's decision and rights to appeal.

0300.01.G. Severability
October 2013

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

0301 Payments and Providers

0301.01 Scope and Purpose

The Rhode Island Medicaid program provides health care coverage authorized by Title XIX of the Social Security Act (Medicaid law) and Title XXI (federal Children's Health Insurance Program (CHIP) law) as well as the State's Section 1115 demonstration waiver. To participate in the Medicaid program, health care providers must be certified and agree to abide by the requirements established in Title XIX, Title XXI, Rhode Island General Laws, and State and federal rules and regulations. To qualify for federal matching funds, payments to certified providers for authorized services must be made in accordance with methodologies established by the State and approved for such purposes by the Secretary of the U.S. Department of Health and Human Services (DHHS) and/or the federal Centers for Medicare and Medicaid Services (CMS). The Secretary of the EOHHS is authorized to set forth in rule, contractual agreements, provider certification standards, and/or payment methodologies the requirements for obtaining federal financial participation established in federal laws, regulations, or other such authorities. This rule governs participation of and payments to health care providers participating in the Medicaid program.

0301.05 Definitions

As used in this rule, the following terms and phrases have the following meanings:

Provider means any individual, firm, corporation, association, institution, or group qualified to perform and provide the medical services and supplies, which are within the scope of the services covered by the Rhode Island Medicaid Program.

Rhode Island Medicaid Program means a combined state and federally funded program established on July 1, 1966, under the provisions of Title XIX of the Social Security Act, as amended (P. L. 89-97). The enabling State legislation is to be found at Title 40, Chapter 8 of the Rhode Island General Laws, as amended.

Secretary means the Rhode Island Secretary of the Executive Office of Health and Human Services who is responsible for the oversight, coordination, and cohesive direction of state-administered health and human services, including the Medicaid agency, and for ensuring all applicable laws are executed.

State Agency means the Rhode Island Executive Office of Health and Human Services (EOHHS) which is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

0301.10 Medicaid Payment Policy

Medicaid is the payor of last resort. Community, public, and private resources such as federal Medicare, Blue Cross/Blue Shield, Veteran's Administration benefits, accident settlements, or other health insurance plans must be utilized fully before payment from the Medicaid program can be authorized.

Payments to physicians and other providers of medical services and supplies are made in accordance contractual arrangements with health plans or on a fee-for-service basis in accordance with applicable

federal and State rules and regulations, the Medicaid State Plan, and the State's Section 1115 demonstration waiver. Payments to Medicaid providers represent full and total payment. No supplementary payments are allowed, except as specifically provided for by contract. Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct a denial that is reversed on appeal.

0301.15 Long-term Care Facilities --Surveys

The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID) for compliance with the federal participation requirements of the Medicare and Medicaid programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

Statements of provider deficiencies must be made available to the public as follows:

- **Nursing Facilities (NF**) - Reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located, and the Medicaid agency.

- **Intermediate Care Facilities/Intellectual Disabilities (ICF/ID)** Reports are sent to the Medicaid agency. The agency is required to send the reports for both Nursing and Intermediate Care Facilities to the appropriate Long-term Services and Supports (LTSS) Unit covering the district in which the facility is located. The agency must also send the ICF/ID reports to the SSA office covering the catchment area in which the facility is located.

These files are available to the public upon request. Material from each survey must be held at both EOHHS and the LTSS Unit for three (3) years and then destroyed.

0301.20 Medicaid Provider Administrative Sanctions

In accordance with Title 42 Chapter 35 of the General Laws of Rhode Island (The Administrative Procedures Act), and Title 40 Chapter 8.2, the EOHHS is authorized to establish administrative procedures to impose sanctions on providers of health services and supplies for any violation of the rules, regulations, standards, or laws governing the Rhode Island Medicaid Program. The federal government mandates the development of these administrative procedures for the Title XIX Medicaid Program in order to ensure compliance with Sections 1128 and 1128A of the Social Security Act, which imposes federal penalties for certain violations.

(1) **Sanctionable Violations.** All providers of Medicaid and CHIP-funded health care services and supplies are subject to the Rhode Island General Laws and the rules and regulations governing the Medicaid program. Sanctions may be imposed by the EOHHS against a Medicaid provider for any one (1) or more of the following violations of applicable law, rule, or regulation:

(a) Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.

(b) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.

(c) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

(d) Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid recipients and records of payments made for such services.

(e) Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as determined by an official body of peers.

(f) Engaging in a course of conduct or performing an act deemed improper or abusive of the Medicaid Program or continuing such conduct following notification that said conduct should cease.

(g) Breach of the terms of a Medicaid provider agreement or failure to comply with the terms of the provider certification of the Medicaid claim form.

(h) Over utilizing the Medicaid Program by inducing, furnishing, or otherwise causing a beneficiary to receive services or supplies not otherwise required or requested by the beneficiary.

(i) Rebating or accepting a fee or portion of a fee or charge for a Medicaid beneficiary referral.

(j) Violating any provisions of applicable federal and State laws, regulations, plans, or any rule or regulation promulgated pursuant thereto.

(k) Submission of false or fraudulent information in order to obtain provider status.

(l) Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

(m) Conviction of a criminal offense for any intentional, reckless, or negligent practice resulting in death or injury to beneficiaries.

(n) Failure to meet standards required by State or federal laws for participation such as licensure and certification.

(o) Exclusion from the federal Medicare program or any state health care program administered by the EOHHS because of fraudulent or abusive practices.

(p) A practice of charging beneficiaries or anyone acting on their behalf for services over and above the payment made by the Medicaid Program, which represents full and total payment.

(q) Refusal to execute a provider agreement when requested to do so.

(r) Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.

(s) Formal reprimands or censure by an association of the provider's peers for unethical practices.

(t) Suspension or termination from participation in another governmental health care program under the auspices of Workers' Compensation, Office of Rehabilitation Services, Medicare, or any State program administered by the EOHHS or one of the agencies under the EOHHS umbrella.

(u) Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(v) Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments.

(2) **Provider Sanctions.** Any one (1) or more of the following sanctions may be imposed against providers who have committed any one (1) or more of the sanctionable violations above:

(a) Termination from participation in the Medicaid program or any state health care program administered by EOHHS.

(b) Suspension of participation in the Medicaid Program or any State health care program administered by EOHHS or an agency under the EOHHS umbrella.

(c) Suspension or withholding of payments.

(d) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement.

(e) Prior authorization required before providing any covered medical service and/or covered medical supplies.

(f) Monetary penalties.

(vii) Prepayment audits will be established to review all claims prior to payment.

(g) Initiate recovery procedures to recoup any identified overpayment.

(h) Except where termination has been imposed, a provider who has been sanctioned may be required to attend a provider education program as a condition of continued participation in any health care program administered by EOHHS. A provider education program will include instruction in: (a) claim form completion; (b) the use and format of provider manuals; (c) the use of procedure codes; (d) key provisions of the Medicaid Program; (e) reimbursement rates; and (f) how to inquire about procedure codes or billing problems.

(3) **Notice of Violations and Sanctions.** When the Medicaid agency intends to formally suspend or terminate a provider as a consequence of a sanctionable violation, a notice of violation must be sent to the provider by registered mail. The notice must include the following:

(a) A plain statement of the facts or conduct alleged to warrant the intended EOHHS action. If the Medicaid agency is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved and a detailed statement shall be furnished as soon as is feasible.

(b) A statement of the provider's right to a hearing that indicates the provider must request the hearing within fifteen (15) days of the receipt of the notice.

(4) **Informal Hearing.** Within fifteen (15) days after the receipt of a notice of an alleged violation and a sanction, the provider may request an informal hearing with the Medicaid agency.
This informal hearing provides an opportunity for the provider to discuss the issues and attempt to come to a mutually agreeable resolution, thereby obviating the need for a formal administrative hearing. Informal dispositions may also be made of any contested case by stipulation, consent order, or default.

(5) **Administrative Hearing.** The right to an administrative appeal is conditioned upon the appellant's compliance with the procedures contained in this rule and the hearing will be held in compliance with the provisions of the State's Administrative Procedures Act, as found at RIGL 42-35, as amended, and in conformance with DHS and EOHHS Policy Section 0110 et al.

(6) **Appeal for Judicial Review. A**ny provider who disagrees with the decision entered by the Hearing Officer as a result of the Administrative Hearing has a right to appeal for judicial review of the Hearing decision by filing a complaint with the Superior Court within thirty (30) days of the date of the decision in accordance with RIGL 42-35-15.

(7) **Administrative Actions.** Once a sanction is duly imposed on a provider, EOHHS shall notify the Rhode Island Department of Health (the licensing agent)and the federal Medicare Title XVIII program if appropriate, state health care programs as defined in Section 1128(h) of the Social Security Act (as amended), state-funded health care programs administered by the Medicaid agency, or any other public or private agencies involved in the issuance of a license, certificate, permit, or statutory prerequisite for the delivery of the medical services or supplies. Furthermore, EOHHS shall notify all affected Medicaid beneficiaries.

(8) **Stay of Order.** Orders may be stayed in accordance with RIGL 42-35-15 and 40-8.2-17.

(9) **Reinstatement.** Pursuant to 42 CFR 1002.214 Subpart C, a State may afford a reinstatement opportunity to any provider terminated or suspended at the State’s initiative. The provider may only be reinstated to participate in the Medicaid program by the EOHHS, in its capacity as the Medicaid single state agency. The sanctioned provider may submit a request for reinstatement to EOHHS at any time after the date specified in the notice of termination or suspension.

(a) EOHHS may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. Factors EOHHS will consider in making such a determination are contained in 42 CFR 1002.215(a)(l)(2)(3) Subpart C.

(b) If EOHHS approves the request for reinstatement, it will provide the proper notification to the excluded party and all others in accordance with 42 CFR 1002.212 Subpart C. If EOHHS does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with state procedures and not subject to administrative or judicial review.

0301.25 Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

0302 Medicaid Application – Integrated Health Care Coverage Groups

REV: June 2014

A. Applicability. The Executive Office of Health and Human Services (EOHHS) has taken the opportunity pursuant to the federal Affordable Care Act (ACA) of 2010 to reorganize Medicaid/CHIP coverage groups based on the financial standard used to determine eligibility as well characteristics. All populations subject to the modified adjusted gross income (MAGI) standard have been reorganized into the Medicaid Affordable Care Coverage groups. (See the Medicaid Code of Administrative Rules (MCAR) sections 1301 and 1303). Populations exempt from the MAGI who must also meet both clinical and financial eligibility criteria have been reclassified into the Integrated Health Care Coverage (IHCC) groups. This rule applies only to persons applying for Medicaid who are in the following IHCC groups:

- Low-income adults between the ages the ages of nineteen (19) and sixty-four (64) who are blind or disabled and elders age sixty-five (65) and older.
- Persons of any age who require long-term services and supports in an institutional or home and community-based setting, including children seeking eligibility under the Katie Beckett provision.
- Low-income elders and persons with disabilities who applying for the Medicare Premium Payment Program (MPPP) in which Medicaid pays the Medicare Part A and/or Part B premiums for qualified beneficiaries.
- Medically needy individuals seeking to obtain Medicaid eligibility by applying a flexible test of income that enables the individual to "spend down" to the medically needy income limit (MNIL).

B. Contents of the Application Packet

REV: June 2014

For persons seeking Medicaid eligibility in the applicable IHCC groups under MCAR sections 0351, 0374, 0375, and 0378, the application packet consists of the following documents:

IHCC Groups
DHS-2 Application for Assistance
Medicaid Booklet
DHS-14 Office Locations
QMB-2 Information for QMB's
Transportation Information
Return Addressed Stamped Envelope

This packet provides information about the agency, the conditions under which Medicaid is provided, and an applicant's rights and responsibilities under the law. Any applicants for Medicaid health coverage in the IHCC groups must complete and submit in-person or by mail the required application documents and any additional supplemental forms that may be necessary in order for an eligibility decision to be made within the timelines set by the agency. Beginning in January 2015, applicants for Medicaid health coverage in the IHCC groups will also have the option of completing and submitting the application either:

1) on-line through the State's new web-based eligibility system;
2) in-person; or
3) by mail.

C. **Assistance in Completing the Application**
REV: June 2014

Any person applying for Medicaid health coverage may obtain the assistance of a friend, relative, attorney, guardian or legal representative, or an agency representative or other application expert working for or on behalf of the EOHHS when completing the required application forms.

D. **Application Signature or Attestation**
REV: June 2014

All applicants for Medicaid health coverage must attest to the truthfulness of the application information they provide by hand-signing or electronically attesting to a sworn statement to that effect. Whether other members of the applicant's household or family may or must also sign the application varies as follows:

- When two spouses are living together, both spouses must sign the application form;
- A caretaker may sign and file an application form for a child with disabilities or special needs who is under the age of (19);
- A relative may file an application on behalf of a deceased individual for retroactive coverage.

E. Timeliness Standards for Decisions on Eligibility
REV: June 2014

A decision on a Medicaid application for individuals and families eligible under section 1301 of the MCAR and for persons who are blind or low-income elders in the IHCC groups is made within THIRTY (30) DAYS of the receipt of the completed application by the EOHHS, or the Department of Human Services (DHS) while operating under an agreement with the EOHHS to make eligibility determinations on its behalf. An eligibility decision for a person who has a disability and/or is seeking Medicaid-funded long-term services and supports must be made within NINETY (90) DAYS of the receipt of the completed application by the EOHHS or DHS.

(1) Good cause exemption for determination delay – IHCC groups only. An eligibility decision may exceed the timeliness standards in unusual circumstances when good cause for a delay exists. Good cause exists when:

(a) The agency representative cannot reach a decision because the applicant or the applicant's treating physician or other provider responsible for providing information material to the application delays or fails to take a required action, provided that the agency promptly reviews submitted medical and social data and requests any necessary additional medical documentation from the treating provider within two weeks from the date the completed forms (e.g., Physician's Report, Information for Determination of Disability Release of Information Authorization) are received by the agency, or within two weeks of learning of the existence of a treating provider or of the need to obtain supplementary treating provider information; or

(b) There is an administrative or other emergency beyond the agency's control. The reason for the delay must be documented in the case record. In addition, the applicant must be provided with written notification stating: the reason for delay; and the opportunity for an expedited hearing to contest the delay.

(2) Basis for making a determination. The agency representative makes the decision on eligibility on the basis of information submitted on the application. In every instance, information regarding the applicant's income is verified. Other information is verified as required. Any information on the application which is questionable must be confirmed before eligibility can be certified.

(a) If a decision cannot be made because of omissions or inconsistencies, the agency representative must contact the applicant by mail, phone, or in person for clarification, additional information, or verification. If it is necessary for the agency to obtain or confirm any information, the applicant is advised of the necessary steps the applicant or the agency must take before a determination of eligibility can be made. If other collateral sources of information must be contacted, the applicant should be informed of why the information is necessary and how it will be used by the agency. The applicant must sign a *Release of Information Authorization* and permit the State to use public records and contact collateral sources for purposes of the eligibility determination.

(b) If an applicant or beneficiary refuses to either provide the information the agency requests or sign the release(s) necessary for the agency to obtain the information on its own, the agency will deny or discontinue Medicaid health care coverage.

D. **Period of Eligibility**
REV: June 2014

Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the "*eligibility period*" -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follows:

(1) General eligibility period. When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility begins on the first day of the month in which the individual is determined eligible. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist. Individual and couple cases remain eligible for Medicaid for up to a maximum of twelve (12) months. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.

(2) Special eligibility period – Medically-needy**.** In cases where the *flexible test of income* policy is applied, eligibility is established on the day the excess income is absorbed (i.e., the day the health service was provided). Eligibility is for the balance of the six (6) month period. Medically-needy eligibility continues for the full six (6) months or the balance of the six (6) month period.

(3) Medicare Premium Payment Program. Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary (SLMB) or a Qualified Working

Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

E . Medicaid as Payor of Last Resort
REV: June 2014

Health insurance coverage from another party is not a bar to Medicaid eligibility. However, as the payor of last resort, Medicaid payment is only made for services that are not covered by a beneficiary's other forms of health insurance. In addition, beneficiaries are required to sign over to the Medicaid agency their right to any such third party payments at the time application is made. State law makes it illegal for insurance companies to exclude Medicaid beneficiaries from benefits, reinforcing the requirement of third-party liability (TPL) and that Medicaid is the last payer. (See sections 40-8-4 and 40-6-29 of the Rhode Island General Laws, as amended).

For Further Information or to Obtain Assistance
March 2014

1. Applications for affordable coverage are available online on the following websites:
   - www.eohhs.ri.gov
   - www.dhs.ri.gov
   - www.HealthSourceRI.com

2. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

3. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

Severability
October 2013

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

0304 Citizenship and Immigration Status Requirements

0304.05 Requirements of Citizenship and Immigration Status

REV: October 2013

A. **Immigration Status --** An individual must meet the requirement for citizenship or immigration status in order to qualify for Medicaid. An otherwise eligible individual must be a member of one of the following categories:

1. A qualified non-citizen (Section 0304.05.15)

   a. Exempt from the five (5) year ban

   b. Subject to the five (5) year ban

2. A lawfully residing member of the state-funded coverage group described in Section 0304.05.45

3. A pregnant woman as described in Section 0304.05.15 and 1305.05

4. A child under 19 as described in Section 0304.05.45 and 1305.05

B. The Federal Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) as well as Public Laws (PL) 104-193, 104-208 and 105-33 restricts eligibility for federally reimbursed Title XIX Medicaid to U.S. citizens and certain qualified non-citizens. PL 105-306 restricts eligibility to lawfully residing non-citizens who receive SSI.

1. Individuals who are not U.S. citizens must comply with the requirements for non-citizen eligibility established in the Personal Responsibility and Work Opportunity Act of 1996 (PL 104-193) (PRWOA) and may not be eligible for Title XIX Medicaid benefits.

2. Non-qualified non-citizens are not eligible for Title XIX Medicaid benefits.

C. The Federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (PL 111-3) authorized States to elect the CHIPRA option to provide full Medicaid coverage to:

   1. Qualified non-citizens under the age of nineteen (19) who are lawfully present in the United States as identified in Section 0304.05.15, paragraph B, if otherwise eligible under Section 1305.

   2. Non-citizen pregnant women, without regard to immigration status, who are residents of Rhode Island including qualified non-citizen pregnant women identified in Section 0304.05.15 and both lawfully present and non-immigrant non-citizen pregnant women who are otherwise eligible under Section 1305.

D. Title XIX Medicaid for emergency services as stated in EOHHS Policy Section 0316.10 is accessible to individuals regardless of immigration status, provided they are residents of Rhode Island and meet all other financial and non-financial criteria for the Medicaid Program. This includes persons who, but for citizenship status, meet the criteria for Medicaid under any of the coverage groups identified in Sections 1303 and 0351.15.

0304.05.05 The SAVE Program
REV: October 2013

A. The Immigration Reform and Control Act of 1986 mandated the establishment of the Systematic Alien Verification for Entitlements (SAVE) Program. SAVE enables states and federal assistance programs to exchange information regarding the immigration status of non-citizens applying for benefits from federally-funded programs (Refer to MCAR Sections 0104.40 and 1308 as appropriate).

B. Unless exempt, applicants for Medicaid programs must declare in writing that they are United States citizens or nationals, or that they are in satisfactory immigration status.

0304.05.10 Eligibility as a United States Citizen
REV:06/1994

A United States citizen is defined in the Immigration and Nationality Act as any person born in any of the 50 States, the District of Columbia, Puerto Rico, Guam or the United States Virgin Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens, as are those persons who are naturalized U.S. Citizens.

0304.05.10.05 Verification of Citizen Status
REV: October 2013

If the state is unable to verify citizenship and identity via the State Verification and Exchange System (SVES) interface with the Social Security Administration, it is the responsibility of the applicant/recipient to provide the required verification as follows:

A. CITIZENSHIP – Effective January 1, 2014, acceptable verification for MACC groups identified in Section 1303 are as set forth in Section 1308.04. For all other Medicaid coverage groups, appropriate documentation of citizenship is as follows until further notice:

1. FIRST LEVEL (PRIMARY DOCUMENTATION)

a. The following forms of documentation qualify as both proof of citizenship and identity:
   i. A U.S. Passport

   - Passport does not have to be currently valid to be accepted as proof of citizenship
   - Passports issued with a limitation are not considered evidence of U.S. citizenship but is considered proof of identity.

   ii. A Certificate of Naturalization (Forms N-550 or N-570)

   iii. A Certificate of U.S. Citizenship (Form N-560 or N-561)

b. Applicants and recipients born outside of the United States who were not U.S. citizens at birth, must submit First Level documentation as evidence of U.S. citizenship.

c. If the applicant/recipient does not possess any of the above forms of documentation, then documentation of both the individual's citizenship (preferably from the Secondary tier of documentation) and identity is necessary.

2. SECOND LEVEL (SECONDARY)

a. If documentation from the First Level (Primary Documentation) of citizenship is not available, the applicant/recipient must submit both a document from one of the lower levels of citizenship documentation as well as a document from the list of acceptable forms of identity documentation.

b. Secondary level documentation includes:

i. A U.S. Birth Certificate

ii. A Certification of Birth Issued by the Department of State (Form DS-1350)

iii. A Report of Birth Abroad of a U.S. Citizen (Form FS-240)

iv. A Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350)

v. A U.S. Citizens I.D. Card (Form I-197 or prior version I-179)

vi. An American Indian Card, I-872 issued by the Department of Homeland Security with the classification code "KIC" issued to identify U.S citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border

vii. Final Adoption Decree showing the child's name and U.S. birthplace

viii. Evidence of Civil Service employment by the U.S. government before June 1976

iv. An official military record of service showing a U.S. place of birth

x. A Northern Mariana Identification Card, I-873 (issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4,1986)

B. IDENTITY -- Effective January 1, 2014, the verification provisions set forth in Section 1308.04 apply for the MACC groups identified in Section 1303. Until further notice, for all other Medicaid coverage groups the following forms of documentation qualify as proof of identity and must accompany any documents establishing citizenship that were submitted from the second level of citizenship documentation.

a. A current U.S. state or territory driver's license bearing the individual's picture or other identifying information such as name, age, sex, race, height, weight, or eye color

b. Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document

c. Any identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act

d. School identification card with a photograph of the individual

e. U.S. military card or draft record

f. Identification card issued by the Federal, State, or local government with the same information included on the driver's license issued by the Federal, State, or local government.

g. Military dependent's identification card

h. Native American tribal document

i. U.S. Coast Guard Merchant Mariner card

j. Cross match with federal or state government agency, including but not limited to Vital Statistics and Division of Motor Vehicles.

k. In addition to the above identity documents, children who are sixteen (16) years of age or younger may prove their identity through the use of the following documents:

i. School records including nursery or day care records

ii. Affidavit signed under penalty of perjury by a parent or guardian attesting to the child's date and place of birth. This cannot be used if an affidavit was submitted to document citizenship.

l. Various "documents" issued by an organization called the World Council of Washington, D.C. are considered bogus and unacceptable as evidence of identity, citizenship, age, etc., for enumeration or other official purposes. These "documents" include: World Birth Certificates, World Citizen Cards, World Identity Cards, and World Marriage Certificates.

C. REASONABLE OPPORTUNITY -- Effective January 1, 2014, the eligibility verification provisions set forth in Section 1308.04 apply to MACC groups. For all other Medicaid coverage groups appropriate documentation of citizenship is as follows until further notice:

1. Applicants/recipients will be given a reasonable opportunity to present documents that establish U.S. citizenship and identity.

2. Applicants will not be eligible to receive Medicaid benefits until they have presented the required documentation of citizenship and identity.

a. Applicants have thirty (30) days from the time the application is filed to submit documentation of citizenship and identity.

b. After the thirty (30) day period, eligibility will be denied for applicants who did not submit acceptable proof of citizenship and identity.

3. The agency will assist an applicant or recipient to document their U.S. citizenship and identity if they:

a. Are unable to obtain the required documents, and

b. Require assistance (i.e. are homeless, mentally impaired, or physically incapacitated), and

c. Do not have someone who can act on their behalf.

4. Medicaid applicants and recipients are allowed to submit proof of citizenship and identity documentation to the Medicaid agency through an authorized representative. Authorized representatives transmit such documentation to the Department of Human Services (DHS) field offices or other authorized representatives.

Authorized representatives include:

a. Navigators

b. Hospitals

c. Community health centers

d. Contact Center personnel.

0304.05.15 Eligibility as a Qualified Non-Citizen

REV: October 2013

A. QUALIFIED NON-CITIZENS EXEMPT FROM THE FIVE (5) YEAR BAR:

1. The following "qualified" non-citizens are exempt from the five (5) year bar and meet immigration requirements for Title XIX Medicaid regardless of date of entry into the U.S:

a. Refugees admitted under Section 207 of INA including Afghan and Iraqi Special Immigrants (SIV's) as permitted under PL 111-118;

b. Non-citizens granted Asylum under Section 208 of INA;

c. Non-citizens who have had deportation withheld under 243(h) of INA;

d. Amerasian entrants pursuant to Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988 (as contained in Section 101(e) of PL 100-202 and amended by the 9th provision under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988, PL 100-461 as amended);

e. Cuban or Haitian entrants as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

f. Lawfully residing honorably discharged veterans (except one discharged for reasons of immigration status), non-citizens on active duty in the U.S. Armed forces, their lawfully residing spouses and unmarried dependent children, and the unremarried widow or widower of the veteran;

g. Certain battered spouses, battered children or parents, or children of a battered person with a petition approved or pending under Section 204(a)(1)(A) or (B) or Section 244(a)(3) of INA;

h. An American Indian born outside the U.S. who:

i. was born in Canada and is at least fifty percent 50% American Indian blood and to whom the provisions of Section 289 of the INA apply; or

ii. is a member of a federally recognized tribe as defined in Section 4(e) of the Indian Self-Determination and Education Act.

i. An individual certified by the U.S. Department of Human Services (HHS) Office of Refugee Resettlement pursuant to Section 107(b.) of the Victims of Trafficking and Violence Protection Act of 2000, as a victim of a severe form of trafficking.

j. Disability Assistance for any qualified non-citizen, subject to the five (5) year bar, who legally entered the U.S. on or after 8/22/96 and received disability related benefits for a condition that is a disability or is pending a disability determination in accordance with 42 USC Sub Section 1381.

k. Under provisions of PL 105-306, SSI benefits, and associated Title XIX Medicaid were continued for “non-qualified" aliens who were lawfully residing in the U.S. and receiving SSI on 8/22/96.

B. QUALIFIED NON-CITIZENS ABOVE AGE NINETEEN (19) SUBJECT TO THE FIVE

1. The following "qualified" non-citizens who are age nineteen (19) or above are subject to the five (5) year bar. They meet the immigration requirement and are potentially eligible for Title XIX benefits if they entered the U.S. prior to 8/22/96. When entering the U.S. on or after 8/22/96, they meet the immigration requirement for Title XIX Medicaid only after the five (5) year bar described in Section 0304.05.15.05.

a. Lawful permanent residents (LPRs);

b. Non-citizens granted parole for at least one (1) year under 212(d)(5) of the Immigration and Nationality Act (INA);

c. Non-citizens granted conditional entry under 203(a)(7) of immigration law in effect before April 1, 1980.

2. Under provisions contained in PL 105-306, Title XIX Medicaid is also provided to certain SSI recipients who were lawfully residing in the U.S. and receiving SSI on 8/22/96.

C. QUALIFIED NON-CITIZEN CHILDREN UNDER AGE NINETEEN (19) AND PREGNANT WOMEN EXEMPT FROM THE BAR

1. The following qualified non-citizen children and pregnant women are NOT subject to the five (5) year bar regardless of date of entry in the U.S. and are potentially eligible for Title XIX or XXI benefits.

   a. Lawful permanent residents (LPRs)

   b. Non-citizens granted parole for at least one (1) year under 212(d)(5) of the Immigration and Nationality Act (INA);

   c. Non-citizens granted conditional entry under 203(a)(7)of immigration law in effect before April 1, 1980.

   d. Legal non-immigrants whose admission to the United States is not conditioned on having a permanent residence in a foreign country (such immigrants include citizens of the Compact of Free Association States who are considered permanent non-immigrants but does not include visitors for business or pleasure or students) as described in Section 0304.05.15.

2. In addition, the following categories of children under age nineteen (19) and pregnant women are eligible for Medicaid under Title XIX or XXI as authorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and as described in 8 CFR 103.12(a)(4).

   a. Aliens currently in temporary resident status pursuant to Section 210 or 245A of the Immigration and Nationality Act (INA)

   b. Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA

   c. Cuban-Haitian entrants, as defined in section 202(b) P. L. 99-603, as amended

   d. Family Unity beneficiaries pursuant to section 301 of P. L. 101-649, as amended, as well as pursuant to section 1504 of PL 106-554

   e. Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President

   f. Aliens currently in deferred action status pursuant to Service Operations Instructions at OI 242.1(a)(22)

   g. Aliens who are the spouse or child of a United States citizen whose visa petition has been approved and who have a pending application for adjustment of status.

3. The following categories of non-immigrant children and pregnant women under 101(a)(15) of the immigration and Nationality Act (INA) are also eligible for coverage under Title XXI.

   a. Parents or children of individuals with special immigration status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA

b. Fiance(ee) of a citizen as permitted under section 101(a)(15)(K)of the INA

c. Religious workers under section 101(a)(15)(R)

d. Aliens who the Attorney General of the United States has determined are in possession of critical reliable information concerning a criminal or terrorist organization, enterprise or operation as permitted under section 101(a)(15)(S) of the INA

e. Aliens who are or have been victims of trafficking as permitted under section 101(a)(15)(T) of the INA

f. Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(U) of the INA

g. Battered aliens

h. Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA

0304.05.15.05 Five Year Ban

REV: October 2013

A. Unless exempt, qualified non-citizens who are age nineteen (19) or older, entering the U.S. on or after 8/22/96 are subject to a five (5) year bar during which they are ineligible for full Title XIX Medicaid.

B. The five (5) year period of ineligibility begins on the date the qualified non-citizen entered the U.S., or the date a previously unqualified non-citizen attained qualified non-citizen status.

1. To determine the five (5) year bar:

a. From USCIS Form I-94, the date of the qualified non-citizen's admission is the start of the five (5) year bar on Title XIX eligibility;

b. If the non-citizen presents a USCIS grant letter or court order, derive the date qualified non-citizen status was granted from the date of the letter or court order. This date starts the five (5) year bar.

c. If the non-citizen presents an employment authorization document, ask the individual to present Form I-94. If Form I-94 is not available, further contact with USCIS will be needed to ascertain the date status was granted. Obtain signed release or signed SAVE-1 before contacting USCIS.

2. Eligibility for Title XIX emergency services may be established during the five (5) year bar period.

3. Pregnant women who are ineligible for full Title XIX benefits due to the five (5) year bar, may establish eligibility for state-funded coverage. (See Sections 0305.05.45 and 0348.)

0304.05.20 Eligibility as an Amerasian

REV:01/2007

Amerasians born in Vietnam between January 1, 1962 and January 1, 1976 and residing in Vietnam as of December 1987 who were fathered by an identified U.S. citizen may be granted immigrant visas and may have a claim to U.S. citizenship under Section 301(g) of the Immigration and Nationality Act, as made applicable by Section 309(a) (amended November 14, 1986).

These individuals meet the Title XIX immigration status requirement regardless of date of entry into the U.S.

0304.05.20.05 Verification of Amerasian Status

REV:04/2010

A. Verification of Amerasian immigrant status includes:

1. Unexpired temporary I-551 stamp in a foreign passport or on USCIS Form I-94 with code AMI, AM2 or AM3i or

2. USCIS Form 551 annotated with code AM6, AM7 or AM8.

0304.05.21 Eligibility as a Lawful Permanent Resident (LPR)

REV: October 2013

A. A lawful permanent resident (LPR) is one who was lawfully admitted for permanent residence in accordance with the immigration laws.

1. LPRs who entered the U.S. prior to 8/22/96 meet the immigration status requirement for Medicaid and are not subject to the deeming of income and/or resources from their sponsor(s).

2. LPRs who entered the U.S. on or after 8/22/96 (except honorably discharged veterans, members of the U.S. Armed Forces, their spouses and unmarried dependent children) are ineligible for Title XIX Medicaid benefits (except for emergency services) for five (5) years from their date of entry. Non-citizens who entered the U.S. with a non-qualified immigration status (or no immigration status) but who later adjust to an LPR status are ineligible for five (5) years from the date LPR status was granted.

3. Eligibility for refugees, asylees, Amerasians, and individuals whose deportation has been withheld under Section 243(h) of INA whose status is subsequently adjusted to LPR is determined under the original status. That is, they are not subject to the five (5)year bar.

B. Otherwise eligible pregnant women may receive state funded Rite Care or Rite Share benefits during the five (5) year bar. Otherwise eligible lawfully residing children under the age of nineteen (19) may receive Medicaid coverage under Title XIX or Title XXI and are not subject to the five (5) year bar.

0304.05.21.05 Verification of LPR Status

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Any of the following USCIS forms may be used as evidence to determine whether an alien is lawfully admitted for permanent residence:

1. For recent arrivals, a temporary I-551 stamp in a foreign passport or on USCIS Form I-94;

2. Form I-551, Resident Alien Card. This is the current document given to a lawful permanent resident non-citizen and is valid indefinitely. It is commonly referred to as a "green card";

3. Unexpired Re-entry Permit (Form I-327). This document is issued to lawful permanent residents before leaving the U.S. for a one (1) to two (2) year period; or

4. Forms AR-3 and AR-3a, Alien Registration Receipt Card. This document was issued between 1941 and 1949 and pertains to lawful permanent resident status. If an applicant presents an expired USCIS document or is unable to present any document demonstrating immigration status, refer the person to the Providence USCIS office to obtain evidence of status unless he or she can provide an alien registration number. If the applicant provides an alien registration number, request permission to send USCIS Form G-845 along with the alien registration number to USCIS, to verify status. The application may be held in a pending status for up to thirty (30) days awaiting verification of status.

0304.05.25 Eligibility as an American Indian Born Outside the US

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Certain American Indians born outside of the U.S. meet the immigration requirement for Title XIX benefits regardless of date of entry into the U.S. To qualify under this category the American Indian must be:

1. Born outside of the U.S. in Canada with at least fifty percent (50%) American Indian blood. (This category does not include the non-citizen spouse or dependent child of such Indians, unless such person is at least fifty percent (50%) or more American Indian Blood.) OR

2. A member of a federally recognized tribe as defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act.

0304.05.25.05 Verification of Status as American Indian Born Outside the US

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Verification of American Indian Status includes:

1. Birth or baptismal certificate issued on a reservation;
2. Tribal records;
3. Letter from the Canadian Department of Indian Affairs; or
4. School records.

0304.05.30 Eligibility as a Conditional Entrant

REV: October 2013

A. Conditional entrants are generally granted conditional entry into the U.S. because of a fear of persecution in their home country due to race, religion, political opinion, or because of a natural disaster.

1. An individual who entered the U.S. prior to 8/22/96 and was granted conditional entry under the immigration law in effect before April 1, 1980 meets the immigration status requirement for Title XIX Medicaid.

2. A conditional entrant entering the U.S. on or after 8/22/96 is subject to a five (5) year bar on receiving Title XIX Medicaid (except for emergency services), in the same manner as an LPR. After the five (5) year bar, the individual, who entered the U.S. on or after 8/22/96 and was granted conditional entry under the immigration law in effect before April 1, 1980, may receive Title XIX benefits if otherwise eligible.

0304.05.30.05 Verification of Conditional Entry

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Acceptable verification of conditional entrant status includes:

1. USCIS Form I-94 with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry;

2. USCIS Form I-688B (or USCIS employment authorization card) annotated "274a.12(a)(3); or

3. USCIS Form I-766 annotated A3.

0304.05.35 Eligibility as a Battered Non-Citizen

REV: October 2013

A. A battered non-citizen is one who meets the following four (4) requirements:

1. USCIS has granted a petition on behalf of the battered non-citizen, the non-citizen's child, or the non-citizen child's parent; or has found that a pending petition sets forth a prima facie case under Section 204(a)(1)(A) or 244(a)(3) of the INA

2. The non-citizen, the non-citizen's child or the non-citizen child's parent has been battered or subjected to extreme cruelty in the U.S. by a spouse or parent of the non-citizen, or by a member of the spouse or parent's family residing in the same household as the non-citizen, if the spouse consents to or acquiesces in the abuse and, in the case of the non-citizen's child, the non-citizen did not actively participate in the abuse

3. The state determines, based on guidance issued by the U.S. Attorney General, that there is a substantial connection between the abuse and the need for Medicaid

4. The battered non-citizen, child or parent no longer resides with the abuser

B. Such individuals meet the immigration requirement for Title XIX Medicaid regardless of date of entry into the U.S.

C. Battered LPRs are exempt from the sponsor deeming requirements in certain circumstances. See Section 0304.05.90 for information about deeming.

0304.05.35.05 Verification - Battered Immigrant

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Anyone of the following documents are acceptable as verification of battered non-citizen status:

1. For lawful permanent residents who are victims of domestic violence - IRS form I551 or I551B coded IB1 through IB3, IB6 through IB8, B11, B12, B16, B17, B20 through B29, B31 through B33, B36 through B38, BX1 through BX3, BX6, BX7 or BX 8.

2. For victims of domestic violence petitioning for legal status who are considered as "qualified aliens" under PROWORA - IRS Form 797 showing an approved 1-360 or 1-13 self petitioning as a spouse or child of a U.S. citizen or lawful permanent resident; OR USCIS Form 797 showing a Notice of Prima Facie Determination.

0304.05.45 State-Funded Coverage Group Defined

REV: October 2013

A. The state-funded alien group is comprised of lawfully residing non-citizens who do not meet the citizenship/alienage criteria under Title XIX or XXI. This group includes:

1. Persons with a pending application for political asylum or withholding of deportation who have employment authorization or if under age fourteen (14) have an application pending for at least one hundred eighty (180) days;

2. Deportable non-citizens residing in the U.S. pursuant to an indefinite stay of deportation;

3. Non-citizens granted suspense of deportation pursuant to Section 244 of the INA (8 USC 1254) whose departure the USCIS does not contemplate enforcing;

4. Non-Citizens residing in the U.S. pursuant to an Order of Supervision;

5. Non-citizens residing in the U.S. prior to January 1, 1972;

6. Western Hemisphere non-citizens, who applied for a residency visa between July 1, 1968 and December 31, 1976 but entered the U.S. before their visa was granted and whose last entry was before March 11, 1977, allowed to remain in the U.S. until further notice under a temporary restraining order granted in the U.S. District Court, Northern District, Illinois (Silva v. Levi);

7. Lawful Temporary Residents (under the Immigration Reform and Control Act of 1986)

0304.05.45.05 Eligibility as a State Funded Non-Citizen

REV: October 2013

Otherwise eligible persons must possess a lawfully residing immigration status (See 0304.05.45) AND show that they were:

1. lawfully residing in the U.S. prior to 8/22/96; and

2. a RI resident prior to 7/1/97.

0304.05.45.10 Verification of Lawfully Residing Status

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Documents which may be used to verify alien status include:

1. In general,

   a. USCIS Form I-94 with date of admission and annotated with unexpired status as listed in Section 0304.05.45.05;

b. Dated USCIS letter or court order indicating a lawfully residing status listed in Section 0304.05.45.05; and/or

c. An unexpired USCIS employment authorization document (I-688-B) annotated with status code.

2. More specifically

a. Applicants for asylum: I-94, I-589 on file, I-688B coded 274a.12(c)(8).

b. Applicants for suspension of deportation: I-94, I-256A on file, I-688B coded 274a.12(c)(10);

c. Non-citizens granted stays of deportation by court order statute or regulation or by individual determination of USCIS whose departure the USCIS does not contemplate enforcing: letter or Granted a stay of deportation, I-688B coded 274.12(c)(12);

d. Non-citizens granted suspension of deportation pursuant to Section 244 of INA (8 USC 1254) whose departure the USCIS does not contemplate enforcing: letter/order from the immigration judge and a Form I-94 showing suspension of deportation granted;

e. Non-citizens residing in the U.S. pursuant to an Order of Supervision: USCIS Form I-220B, I-688B coded 274a.12(c)(18);

f. Temporary Protected Status: I-94 "Temporary Protected Status" and/or I-688B employment authorization coded 274a.12(a)(12);

g. Deferred Enforced Departure: Letter from USCIS; I-688B coded 274a.12(a)(11);

h. Family Unity: USCIS approval notice, I-797, and/or I-688B coded 274a.13;

i. Non-citizens granted deferred action status: Letter indicating that the non-citizen's departure has been deferred and/or I-688B coded 274a.12(c)(14).

j. Non-citizens who have filed applications for adjustment of status whose departure the USCIS does not contemplate enforcing: Form I-94 or I-181 or passport stamped with either of the following : "adjustment application" or "employment authorized during status as adjustment applicant"; and/or I-688B coded 274a.12(c)(9).

3. To determine if the applicant was lawfully residing in the U.S. prior to 8/22/96 use the following:

a. Form I-94, date of admission;

b. If an applicant presents an USCIS grant letter or court order, derive date status was granted from the date of the letter or court order. If missing, contact USCIS to verify date of grant by filing Form G-845, attaching copy of document.

c. If employment authorization documents are presented, ask for I-94 or other USCIS documentation showing effective date of status. If not available contact USCIS by submitting Form G-845, attaching a copy of the document presented.

4. Expired or absent documentation:. If an applicant presents an expired USCIS document, a receipt indicating that s/he applied to USCIS for a replacement document, or is unable to present any document demonstrating his or her immigration status, further verification of current alien status must be obtained before eligibility can be established. The DHS worker offers to assist the applicant in obtaining the required documentation from USCIS. The applicant may decline this assistance, in which case eligibility is denied. Otherwise, the worker completes and files USCIS Form G-845 (secondary verification) along with the alien registration number, a copy of the expired document and a copy of photo I.D. (if available) with the USCIS office to verify status.

0304.05.45.15 Documentation of RI Residency Before 7/1/97

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Anyone of the following documents which are dated prior to 7/1/97 and contain the applicant's address at that time will meet the verification requirement:

1. Utility/telephone bills;
2. Rent receipt, lease, mortgage bill/receipt;
3. Tax receipts or tax records;
4. Insurance policy or insurance records;
5. Employment records/pay stubs;
6. USCIS documents;
7. Court records;
8. State agency records;
9. Medical dental records;
10. State-issued I.D. or license (drivers, professional, or recreational) showing issuance date;
11. School records; and
12. Other legal document; such as marriage license, will, etc.

B. Also acceptable as verification are contemporary documents attesting to the alien's residency prior to 7/1/97 signed by an authorized person. (Two collateral sources are necessary to meet verification requirement.)

1. Employer letter on company letterhead;
2. Agency (government or private) letter on agency letterhead;
3. Doctor/health care provider on appropriate letterhead;
4. Religious institution letter from authorized person;

5. Third party affidavit attesting to alien's residency prior to 7/1/97 and the basis for that knowledge.

C. Verification of RI residence at any time prior to 7/1/97 is sufficient; residence in RI need not be continuous.

0304.05.50 Eligibility as a Refugee

REV: October 2013

A. Under Section 207 of the INA, refugees are granted permission to enter and reside in the U.S. due to a well-founded fear of persecution in their home countries. Individuals apply for refugee status prior to entering the U.S. Refugees can apply for a status adjustment to LPR after one (1) year.

B. Refugees meet the immigration status requirement for Title XIX Medicaid regardless of date of entry into the U.S. Individuals who enter the U.S. as a refugee are not subject to the five (5) year bar on Title XIX eligibility, even if immigration status is subsequently adjusted to LPR.

0304.05.50.05 Verification of Refugee Status

REV:04/2010

A. Verification of refugee status includes:

1. USCIS Form I-94 annotated with stamp showing entry as a refugee under Section 207 of the INA and date of entry;

2. USCIS Form I-688B (or USCIS Employment Authorization Card) annotated 274a.12(a)(3);

3. USCIS Form I-766 annotated A3;

4. USCIS Form I-571;

5. USCIS Form 551 (Resident Alien Card) coded RE-6, RE-7, RE-8, or RE-9.

0304.05.55 Eligibility as an Asylee

REV: October 2013

Individuals already in the U.S. who have a well founded fear of persecution in their home countries may apply for asylum. A person granted asylum under Section 208 of the INA meets the immigration requirements for Title XIX Medicaid regardless of date of entry in to the U.S.

0304.05.55.05 Verification of Asylee Status

REV:04/2010

A. Anyone of the following unexpired forms is acceptable verification of asylee status:

1. USCIS Form I-94 annotated with stamp showing a grant of asylum;

2. Grant letter from the Asylum Office of the USCIS;

3. USCIS Form I-688B annotated with 274a.12.(a)(S);

4. USCIS Form I-766 annotated AS; or

5. Order from Immigration Judge granting asylum.

0304.05.60 Eligibility as Deportation Withheld

REV:01/2007

An individual whose deportation is withheld under Section 243(h) of the INA meets the immigration status requirement for Title XIX benefits regardless of date of entry into the U.S. The USCIS withholds deportation of these individuals because of a threat to life or freedom in the person's home country.

0304.05.60.05 Verification of Deportation Withheld

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Verification of deportation withheld includes any of the following unexpired documents:

1. Order from an Immigration Judge showing the date of a grant of deportation withheld under Section 243(h) of the INA;

2. USCIS Form I-688B (or USCIS employment authorization card) annotated 274a.12(a)(10); or

3. USCIS Form I-766 annotated A10.

0304.05.65 Eligibility as a Cuban/Haitian Entrant

REV: October 2013

Certain immigrants from Cuba and Haiti are granted special status as Cuban or Haitian Entrants. A Cuban or Haitian entrant as defined in Section 50l(e) of the Refugee Education Assistance Act of 1980 meets the immigration status requirement for Title XIX Medicaid regardless of date of entry into the U.S.

0304.05.65.05 Verification of Cuban/Haitian Status

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Verification of Cuban/Haitian Entrant Status includes:

1. USCIS Form 551 with codes CU6, CU7, or CH6.

2. Unexpired temporary I-551 stamp in a foreign passport or USCIS Form I-94 with codes CU6 or CU7.

3. USCIS Form I-94 with stamp showing the individual paroled as a Cuban/Haitian Entrant under Section 212(d)(5) of the INA.

0304.05.70 Eligibility as a Member of US Armed Forces/Veteran

REV: October 2013

A. Honorably discharged veterans and members of the U.S. Armed forces, their spouses and their unmarried dependent children meet the immigration status for Title XIX Medicaid regardless of date of entry into the U.S.

B. Veterans honorably discharged due to immigration status do not qualify under this category.

C. LPRs who are honorably discharged veterans, members of the U.S. Armed forces, or the spouse or unmarried dependent child of an honorably discharged veteran or member of the U.S. Armed Forces, are not subject to the five (5) year ban on Title XIX eligibility, but are subject to the deeming of income and/or resources from their sponsor(s) when entering the U.S. on or after 8/22/96 under the new affidavit of support. See Section 0304.05.90 for a detailed discussion on deeming.

0304.05.70.05 Verification of Veteran/US Armed Forces

October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. Verification of veteran/U.S. Armed Forces status includes:

1. Original or notarized copy of U.S. discharge certificate (DD Form 214) that shows CHARACTER OF SERVICE as "Honorable" and does not show in the NARRATIVE REASON FOR DISCHARGE entry, that the discharge was based on immigration or alien status, lack of U.S. citizenship, or other reasons related to "alienage."

2. Original or notarized copy of current orders showing full time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard; or

3. Current Military Identification Card.

B. Verification for spouse or unmarried dependent child includes:

1. Anyone of the above together with proof of relationship (e.g., marriage certificate, birth certificate, baptismal certificate, or medical or school records).

0304.05.75 Eligibility as a Parolee

REV: October 2013

A. Individuals who have been paroled into the U.S. for at least one (1) year have authorization to remain in the U.S. at the discretion of the U.S. Attorney General. Generally, parole is granted for emergency reasons, such as to obtain medical care or for other reasons determined to be in the public interest.

1. Individuals paroled into the U.S. for at least one (1) year prior to 8/22/96 meet the immigration status for Title XIX Medicaid.

2. Parolees entering the U.S. on or after 8/22/96 are subject to the five (5) year ban on Title XIX eligibility and are ineligible for Title XIX benefits (with the exception of emergency services) for a period of five (5) years from their date of entry. After the five (5) year ban, they meet the Title XIX immigration status requirement, and if otherwise eligible, may receive benefits.

B. Parolees under the age of nineteen (19) who are otherwise eligible aliens lawfully residing in United States may be eligible for Medicaid under Title XIX or XXI and are not subject to the five (5) year ban.

0304.05.75.05 Verification of Parolee Status

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

An USCIS Form I-94 annotated with a stamp showing grant of parole under 212(d)(5) of the INA and a date showing granting of parole for at least one (1) year is acceptable verification of this status.

0304.05.80 Eligibility as an SSI Recipient

REV: October 2013

Under provisions of Public Law 105-306, SSI benefits, and associated Title XIX Medicaid were continued for "non-qualified" aliens who were lawfully residing in the U.S. and receiving SSI on 8/22/96.

0304.05.85 Eligibility as a Victim of Trafficking

REV: October 2013

A. The Victims of Trafficking and Violence Protection Act of 2000 (PL 106-38) was enacted in October 2000 to combat, through increased law enforcement, the trafficking of human beings:

1. To ensure effective punishment of traffickers,

2. To protect victims, and

3. To provide certain Federal and State assistance to victims.

B. An individual certified by the U.S. Department of Human Services (HHS) Office of Refugee Resettlement pursuant to Section 107(b) of the Victims of Trafficking and Violence Protection Act of 2000, as a victim of a severe form of trafficking meets the citizenship/immigration status requirement for Title XIX Medicaid. Individuals so certified may qualify for Medicaid without regard to the victim's actual immigration status or date of entry into the U.S.

0304.05.85.05 Verification of Victim of Trafficking Status

REV: October 2013

Effective January 1, 2014, acceptable verification is as set forth in Section 1308.04 for MACC groups identified in Section 1303. For all other Medicaid coverage groups appropriate documentation is as follows until further notice.

A. The HHS Office of Refugee Resettlement is responsible for determining that an individual is a victim of a severe form of trafficking and, therefore, potentially eligible for Medicaid.

1. ORS issues a certification letter to adults and a letter of benefit eligibility pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000 to children under eighteen (18) years of age.

   i. For adult, the ORS certification letter is proof of qualified non-citizen status.

   ii. For children under age eighteen (18), the ORS letter of benefit eligibility is proof of qualified non-citizen status.

0304.05.90 Sponsor Deeming

REV: October 2013

Effective January 1, 2014, sponsor deeming is no longer required for MACC groups identified in Section 1303. For all other Medicaid coverage groups sponsor deeming is as follows until further notice.

Under deeming provisions, the income and resources of the sponsor(s) are counted as available and received, even if not in fact received, by the applicant. Income and resources of the sponsor(s) and of the sponsor's spouse (when living together) are counted when determining the income and resources of the non-citizen applicant.

1. Deeming applies ONLY to Lawful permanent residents (LPR) who:

   a. Entered the U.S. or were granted LPR status on or after 12/19/97; and

   b. Were sponsored by an individual or individuals (family-based immigrants and some employment based immigrants whose employer is a family owned business); and

   c. Whose sponsors signed new, legally binding affidavits of support (USCIS form 1-864).

2. Deeming continues until the individual:

a. Attains U.S. citizenship; or

b. Can be credited with forty (40) quarters of work as defined under Title II of the Social Security Act, provided that no credit is given for any quarter after 12/31/96 in which any federal means tested benefit was received. Immigrants may be credited with quarters from their own employment, their spouse's employment, and their parent's employment. Verification of qualifying quarters must be obtained from Social Security Administration records. A written statement, signed by the applicant under penalty of perjury, may be used as temporary verification of quarters worked while awaiting information requested from Social Security.

B. Deeming provisions may be waived for a period for one (1) year when sponsored immigrant can demonstrate that:

1. They or their children have been battered or subjected to extreme cruelty while in the U.S. by certain persons who were living in the same household

a. Documentation of abuse in the U.S. includes but is not Limited to:

i. an approved USCIS petition

ii. restraining order

iii. third party affidavit, signed affidavit from the applicant, or school

iv. medical, public or private agency records.

2. The battery has a substantial connection to the need for Medicaid benefits

a. to enable the immigrant or the immigrant's child to become self-sufficient following separation from the abuser;

b. to enable the immigrant or immigrant's child to escape the abuser or the community where the abuser lives, or to ensure the safety of the immigrant or child from the abuser;

c. due to a loss of income suffered as a result of separation from the abuser;

d. because the immigrant or child is disabled as a result of the abuse;

e. to provide medical care for pregnancy resulting from the abuser's sexual assault of, or relationship with the immigrant, the immigrant's child or to care for any resulting children; or

f. to replace medical coverage or resources the immigrant or child had when living with the abuser.

3. He/she is indigent, meaning that the immigrant's own income and assistance provided by the sponsor or any other individuals is not enough for the immigrant to obtain food and shelter without assistance. An immigrant is considered "indigent" if the sum of the immigrant's household's own income and any cash or in-kind assistance provided by the sponsor or others is less than one hundred thirty percent (130%) of the poverty income line. The amount of the

income and resources attributed to the non-citizen through deeming cannot exceed the amount actually provided for up to a twelve (12) month period.

a. In this case, only the income and resources actually provided by the sponsor or the sponsor's spouse are counted in the determination of Medicaid eligibility.

b. However, DHS must provide the United States Citizenship and Immigration Services (USCIS) with the name of the sponsor and the sponsored immigrants receiving Medicaid under this provision, and the sponsor has the obligation to reimburse the Department for any benefits paid, with the exception of payments made for emergency services.

C. A twelve month waiver can be renewed in the following situation:

1. if the immigrant demonstrates that the battery or cruelty has been recognized in the order of a judge or administrative law judge or a prior determination of the USCIS and the Department agrees that the need for Medicaid benefits remains the same.

2. If the immigrant continues to present that he/she is indigent, as defined in B-3 above.

D. Deeming provisions do not apply to eligibility determinations for emergency services.

E. The methodologies for determining the amount of income and resources deemed to the sponsored immigrant are described in Sections 0330 (family related income), 0366 (SSI related-income), 0388 (LTCincome), 0338 (family related resources), 0356 (SSI related resources), 0382 (LTC resources).

0304.10 Residency Requirement

REV: October 2013

The Medicaid Program exists primarily to meet the needs of residents of the Rhode Island. Therefore, as a factor of eligibility, an individual who is applying for eligibility must be a resident of the state. Any person living in the state voluntarily and intending to make Rhode Island his/her home, for whatever reason, is a resident of the state.

0304.10.05 Medicaid Residency Requirements

REV: October 2013

The residency definitions apply to SSI individuals, Medicaid individuals who are aged, blind or disabled age 21 and over, Medicaid individuals under twenty one (21), and institutionalized Medicaid individuals.

0304.10.05.05 SSI Individual

REV:06/1994

For an individual eligible for SSI and receiving a State Supplementary Payment (SSP), the State of Residence is the state paying the SSP. (In some instances, a person may have sufficient income to receive only the State Supplement.)

0304.10.05.10 Medicaid Affordable Care Coverage Groups

REV: October 2013

See MCAR Section 1305 for the applicable residency requirements for the Medicaid Affordable Care Coverage groups identified in MCAR Section 1303, effective January 1, 2014. Verification procedures are set forth in MCAR Section 1308.

0304.10.05.25 Institutionalized Medicaid Individual

REV: October 2013

A. For Medicaid individuals living in institutions, applying for Medicaid (Public, Medical or Group Care Facilities), the State of Residence is as follows

1. If a state places an individual in an institution in another state, the state making the placement is the State of Residence, irrespective of the individual's indicated intent or ability to indicate intent; otherwise,

2. If over 21, the State of Residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period; however,

3. If the individual is under 21 (or is age 21 or older and became incapable of indicating intent before age 21), the State of Residence is:

   a. that in which his/her parent(s) or legal guardian, if one had been appointed, resides; or

   b. that of the parent applying on the individual's behalf if the parents reside in separate states and no legal guardian has been appointed.

4. If the individual became incapable of indicating intent at, or after age 21, the State of Residence is the state in which the individual was living when (s)he became incapable of indicating intent. If this cannot be determined, the State of Residence is the state in which the individual was living when (s)he was first determined to be incapable of declaring intent.

B. In any case, the state in which the institution is located is the State of Residence unless that state determines that the individual is a resident of another state according to the above rules.

0304.15 Requirement for Social Security Number

REV: October 2013

A. Section 2651 of the Deficit Reduction Act (DEFRA) of 1984 (PL98-369) requires that each individual (including children) requesting Medicaid furnish his or her own Social Security Number (SSN) as a CONDITION OF ELIGIBILITY for the program.

1. Applicants/recipients receiving Social Security benefits through claim numbers, the Social Security number of a parent or spouse with a letter(s) suffix, must procure their own SSNs.

2. Applicant/recipient must be notified that the furnishing of the SSN is a condition of eligibility and that the number will be utilized only in the administration of the Medicaid Program, including its use in verifying income and eligibility.

0304.16 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

0306 Characteristic Requirements

0306.05 Characteristic Requirements for Individuals & Couples

REV: October 2013

Characteristic requirements are SSI-related. The term "SSI-related" refers to the methodology to be used for evaluating the individual's or the couple's income and resources, and the standards to be met for Medicaid eligibility. Thus, an individual or couple who applies for Medicaid may be eligible for one of the SSI-related coverage groups if s/he possesses an SSI-related characteristic and has limits and resources within the limits required for Medicaid eligibility.

The SSI-related characteristics are:

- Age (65 years old and older);
- Blindness; or
- Disability.

0306.05.05 SSI-Related Age Requirement

REV: October 2013

An individual applying for Medicaid on the basis of the SSI-related characteristic of age must be 65 years of age or older. The age as stated on the application must be verified. Appropriate sources of verification are:

- Birth certificate;
- Birth record of a child over 50 as evidence that the parent is over 65;
- Birth record of child where age of parent is recorded;
- Marriage certificate; or
- Other documents such as insurance policies, passport or naturalization papers, employment, school, military or alien registration records.

0306.05.10 Eligibility Based on Blindness

REV:06/1994

To be eligible on the basis of blindness, the individual's (adult or child) vision must meet the policy definition: in terms of ophthalmic measurement, central vision acuity of 20/200 or less in the better eye with corrective lenses, or a field defect in which the peripheral field is contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees.

0306.05.15 Eligibility Based on Disability

REV: October 2013

To be eligible for Medicaid because of permanent or total disability, a person (adult or child) must have a permanent physical or mental impairment, disease or loss, other than blindness, that substantially precludes engagement in useful occupations within his/her competence.

A physical or mental impairment is an impairment which results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable, clinical and laboratory diagnostic techniques.

For purposes of eligibility, an individual is disabled if s/he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted, or can be expected to last for a continuous period of not less than twelve (12) months or, in the case of a child, if s/he suffers from any medically determinable physical or mental impairment of comparable severity.

Statements of the applicant, including the individual's own description of the impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment.

0306.10 Charact Reqs for Families See Section 1301

Repealed October 2013

0306.10.10 Relationship Requirement

Repealed October 2013

0306.10.15 Deprivation of Parental Support

Repealed October 2013

0306.10.20 Exceptions to the Req of an AFDC Charact

Repealed October 2013

0306.11 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

0308 Cooperation Requirements

0308.01 Applicability

REV: June 2014

Unless otherwise stipulated herein, the provisions in this section do not apply to the individuals and families in the Medicaid Affordable Care Coverage (MACC) Groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid affordable coverage groups included in section 1301 are located in MCAR section 1303.

0308.05 Applicant Required to Cooperate

REV: October 2013

As a condition of eligibility, the Medicaid applicant must meet certain cooperation requirements. These requirements include:

- Providing the information needed for an eligibility determination;
- Assignment of rights to medical support or other third party payments for medical care to the state;
- Cooperating in establishing paternity and obtaining support (an exception exists for pregnant women with no other children, pregnant women are not required to cooperate with Child Support Enforcement until the birth of the child);
- Cooperating in identifying and providing third party liability information;
- Making resources available and utilizing resources;
- Cooperating in Quality Control procedures;
- Enrollment in cost effective employer-sponsored health insurance through the RIte Share Premium Assistance Program (Section 1312).

0308.10 Assignment of Rights

REV: October 2013

By applying for Medicaid, the applicant makes an assignment of his/her rights to any medical support available under an order of a court or an administrative agency to the state. The applicant also assigns to the EOHHS any third party payments for medical care and payments for any other individual eligible under the Medicaid State Plan for whom he/she has the legal authority under State law to make an assignment. This assignment is automatic under State law upon an applicant's filing for Medicaid.

0308.10.05 Cooperation in Establishing Paternity & Obtaining Support

REV: October 2013

Except for poverty level pregnant women, the applicant must cooperate in establishing the paternity of a child born out of wedlock for whom the applicant can legally assign rights and in obtaining

medical care support and medical care payments for himself/herself, as well as for any other person for whom the individual can legally assign rights.

0308.10.10 Cooperation in Identifying & Providing Third Party Liability (TPL) Information

REV: October 2013

The applicant must cooperate in identifying and providing information to assist the EOHHS and Department of Human Services in pursuing any third party which may be liable to pay for care and services available under the plan. Individuals are not required to pursue collections themselves; pursuit is the responsibility of the provider or the State.

As part of this cooperative relationship, the agency may require an individual to:

- Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;
- Appear as a witness at a court or other proceeding;
- Provide information, or attest to lack of information, under penalty of perjury;
- Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and
- Take any other reasonable steps to assist in establishing paternity and securing medical support and payments and in identifying and providing information to assist the State in pursuing any liable third party.

0308.15 Requirement to Utilize Resources

REV: 06/1994

Clients are required, as a condition of eligibility, to take all reasonable actions to make income/resources available to meet needs. A reasonable action is one that will likely result in more financial benefit accruing to a household than the cost of obtaining the benefit. Reasonable actions also include the requirement to file applications for other benefits to which the individual is entitled. The individual must make a good faith effort to bring the resources or income into a state of availability.

The actions which may be required of clients to make income/resources available include, but are not limited to:

- Formal written requests to other joint owners to sell otherwise liquidate jointly held property;
- Formal written requests to guardians, trustees, etc. to make resources or income available from estates, trusts, settlements, etc.;
- Retention of counsel to petition a court to adjudicate any monetary or property claim which the client may have against any person;

- Periodically (at least quarterly) report to the agency on the progress being made toward making the resource or income available for use. For eligibility to continue to exist, the client must continue to show a good faith effort to obtain resources or income.

0308.15.05 District Office Procedures When Unavailable
REV: October 2013

District Office staff must identify sources of income or resources which are not currently available to the client. If the income or resource would, in addition to other income or resources, render the case ineligible, further action is needed.

Staff must obtain all available documentation regarding the item, and refer the case to the Chief Supervisor or Regional Manager (or the Administrator of Long Term Care or his/her designee) for determination as to the availability of the resource or income.

Copies of all relevant documents relating to the resource, such as trust documents, settlement agreements, account agreements and statements, deeds, etc. should accompany the referral memo.

The Office of Legal Counsel is available to assist the Regional Manager in the determination of the current availability of the income or resource. The Regional Manager or LTC Administrator, in consultation with the Office of Legal Counsel, determines the action(s) that the client must take to make the income or resources available, and the time frame for taking the action(s).

If the income or resource in question is determined to be unavailable and the client agrees to take the action prescribed by the Office of Legal Counsel, the resource is not countable.

Eligibility exists if the case is otherwise eligible. It is the responsibility of the District Office staff to track and review such cases to assure that the client takes the required actions in a timely manner, and that any periodic reporting requirement is met.

Periodic reports, if required, are forwarded to the Office of Legal Counsel for review to assure that continuing eligibility exists.

0308.20 Applicant's Pursuit of Other Benefits
REV: 06/1994

It is important to assess the other benefit programs available to help those in need. These may be programs for which an individual is eligible based on his or her own activities or based on indirect qualification through family circumstances.

0308.20.05 Availability of Other Program Benefits
REV: October 2013

Other program benefits for which an individual must file, upon written notification, include annuities, pensions, RSDI benefits (e.g., retirement, disability, widows, parents' benefits), and payments similar to those discussed below. These benefits have the following characteristics in common:

- They require an application or similar action;

- They have conditions for eligibility;
- They make payments on an ongoing or one-time basis; and
- They are sources of income that increase countable income.

The client must file for benefits which will increase his/her countable resources or income. Such benefits include:

- RSDI Benefits;
- Veterans' Pension and Compensation Payments;
- Workers' Compensation Payments;
- Pensions;
- Unemployment Insurance Benefits;
- Temporary Disability Benefits; and
- Earned Income Tax Credits (EITC).

The client is not required to file for benefits that are welfare payments based on need, or for benefits that will not increase his/her countable income or resources. Such benefits are:

- RI WORKS;
- General Public Assistance;
- Bureau of Indian Affairs General Assistance; and
- Other Federal, State, local or private programs whose payments are disregarded in the determination of eligibility.

0308.20.10 Requirement to Pursue Other Benefits

REV: October 2013

A client cannot be eligible for Medicaid benefits if (s)he is advised in a written, dated notice, of potential eligibility for other benefits; and (s)he does not take all appropriate steps to file for and, if eligible, obtain any such payments within 30 days of receipt of such notice.

A client must take all appropriate steps to pursue eligibility for other benefits. If the type of benefit for which a claimant/recipient must file offers a choice about the method of payment, the client must file for all benefits payable in the highest amount available.

Taking appropriate steps includes:

- Applying for the benefit; and

- Providing the other benefit source with necessary information to determine eligibility for the benefit.

Where a client files for the other benefit but does not pursue the claim, he/she is not eligible for Medicaid.

A client is not required to pursue a claim for other program benefits through the appeals process.

0308.20.15 Good Cause for Not Pursuing Other Benefits
REV: October 2013

An individual is eligible for Medicaid despite failure to apply for other benefits within the 30-day period or take other necessary steps to obtain them if there is good cause for not doing so. For example, there is good cause if:

- The individual is unable to file for other benefits because of illness; or

- It would be useless to apply because the other program has already turned down the individual for reasons that have not changed.

0308.21 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

0310 Retroactive Coverage

0310.01 Applicability

REV: June 2014

The provisions in this section do not apply to the individuals and families in the Medicaid Affordable Care Coverage (MACC) Groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid Affordable Coverage Groups included in section 1301 is located in MCAR section 1303.

0310.05 Retroactive Coverage Defined

REV: October 2013

Medicaid beneficiaries who meet the SSI-related eligibility criteria may request retroactive eligibility for UP TO THREE (3) MONTHS PRIOR TO THE MONTH OF APPLICATION. To obtain retroactive coverage, applicants must meet all eligibility criteria during the retroactive period.

Retroactive coverage is also available to IV-E and non IV-E foster children and adoption subsidy family-related coverage groups.

The following chart details the family-related coverage groups who are eligible/ineligible for retroactive services:

Coverage Group	*Eligible For Retro*
IV-E and non IV-E Foster Children	Y
Adoption Subsidy Children Coverage Groups	Y
SSI-related coverage groups categorically or medically needy	Y
Non-citizens who are ineligible for ongoing Medicaid due to immigration status - All coverage groups	Y

At the time of application for Medicaid, if the applicant indicates that an unpaid medical bill was incurred in the three month period preceding the application, eligibility for retroactive coverage must be determined.

Current eligibility for SSI, RI WORKS, or Medicaid does NOT affect retroactive eligibility. Individuals who are denied SSI, RI WORKS, or Medicaid in the month of application may be eligible for retroactive coverage.

An applicant need not be alive when an application for retroactive coverage is filed.

Retroactive eligibility is not available to persons who were not residents of Rhode Island in the retroactive period and at the time the service was provided.

0310.10 Eligibility Requirements

REV: October 2013

Retroactive coverage applies only to unpaid medical bills for services provided within the scope of the Medicaid Program. The medical bills must have been incurred during the three month

retroactive period. The applicant must meet Medicaid eligibility requirements for each month in which an unpaid medical bill was incurred. Thus, retroactive eligibility may be determined for one, two, or three months of the retroactive period.

ONLY THE INCOME AND RESOURCES AVAILABLE TO THE APPLICANT IN THE RETROACTIVE PERIOD ARE USED TO DETERMINE ELIGIBILITY.

All services are subject to the same Title XIX utilization review standards as all other medical services of the Medicaid Program.

0310.15 Procedures for Determining Retroactive Eligibility

REV: October 2013

In determining retroactive eligibility, the applicant's net income (after allowable deductions and disregards) and resources are compared to Medically Needy limits UNLESS the unpaid medical bill is for Categorically Needy service only. In this case, eligibility must be based on the applicable Categorically Needy limits.

To determine retroactive eligibility, complete the following:

- Verify that the bill is unpaid and is for a covered service provided within the three (3) months prior to the first of the month of application for SSI, RI WORKS, or Medicaid.

- Establish eligibility based on:

    - Residence
    - Characteristic (if required)
    - Relationship (if required)
    - Citizenship or alienage; and at the time of application, the applicant must fulfill cooperation and enumeration requirements.

- Compare the resources and net income (after allowable deductions and disregards) to the appropriate income limit for the month(s) in which there is a verified, unpaid bill(s) (income limits refer to Categorically Needy income limits, Medically Needy income limits and Low Income Aged and Disabled income limits). Resources must be within the applicable resource limit as of the first day of each month for which eligibility is being determined.

- Determine whether retroactive coverage is available to individual's coverage group.

- If eligible, certify the case for the month or months of eligibility. Retroactive eligibility is for one (1), two (2), or all of the three (3) months immediately preceding the month of application.

- If the income exceeds the Medically Needy Income Limits apply the Flexible Test of Income. If the Flexible Test of Income results in achieving Medicaid retroactive eligibility, only those bills not applied to excess income are authorized for retroactive coverage.

If the bill is for a service not provided under the Medically Needy scope of services, the application must be determined for eligibility as Categorically Needy.

- If an unpaid bill is for a Categorically Needy service and the applicant's income exceeds the Categorically Needy Income Limits, the application for retroactive eligibility is denied. There is no Flexible Test of Income for income in excess of the Categorically Needy Income Limits.

- If unpaid bills for both Medically Needy and Categorically Needy services are submitted, the applicant must be found eligible as Categorically Needy or the bill(s) for the Categorically Needy service(s) must be denied. If the individual is eligible as Medically Needy, only the bill(s) for Medically Needy services can be authorized for retroactive coverage.

0310.20 Authorization of Retroactive Eligibility

REV: October 2013

Retroactive eligibility is determined on a month by month basis.

No bill can be paid unless it is submitted by the provider and received by the Medicaid agency WITHIN TWELVE (12) MONTHS OF THE DATE THE SERVICE AS PROVIDED.

A copy of each medical bill or other verification that a medical expense exists during the retroactive period must be included in the case record to support the decision on the application.

0310.21 Severability

October 2013

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

Medicaid

Section 0311

INTERCEPTION OF INSURANCE PAYMENTS

September 4, 2012

0311 INTERCEPTION OF INSURANCE PAYMENTS

0311.05 LEGAL BASIS

EFF:09/2012

In accordance with state law and applicable administrative rules, when applying for Medicaid, an applicant automatically assigns his/her rights to the Executive Office of Health and Human Services, the RI Medicaid state agency, any third party payments from insurers. Nothing in these sections shall limit the Executive Office of Health and Human services from recovery of any other monies allowed, to the extent of the distribution, in accordance with all state and federal laws.

0311.10 PROCESS

EFF:09/2012

Every domestic insurer or insurance company authorized to issue policies of liability insurance and any worker's compensation insurer, shall review information provided by the Executive Office of Health and Human Services, pursuant to R.I.G.L. chapter 27-57.1, indicating whether or not the claimant has received Medicaid funded services as a result of an accident or loss which is the basis of the claim. Said review shall occur within thirty (30) days prior to making any payment equal to or in excess of five hundred dollars ($500.00) to any claimant who is a resident of this state, for personal injury or workers' compensation benefits under a contract of insurance

The Executive Office of Health and Human Services shall electronically furnish these insurers and insurance companies with a database data match option report of names of individuals with last known addresses, as of the date of the report, who have received Medicaid in excess of five hundred dollars ($500).

To facilitate the efficient and prompt reporting of those Medicaid beneficiaries in one centralized location, the duty and responsibility of the insurance companies doing business is as follows:

- Utilize one centralized database, to which the Executive Office of Health and Human Services shall report and administer.

- Any insurer receiving information identifying a Medicaid beneficiary shall maintain the confidentiality of that information to the full extent required under federal and state law. Minimal data elements, including, but not limited to, the date of injury and other necessary identifying information, shall be shared with an agency contracted by the Executive Office of Health and Human Services which maintains a centralized database of insurance claims.

- The contracted centralized database is required to keep confidential: any personal and personnel information; records sufficient to identify a person applying for or receiving Medicaid; preliminary drafts, notes, impressions, memoranda, working papers, and work products; as well as any other records, reports, opinions, information, and statements deemed confidential pursuant to state or federal law or regulation, or rule of

court. Any such confidential data shall not be disclosed to the insurer.

- Matched results indicating that a beneficiary is a claimant of an insurer are returned to the Executive Office of Health and Human Services through its contracted agency. Proper quality assurance shall be performed by the contracted agency to insure the claim is open. The contracted agency may also collect additional information from the insurer including but not limited to contact information.

If the insurer determines from the information provided by the Executive Office of Health and Human Services, pursuant to R.I.G.L. 27-57.1-4, that the claimant or payee has received Medicaid funded services, as a result of an accident or loss which is the basis of the claim, the insurer shall, except to the extent that payments are subject to liens or interests (i.e. health care providers, attorney fees, holders of security interests, or the assignment of rights under R.I.G.L. 40-6-9 and 40-6-10), withhold from payment the amount to the extent of the distribution for Medicaid as a result of an accident or loss, dating back to the date if the incident. The insurer shall pay such amount to the Executive Office of Health and Human Service and shall pay the balance to the claimant or other entitled person. Workers' compensation claimants who receive Medicaid, provided in accordance with chapter 40-8, shall be subject to the provisions of R.I.G.L. 27-57.1. The workers' compensation reimbursement payments made to the Executive Office of Health and Human Services in accordance shall be limited to that set forth in chapter 28-33 and section 40-6-10.

0311.15 NOTICE

EFF:09/2012

The Executive Office and Health and Human Services shall provide written notice to the insurer, claimant and his/her attorney, if any, which shall include the date, name, social security number, case number, total amount of the payment proposed to be withheld to reimburse the state for Medicaid funded services and a list of the items and services, including dates of service for which reimbursement is sought. The notice shall explain the right to request a hearing pursuant to section 0311.20.

0311.20 REQUEST FOR HEARING

EFF:09/2012

Any payments made by an insurer pursuant to this chapter, shall be made to the Executive Office of Health and Human Services, unless there is a request for an administrative hearing by the claimant. Any claimant aggrieved by any action taken under these procedures may, within thirty (30) days of the date of the notice to the claimant, request an administrative hearing from the Executive Office of Health and Human Services. If there is an administrative hearing, the insurer must remit payment within ten (10) business days of and in accordance with the hearing decision.

0311.25 PAYMENT BY INSURER

EFF:09/2012

The insurer shall make any payments required, pursuant to this chapter, to the Executive Office of Health and Human Services, thirty (30) days after the date of notification to the claimant or his/her attorney. Provided, however, that if the claimant has requested a hearing, payment shall not be made until ten (10) days after the hearing decision and in accordance with the hearing decision.

0312 LIENS & RECOVERY OF MA PAYMENTS

0312.05 LEGAL BASIS

REV: 11/2012

To conform with federal mandates enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and Rhode Island law (section 40-8-15 as amended June 30, 1995), lien and recovery policy is modified to apply to the estates of recipients, whether categorically or medically needy, fifty-five (55) years of age or older at the time of receipt of Medicaid.

Under previous provisions of state law and the Department of Human Services (DHS) Manual, liens had applied to medically needy recipients, sixty-five (65) years of age and older, as of May 18, 1982 and to categorically needy recipients, sixty-five (65) years of age and older, as of June 1, 1994.

Rhode Island General Law 40-8-15 was again amended in 2012 by the 2013 state budget article (House Bill 7323 Aaa). Effective July 1, 2012, a lien shall attach against property, which is included or includable in the decedent's probate estate, regardless of whether or not a probate proceeding has been commenced in a probate court. Such a lien shall only be effective upon proper prior notice and if the lien is recorded in the land evidence records in accordance with section 40-8-15. The July 1, 2012 amendments also impact notice provisions for: (a) liens filed by the Executive Office of Human Services (EOHHS); and (b) notice to EOHHS upon the filing of a probate estate.

The notice and affidavit provisions of this section apply to all probate proceedings commenced on or after July 1, 2012. All probate estates filed before July 1, 2012 are subject prior notice provisions to the State of Rhode Island the extent provided by law. Nothing in this section shall be interpreted to mean that a probate estate filed before July 1, 2012 is not subject to recovery to the extent of the distribution of Medicaid.

This section, as it applies to all probate proceeding of a decedent aged fifty-five (55) or older, shall include voluntary informal probate proceedings and any references to an executor or administrator shall include, without limitation, a voluntary executor or voluntary administrator.

APPLICATION OF THE LIEN

REV: 11/2012

The lien shall apply to the individual's estate which includes all real and personal property and other assets that are included or includable within the individual's probate estate. Consequently, an individual's probate estate may be comprised of liquid assets as well as real property, including any resources remaining at the time of death which were allowable in the individual's Medicaid eligibility determination. For example, the lien would apply to the previously allowable $4,000 resource (medically needy resource standard).

Other than as provided in section 0312.12, a lien cannot attach to assets which are not the subject of a probate estate initiated within the State of Rhode Island, or in any other state in which the individual was a domiciliary. For example, real or personal property which passes by operation of law, (e.g., passes to a surviving joint tenant(s) or the surviving tenant by the entirety) or passes to

beneficiaries under a contract, deed, annuity, or other instruments such as trust agreements or insurance policies, or any other property which does not require the initiation of a probate process to convey title or beneficial interests or ownership to others, is excluded from the lien process. For other forms of investment or when an asset is in question, the Legal Unit at Central Office may be consulted.

The lien shall attach against property of a recipient, which is included or includable in the decedent's probate estate, regardless of whether or not a probate proceeding has been commenced in the probate court by the Executive Office of Health and Human Services or by any other party. Provided, however that such lien shall only attach and shall only be effective against the recipient's real property included or includable in the recipient's probate estate upon proper prior notice and if such lien is recorded in the land evidence records and is in accordance with section 40-8-15. Decedents who have received Medicaid are subject to the assignment and subrogation provisions of sections 40-6-9 and 40-6-10.

The lien for the recovery of Medicaid expenditures:

- Does not attach during the recipient's lifetime;
- Does not attach to any real or personal property that is not included or includable in the deceased Medicaid recipient's probate estate.

The lien for the recovery of Medicaid expenditures:

- Does cover all periods of receipt of Medicaid from and after age fifty-five (55).
- The recipient does not have to be receiving Medical Assistance at the time of death.
- Does attach at death to all assets included or includable within the individual's probate estate. That is, any and all assets that are subject to Probate or to assets where there is no probate due to the use of the Rhode Island "small estates" statute (RIGL Chapter 33-24-1, *et seq*).
- Does attach to and remain a lien upon the estate property, whether or not the property is transferred, and upon all property acquired by the executor or administrator in substitution therefore while that property remains in his or her hands until the Medicaid is paid, but the lien shall not affect any tangible personal property or intangible personal property after it has passed to a bona fide purchaser for value. If there are questions concerning the passage to a bona fide purchaser, the case will be referred to the EOHHS Legal Office as referenced in section 0312.12.
- Notice of said lien shall be sent to the duly appointed executor or administrator, the decedent's legal representative, if known, or to the decedent's next of kin or heirs at law as stated in the decedent's last application for Medicaid, thirty (30) days prior to filing in the land evidence records. Said notice shall include appeal rights as noted in section 0312.35.05.

0312.12 REQUIREMENTS FOR TRANSFER/SALE OF PROPERTY

REV: September 2015

Whenever an individual who is receiving Medicaid, transfers an interest in real or personal property

on or after July 1, 2012, such individual shall notify the Executive Office of Health and Human Services within ten (10) days of the transfer:

EOHHS Legal Office, Hazard Building
74 West Road, Building #74
Cranston, RI 02920

Such notice shall also be sent to the individual's local office. The notice shall include, at a minimum, the individual's name, social security number or, if different, the Executive Office of Health and Human Services (EOHHS) identification number, the date of transfer and the dollar value, if any, paid or received by the individual who received benefits under this chapter, and the name of the person and relationship of the person to whom the transfer was made.

In the event a Medicaid recipient fails to provide the required notice of the transfer to the EOHHS and in the event the recipient, his/her guardian, conservator or agent under a power of attorney, if applicable, his/her spouse and/or immediate family members knew or should have known that such individual failed to provide such notice and that person(s) receives any distribution of less than fair market value as a result of the transfer, he or she shall be liable to the EOHHS to the extent of the uncompensated value of the transfer, up to the amount of Medicaid benefits paid on behalf of the recipient.

Moreover, any such individual shall be subject to the provisions of RIGL section 40-6-15 and any remedy provided by applicable state and federal laws and rules and regulations. Failure to comply with the notice requirements set forth in the section shall not affect the marketability of title to real estate transferred.

0312.15 EXCEPTIONS TO THE LIEN

REV: 01/2002

A lien SHALL NOT apply:

1. For periods of receipt of Medicaid before the recipient reached the age of fifty-five (55).
2. If the recipient is survived by:
   a. A spouse; or,
   b. A child who is under the age of twenty-one (21);or,
   c. A child who is blind or permanently and totally disabled as defined in Title XVI (SSI) of the Social Security Act.

An individual who is a survivor of the deceased recipient, as described above, need not be residing in property of the estate or be a beneficiary of the estate.

Receipt of SSI, RSDI or Railroad Retirement (RR) benefits is acceptable evidence of disability. However, if the child is not in receipt of such benefits, the characteristic of disability must be determined by the Office of Medical Review located at Central Office.

Staff is to specify on the AP-65 that the purpose of the referral is to determine whether the child qualifies as a disabled child, thus exempting the parent from the lien provision.

0312.15.05 REDUCTIONS OF THE LIEN UNDER QLTCIP PROGRAM

REV: 07/2008

RI has established a Qualified Long Term Care Insurance Partnership (QLTCIP) program.

This Qualified LTC Insurance Partnership provides:

1. For the disregard of a Medicaid applicant's resources in an amount equal to the benefits paid by their QLTCIP policy as of the time of their application for Medicaid; and

2. For the total amount paid by the individual's QLTCIP policy at the time of death to be disregarded in the determination of the amount to be recovered from a beneficiary's estate.

The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination. (There may be continuing QLTCIP policy payments after Medicaid eligibility is established, so if the person later gains assets, he/she may have more protected than he/she had at the time of eligibility.

Thus, the total amount paid by the individual's QLTCIP at the time of death is to be disregarded in the determination of the amount to be recovered from a beneficiary's estate).

0312.20 CLIENT NOTIFICATION

REV: 04/1998

During application for Medicaid for the individual who is fifty-five (55) or older at the time of application or who will turn fifty-five (55) before recertification, the individual, or his/her representative, must be advised that, under Rhode Island law, receipt of Medicaid may constitute a lien upon his/her estate. Similarly, at recertification for Medicaid for an individual who is fifty-five (55) years of age or older or who will become fifty-five (55) before the next recertification, it must be explained to such individual that the lien is an attachment against the individual's estate, taking effect at death, which allows the Executive Office of Health and Human Services to recover from the individual's estate any Medicaid paid on behalf of the individual from the time s/he became fifty-five (55) years of age (and after the effective date of the law). The exceptions in Section 0312.15 relative to certain survivors must be explained to the applicant.

0312.25 PROCEDURES

REV: 01/2002

When an individual aged fifty-five (55) or older is found eligible for Medicaid, the Eligibility Technician/LTC social caseworker completes the sections on the MA-89M pertaining to the recipient's resources and family information.

The MA-89M is filed in the case record. At each recertification, the MA-89M is reviewed with the recipient and the information is revised as needed. The MA-89M remains filed in the case record and used only in event of the individual's death.

0312.30 RECOVERY

REV: September 2015

Recovery of Medicaid expenditures by the Executive Office of Health and Human Services is a function of the Division of Health Care Quality, Financing and Purchasing, Medicaid Third Party Liability (TPL) Unit and the EOHHS Legal Office. However, it is the responsibility of the Eligibility Technician or LTC worker closing a Medicaid case due to the death of an individual aged fifty-five (55) years or older to complete the remaining sections of the MA-89M which has been filed in the case record. The MA-89M is forwarded to the TPL Unit at Central Office.

Based on the information regarding the deceased's resources and the assistance which would by law be recovered, a decision regarding recovery is made by the TPL Unit.

Executive Office of Health and Human Services (EOHHS) Recovery Practices:

A. Upon the filing of a petition for admission to probate of a decedent's will or for administration of a decedent's estate, when the decedent was fifty-five (55) years or older at the time of death, a copy of said petition and a copy of the death certificate shall be sent to the EOHHS Such notice will be sent to:

   EOHHS Legal Office, Hazard Building
   74 West Road, Building #74
   Cranston, RI 02920

   The notice requirements of this section are in addition to any notice that may be required pursuant to R.I.G.L. § 33-11-5.1 entitled Duty to notify known or reasonably ascertainable creditors.

   If the EOHHS requests additional information, an executor or administrator shall complete and send to the EOHHS a form prescribed by that office and shall provide such additional information within thirty (30) days of the request. Petitioners shall maintain documentation evidencing notice to the EOHHS Legal Office and file a copy of this notice with the probate court prior to hearing. In the case of a voluntary probate proceeding, since there is no hearing, a copy of the notice to EOHHS shall be filed with the probate court with the voluntary petition.

   For estates open on or after July 1, 2012, should a petitioner fail to send a copy of the petition and a copy of the death certificate to the EOHHS Legal Office and a decedent has received Medicaid for which the EOHHS is authorized to recover, no distribution and/or payments, including Administration fees, shall be disbursed. Any person and/or entity that receives a distribution of assets from the decedent's estate shall be liable to the EOHHS to the extent of such distribution.

   Compliance with the provisions of this section shall be consistent with the requirements set forth in section 33-11-5 and the requirements of the affidavit of notice set forth in section 33-11-5.2. Nothing in these sections shall limit the EOHHS from recovery, to the extent of the distribution, in accordance with all state and federal laws.

   The TPL Unit initiates estate recoveries upon receipt of information (from internal or external sources) relative to the death of a Medicaid recipient who was at least fifty-five (55) years of

age, and responds to requests from estate representatives to release and/or discharge liens upon payment of reimbursable amounts.

B. The TPL Unit does not automatically file an encumbrance in the land evidence records.

C. Usually, the recovery process begins with a letter to the next of kin or legal representatives requesting estate asset information. In most cases, there are no assets left after payment of funeral expenses and other preferred debts (RIGL 33-12-11), and no recovery is pursued by the EOHHS. If requested, the TPL Unit will issue a discharge of lien. If there are any assets remaining to pay the EOHHS claim, in whole or in part, the TPL Unit will request reimbursement by letter which provides an accounting of the Medicaid expenditures. Upon receipt of payment, the TPL Unit will issue a discharge of lien.

D. If the EOHHS is notified of the pendency of a probate estate either in response to a written notice from the executor/administrator, (see In Re: Estate of Santoro, 572 A. 2d 298, R.I. (1990) and RIGL 33-11-5.1 for notice to creditor requirements), the EOHHS Legal Office will file a formal claim in the estate. Land evidence lien notices are not normally filed at this time.

0312.35 DISCHARGE OF LIEN

REV: 11/2012

The Executive Office of Health and Human Services (EOHHS) will issue a discharge of its lien in each of the following situations:

1. Upon payment in full of its claim;

2. Upon payment of its claim in part by payment to EOHHS of all remaining estate assets after allowance for the preferences outlined in RIGL 33-12-11 and any court approved expenses relating to any pre-existing guardianship or conservatorship of the decedent.

   a. EOHHS does not "compromise" or reduce its claim except as provided above;
   b. EOHHS will require the sale or liquidation of non-liquid assets;

3. Upon determination that #1 and #2 above are satisfied and the lien is recorded in the land evidence records.

0312.35.05 DISCHARGE OF INAPPLICABLE RECORDED LIEN

REV: 11/2012

The Executive Office of Health and Human services will issue a discharge of a recorded lien upon a determination by EOHHS that the lien is inapplicable. Inapplicability occurs in the following situations:

1. If there is a statutory exception as found in section 0312.15; or

2. The decedent was never a recipient of Medicaid, was not age fifty-five (55), or was receiving Medicaid but was not "Medically Needy" or "Categorically Needy" during the relevant time periods; or
3. The EOHHS received reimbursement from another third party source or insurer; or

4. No assets are included or includable in the decedent's probate estate; or

There is no required form to request a discharge of an inapplicable lien. A written request for discharge should be sent to:

Division of Health Care Quality, Financing and Purchasing
TPL Unit, Hazard Building Bldg #74
74 West Road
Cranston, RI 02920

and should contain, at a minimum:

1. A copy of the Death Certificate;

2. The decedent's Social Security number;

3. A detailed explanation of the basis for a finding of inapplicability (for example, no assets of the deceased individual were included or were includable within the individual's probate estate), with appropriate documentation for the finding. Acceptable documentation may include affidavits;

4. A description of the real estate (tax assessor's plat/lot numbers and street address).

The TPL Unit will review and verify the information and will compare with information previously disclosed on Medicaid applications on file with the EOHHS. If approved, the TPL Unit will issue and record a discharge of lien within forty-five (45) days of receipt of the request for discharge due to inapplicability or refer the request to the EOHHS Legal Office, if necessary. Any interested party who disputes the applicability of the land records lien, within thirty (30) days of the proper prior notice as provided in section 0312.10, shall be afforded an opportunity to request an administration hearing (RIGL 42-35-9).

0312.40 UNDUE HARDSHIP CONSIDERATION

REV: 11/2012

The Executive office of Health and Human Services (EOHHS) may make adjustments to and settle estate liens to obtain the fullest amount practicable.

A lien may be postponed in whole or in part when the Department determines execution of the lien would work an undue hardship.

An undue hardship may be found to exist and execution of the lien may be postponed if a sale of real property, in the case of an individual's home, would be required to satisfy a claim, if all of the following conditions are met.

An heir or beneficiary may request that the EOHHS delay the execution of its lien if:

1. An individual was using the property as a principal place of residence on the date of the recipient's death; and

2. That individual resided in the decedent's home on a continual basis for at least twenty-four

(24) months immediately prior to the date of the deceased recipient's death; and

3. That individual has, from the time the Department first presented its claim for recovery against the deceased recipient's estate and after, annual gross income in an amount not to exceed 250 percent of the then applicable federal poverty level (FPL) income standard based on the same family size, and assets not to exceed the then applicable Medically Needy resource standards (see section 0338.05).

If an individual meets the above criteria, the heir(s) or beneficiary(ies) may submit a request to the EOHHS Legal Office for consideration of undue hardship and the delay of the execution of the Department's lien against the property if it appears that the individual is able to continue to reside in the property.

Requests for consideration of undue hardship will be reviewed by a team of three members therein designated by the Medicaid Director, to include the Long Term Care Administrator, one member from the EOHHS Legal Office, and one member from the Medicaid Office of Policy Development. The review team will render decisions by giving due consideration to the equities involved as well as the obligations of the parties involved.

4. Additionally, undue hardship will be determined by the Department on a case-by-case basis and will include, but will not be limited to, the following examples, e.g., the individual or self, on whose behalf the heir(s) or beneficiary(ies) is requesting a consideration of undue hardship, would:

   a. Be rendered homeless without the resources to find suitable housing; or

   b. Lose his/her means of livelihood; or

   c. Be deprived of food, clothing, shelter, or medical care such that life would be endangered should a finding of undue hardship be denied.

0312.40.05 APPLICATION FOR UNDUE HARDSHIP CONSIDERATION

REV: 04/1998

A requestor shall mail his or her application for an undue hardship consideration in writing to the Department within forty-five (45) days after the date the Department has filed its claim with probate court. The application shall include the following information:

1. The relationship of the undue hardship applicant to the decedent and copies of documents establishing that relationship; and
2. The basis for the application and documentation supporting the undue hardship applicant's position; and
3. Supporting documentation that the requestor has the legal standing and will be allowed to continue to reside in the property indefinitely should the undue hardship request be approved.

The Department may require additional documentation, such as a current title examination, a list of existing creditors, etc. as adequate proof that its decision to defer its lien will not otherwise adversely affect its claim.

The Department shall review each application and issue a written decision within ninety (90) days after the application was received by the Department. The Department shall consider and base its decision on all information received with the application and any independent investigation it may undertake.

The decision shall be the final decision of the Department.

UNDUE HARDSHIP GRANTED

REV: 04/1998

If the Department finds that an undue hardship exists, the execution of the lien is delayed for as long as:

- The undue hardship grantee is alive and residing in the property; and has income and assets not to exceed the amounts specified in Section 0312.40.
- The undue hardship circumstances upon which the decision is based continue to exist; and
- As long as the property is adequately maintained and continues to exist in its then current state, (e.g., if the structure is destroyed by fire, the lien will be executed against the real estate if it appears that the home will not be rebuilt).

The circumstances of the hardship will be subject to review by the Department at least every two years provided, however, that the grantee must notify the Department of any material change in circumstances, income and/or assets.

0312.40.15 TRANSFER/SALE OF PROPERTY UNDER HARDSHIP

REV: 11/2012

If the owner of the property sells or transfers ownership of the home, the Executive Office of Health and Human Services will execute the lien.

0312techsept2015
September 10, 2015

0313 COLLECTION OF OVERPAYMENTS VIA STATE TAX REFUND OFFSET

0313.05 SETOFF OF STATE PERSONAL INCOME TAX REFUND

EFF: 10/2009

In accordance with Sections 44-30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 of the Rhode Island General Laws in Chapter 44-30.1 entitled 'Setoff of Refund of Personal Income Tax', DHS through the CCR/Fraud Unit can recover Medical Assistance benefit overpayment claims and cost share arrearages through offset of the individual state income tax refund.

“Medical Assistance benefit overpayment” means any amount of medical assistance benefits which constitutes an overpayment of Medical Assistance benefits. The amount of overpayment of benefits may include the overpayment of benefits due to the fact that the Medical Assistance recipient failed to pay the cost share obligation lawfully imposed in accordance with Rhode Island law. “Medical assistance cost share arrearage” means any amount due and owing to the department of human services as a result of a Medical Assistance recipient’s failure to pay their cost share obligation, including any amount due for a cost sharing obligation or medical assistance premium obligation, imposed in accordance with Title 40, Chapter 8.4 of the Rhode Island General Laws.

0313.05.05 Criteria for Referral for Setoff

EFF: 10/2009

The claim must meet the following requirements for the State Personal Income Tax Refund Offset procedure.

The claim must be:

* Established by court order, by administrative hearing conducted by the Department of Human Services, or by written agreement between the Department of Human Services and the individual;

* Greater than or equal to the minimum amount required for submission for setoff by the R.I. Division of Taxation;

* Submitted in the name of one individual or must be reduced by any amount submitted as a separate claim for other individuals who are jointly or severally liable for the claim; and

* Not involved in a bankruptcy stay or discharged in bankruptcy.

In addition, the agency must notify the individual of the intended action prior to offset and of her or his appeal rights.

0313.05.10 Setoff Procedures and Notification of Debtor

EFF: 10/2009

The CCR/Fraud Unit will notify the individual of its intent to refer a claim to the R.I. Division of Taxation for offset and give the individual thirty (30) days to appeal the intended referral by presenting evidence that all or part of the claim is not legally enforceable. The pre-offset notice or thirty (30) day notice shall contain the following information:

A. The amount of the claim(s);

B. That the individual has been previously notified of the claim;

C. That the claim is legally enforceable;

D. The individual's DHS Case Identifier;

E. That the claim(s) is to be referred to the R.I. Division of Taxation for offset unless the claim is paid in full within thirty (30) days of the date of the letter;

F. Instructions about how to pay the claim(s), and the address and telephone number of the CCR/Fraud Unit to call to discuss the claim and the intended intercept.

G. That the individual has the right to appeal the offset. The notice will advise the individual that:

(1) The individual is entitled to an administrative hearing to contest the setoff. The appeal request must be in writing and must be received by CCR/Fraud Unit not later than thirty (30) days after the date of the notice.

(2) That the individual should be prepared to provide evidence or documentation of his or her defenses to the claim.

(3) The individual's right to judicial review of the administrative hearing decision.

The notice must also state that a claim may not be referred for offset where a bankruptcy stay is in effect or if the claim has been discharged in bankruptcy.

0313.05.15 Transfer of Funds by Division of Taxation

EFF: 10/2009

At the time of the transfer of funds to DHS, the Division of Taxation shall notify the debtor that the transfer has been made.

The notice shall state the name of the debtor, the amount of Medical Assistance benefit overpayment or cost share arrearage being claimed, and the transfer of funds to DHS.

In the case of a joint refund, the Division of Taxation notice shall also state the name of a taxpayer-spouse named in the return, if any, against whom no Medical Assistance benefit overpayment or cost share arrearage is claimed, the opportunity to request that the refund be divided between the spouses by filing an amended income tax return showing each spouse's share of the tax and the contribution to the overpayment of tax resulting in the refund.

Upon receipt of funds transferred from the Division of Taxation, DHS Financial Management deposits and holds the funds in an escrow account until final determination of setoff. Upon final determination of the amount of the claim to be setoff by 1) default for failure to apply for an administrative hearing, or by 2) decision of the administrative hearing officer, the claimant agency shall remove from the account of the claim payment from the escrow account and credit the amount to the debtor's obligation. The pendency of judicial proceedings to review the administrative decision shall not stay nor delay the setoff, transfer, and disbursement of the tax refund in question.

With respect to setoff for Medical Assistance benefit overpayments and cost share arrearages, the Division of Taxation shall provide the debtor's address and social security number to the Department of Human Services. The information obtained by a claimant agency through the Division of Taxation retains its confidentiality and is only used by DHS in pursuit of its Medical Assistance benefit overpayments and cost share arrearages collection duties and practices, and any employee or prior employee of any claimant agency who unlawfully discloses that information for any other purpose, except as specifically authorized by law, is subject to the penalties specified by RIGL 44-30- 95(c).

0313.10 ADMINISTRATIVE HEARINGS

EFF:10/2009

As appropriate, an administrative hearing may be held pursuant to DHS Policy Manual Section 0110. The appeals officer must be issue her or his decision in writing in accordance with Section 0110. If the decision is made that the claim does not meet the requirements for offset, CCR/Fraud must take appropriate corrective action.

0314 MA PAYMENT FOR OUT OF STATE CARE

0314.05 REQUIREMENT OF PRIOR AUTHORIZATION
REV:01/2002

Payment for out-of-state medical services that are provided to eligible MA recipients living within Rhode Island requires PRIOR AUTHORIZATION from the Division of Medical Services.

The following conditions must be met to obtain prior authorization for out-of-state medical services:

- If a patient requires services from an out-of-state hospital or physician, the patient's attending physician must submit written medical justification to the Division of Health Care Quality, Financing and Purchasing;

- The service which is required and being requested must not be available within Rhode Island.

Recipients who inquire about out-of-state medical services are informed that prior authorization is required, and that only those services within Rhode Island MA scope of services will be recognized.

0314.05.05 Exceptions to the Requirement of Prior Auth
REV:06/1994

The following provisions are exceptions to the requirement for prior authorization:

- Emergency medical treatment and hospital services were needed because the recipient's health would have been endangered if required to travel back to Rhode Island;

- Treatment was provided by hospitals and practitioners located in close proximity to the Rhode Island state line(e.g., Attleboro, Seekonk, Fall River, New London, etc.) where it is the general practice for residents to use medical resources outside the State;

- Medical and hospital treatment were provided to foster children residing with families located outside Rhode Island or in out-of-state residential treatment

centers.

0314.05.10 Services Rendered to Temp Absent Recipients
REV:06/1994

Payment for medical care provided to eligible residents of Rhode Island who are temporarily absent from the state is made under certain circumstances. Temporarily absent includes visiting, traveling or residing temporarily in another state without intending to become a permanent resident of the other state. MA payment is authorized only in one of the following circumstances:

- An emergency arises from accident or illness; or
- The health of the individual would be endangered if the care and services were postponed until the individual returned to Rhode Island; or
- The health of the individual would be endangered if s/he undertook travel to return to Rhode Island.

0314.05.15 Follow-up Procedures
REV:01/2002

When bills are received over a continuing period of time for out-of-state medical care not previously authorized, and which was rendered to MA recipients temporarily absent from the state, the following occurs:

- The Division of Health Care Quality, Financing and Purchasing notifies the district office that follow-up is needed;
- The district office mails form AP-719 to the recipient at the out-of-state address;
- If the recipient indicates s/he is planning to return to the state, written notification of this effect is sent to the Division of Medical Services;
- If the recipient indicates s/he plans to reside permanently outside the state, the case is closed at the end of the month following the month of

notification of intent to reside outside Rhode Island.

0318 Medicaid Redetermination

0318.01 Applicability

October 2013

The provisions in this section do not apply to the individuals and families in the Medicaid affordable coverage groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the renewal process for the Medicaid members in these groups are located in MCAR section 1306. Individuals and families who were determined eligible prior to January 1, 2014 and were still enrolled on that date are not subject to a determination of continuing eligibility until 2015 unless there is a change in an eligibility factor for example, income or family size. If such a change occurs, the provisions in MCAR section 1301 and 1306 apply. **Accordingly, the provisions of this section are applicable only to individuals and families who are not subject to the modified adjusted gross income standard (MAGI) on or after January 1, 2014. The characteristics of these "non-MAGI" coverage groups are identified in MCAR section 1301.**

0318.05 Redetermination of Medicaid Eligibility

REV: October 2013

The redetermination of Medicaid eligibility is based on the review and update of eligibility factors subject to change and, as appropriate, supporting documents, as needed, from which a determination is made that the recipient continues to meet all eligibility requirements.

A redetermination results in a recertification for the existing scope of services, recertification for a reduced scope of services or case closure. Redetermination precedes a case closure. A case is not closed without a positive finding of ineligibility.

For Medically Needy INDIVIDUALS and FAMILIES, a full redetermination is completed every twelve (12) months. In addition, eligibility must be re-determined whenever a change in circumstances occurs, or is expected to occur, that may affect eligibility.

0318.10 Redetermination Process

REV: October 2013

Two months prior to the end of a certification period, InRHODES identifies cases due for re-determination and sends to the Management Information Systems (MIS) Unit at the DHS EOHHS Central Office a list of the cases and a name and address label for each case.

The MIS Unit sends the cards, labels and list of cases due for redetermination to the appropriate district office from which redetermination packets are mailed. The list provided to the district office identifies cases as family or adult and also indicates whether the case was previously certified using the DHS-2 or MARC-1 application form.

The redetermination packet consists of the following materials, (plus other forms, and documents as they relate to the individual situation; e.g., the MA-1 Supplement when a spenddown is indicated).

INDIVIDUALS/COUPLES
DHS-2 Statement of Need
Transportation Information
Pre-addressed return envelope

When the application form is returned within the required time period (prior to expiration of the certification period), the eligibility worker compares the information on the new application to the InRHODES record, entering changes once necessary verification has been provided. If the information is the same and the client remains eligible, the recipient's next redetermination date is advanced up to twelve months, as appropriate. If new information results in ineligibility or a change in the level of coverage, the worker must approve the results.

If the application is not received by the 20th of the month or ten days prior to the end of the certification period, the worker enters a non-cooperation code on the InRHODES STAT/STAT panel causing a TEN-DAY NOTICE of discontinuance to be sent.

The case closes at the end of the old certification period if the recipient has not responded by the end of the 10-day notice period.

0318.15 Redetermination in Short Term Flex Test Case
REV: October 2013

Medically Needy Individuals/Couples who are eligible under the flexible test of income are certified for the full six (6) month period of flex test eligibility or the balance remaining on the six (6) month period once spenddown of excess income is achieved.

A flexible test case accepted for two months or less requires an expedited redetermination process. Since the time between the notice of acceptance and the notice of impending discontinuance is shortened, redetermination activity should begin at the time of approval. For cases accepted for less than two (2) months, the time between sending of the application and sending of the notice of eligibility will be shortened. For instance, when a case is accepted during the last two weeks of the flexible test period, the redetermination packet, and the Notification of Eligibility are sent at about the same time.

Many cases accepted using the flexible test of income will have a period of ineligibility between the expiration date of one period and the date of eligibility for a subsequent flex test period.

0318.20 Redetermination of Disability Determination
REV: October 2013

When the MART determines after review that a recipient's disability continues, it must also determine whether medical improvement is expected; and if so, when this review should be conducted.

Cases are reviewed in order to determine whether or not an individual's disability has improved medically to the point where he/she is able to work. When determining whether a medical condition has improved, the Medicaid state agency uses a point of comparison to compare the current severity

of the impairment(s) to the most recent favorable disability determination that the individual has received.

When the MART has decided that a case must be reviewed in the future, all medical documentation, must be sent to the MART for review at the specified time period.

The Medicaid state agency conducts continuing disability reviews when one or more of the following apply in accordance with 20 CFR, Section 416.990(b):

- The date the MART has rescheduled for the expected medical improvement review;
- A recipient has been scheduled for a periodic review by the MART in accordance with Paragraph 1.
- Current medical or other reports are necessary to determine if a recipient's disability has continued (for example, where medical technology has changed);
- A recipient returns to work and successfully completes a trial period of work;
- A recipient informs the Medicaid agency that s/he has recovered from disability or that they have returned to work, or Vocational Rehabilitation reports recipient is working or is able to work;
- Someone in a position to know of recipient's physical or mental condition informs the Medicaid agency that the recipient is not disabled, has not been following prescribed treatment, or has returned to work, and it appears that the report could be substantially correct; or
- The Medicaid agency receives evidence that raises a question as to whether or not an individual's disability continues;
- A recipient has earned substantial wages during the eligibility period, unless otherwise eligible under the Sherlock Act, R.I.G.L. 40-8.7;
- By his/her first birthday, for a child whose low birth weight was a contributing factor material to the disability determination; or
- After his/her first birthday for a child who has an impairment(s) that is not expected to improve by his/her first birthday.

There are several definitions that are important to know in order to understand why an individual's disability determination would be reviewed.

Definitions

Medical Improvement: Any decrease in the medical severity of an individual's impairment(s) which was present at the time of the most recent favorable medical decision that they were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be made on improvement in the symptoms, signs and/or laboratory findings associated with the individual's impairment(s).

Medical Severity: Medical evidence that establishes a physical or mental impairment or combination of impairments of sufficient severity as to be the basis of a finding of inability to engage in any substantial gainful activity.

Point of Comparison: When determining whether medical improvement has occurred, compare the current medical severity of the impairment(s) to the medical severity of the impairment(s) which was present at the time the most recent favorable medical decision of disability was made.

The Medicaid agency upon initiating a continuing disability determination review, will notify the individual by a written notice advising that:

- The Medicaid agency will be reviewing the individual's disability;
- The reason why the disability is being reviewed;
- There are medical improvement standards as listed in 20 CFR, Section416.994(b)(1)(ii),(iii),(iv) and Medicaid Code of Administrative Rules (MCAR) Section 0318.20 that apply;
- The individual has a right to submit medical and/or other evidence to be considered in the review process;
- That the review could result in a later decision to discontinue the individual's Medicaid benefits.

During the continuing disability determination review, the Medicaid agency uses reasonable efforts to obtain the individual's medical reports and develop a complete medical history consisting of at minimum the preceding twelve (12) months.

The MART has the right to request and obtain a consultative examination from the recipient.

An individual's Medicaid benefits will not be terminated for lack of disability until the Medicaid agency has completed the review, determined that the individual has improved medically, or that under standards set out in 20 CFR Section 416.994(b)(3) or (4) has determined that an exception applies, and sent a timely and adequate written advance notice to the individual.

An individual's Medicaid benefits will be discontinued if the individual refuses to:

1. Obtain a consultative examination, or
2. Cooperate in obtaining the required documentation.

Evaluation

To assure that disability reviews are conducted with uniformity, objectivity, and expeditiously, the following steps as referenced in 20 CFR Section 416.994(b)(5) will be followed when determining whether or not an individual's disability continues:

Step 1: An individual has an impairment or combination of impairments that meets or equals the severity of an impairment as listed in 20 CFR Section 416.994, Appendix 1, Subpart P of Part 404.

If the individual does, the disability will be found to continue.

Step 2: If an individual does not meet Step 1, has there been medical improvement in the individual's condition as shown by a decrease in medical severity (as defined). If not, there has been no medical Improvement and the individual's disability will be found to continue.

Step 3: If there has been medical improvement, determine whether it is related to the individual's ability to work, (i.e., whether there has been an increase in the residual functional capacity based on the impairment(s) present at the time of the most recent favorable disability determination).

Step 4: If there is no medical improvement or the Medical improvement is not related to the individual's ability to work, the individual's disability is found to continue.

Step 5: If there is medical improvement and it is shown to be related to an individual's ability to work, all of the individual's current impairments are reviewed to determine whether they are severe as defined in 20 CFR Section 416.921, and whether the impairments in combination significantly limit basic work activities.

Step 6: If an individual's impairment(s) is severe, s/he will be assessed to determine his/her ability to do substantial gainful activity in accordance with 20 CFR Section 416.961. The individual's residual functional capacity based on all of their current impairment(s) is assessed to determine whether s/he can still do the work that was done in the past. If s/he can do such work, the individual's disability will be found to have ended.

Step 7: If an individual cannot perform the work that s/he has done in the past, one final step must be considered. Given the individual's residual functioning capacity assessment and considering his/her age, education, and past work experience, are reviewed to determine if other work can be performed. If the individual can perform other work, the disability will be considered to have ended. If the individual cannot perform other work, the disability will be considered to have continued. All individuals are tested to evaluate the possibility of another eligibility category of Medicaid before Medicaid benefits are discontinued.

0318.21 Severability
October 2013

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

0320 REFERRAL TO OTHER RESOURCES FOR MED CARE

0320.05 AVAILABILITY OF OTHER RESOURCES
REV:01/2002

In addition to the Medical Assistance Program, there are other resources within the State for individuals with medical needs.

Some individuals may be concurrently eligible for more than one of these resources, such as Office of Rehabilitation Services and Medical Assistance. Veterans' benefits may also be received instead of, or in addition to, Medical Assistance or other assistance programs.

Applicants who do not meet the eligibility requirements for Medical Assistance may be eligible for one or more of the following programs:

- Veterans' Benefits (VA);
- Office of Rehabilitation Services (ORS);
- Rhode Island Pharmaceutical Assistance for the Elderly.

0320.10 REHABILITATION (ORS) SERVICES
REV:01/2002

When a recipient of MA is eligible for Office of Rehabilitation Services (ORS), or a recipient of ORS is eligible for MA, the medical expenses are shared by the two agencies.

ORS has the responsibility for the administration of all services needed to preserve or develop to the maximum the self-sufficiency of the individual toward a vocational goal.

0320.10.05 VR Responsibilities
REV:01/2002

In order to fully utilize the services of both agencies, ORS assumes responsibility for the following services:

- A complete general medical examination providing an appraisal of the current medical status of the individual;

- Examination by specialists in all fields as needed, including psychiatric and/or psychological examinations in all cases of suspected mental or emotional illness;

- Such laboratory tests, x-ray services and other indicated studies as are necessary to establish the diagnosis(es), to determine the extent to which disability limits the individual's daily living and work activities, and to estimate the potential results of physical restoration services;

- The initial purchase of durable medical equipment and surgical and prosthetic appliances required as part of a vocational rehabilitation plan;

- Inpatient and outpatient services provided by rehabilitation facilities not covered within the scope of services of the Rhode Island Medical Assistance Program;

- Private psychiatric services within the normal limitations of the ORS program;

- All other medical services and supplies which are required as part of an overall ORS plan that are not covered by the Rhode Island Medical Assistance Program.

0320.10.10 MA Responsibilities
REV:06/1994

The Medical Assistance Program assumes responsibility for payment of the following services:

- Hospital services in licensed general hospitals certified
for participation in the Title XVIII and Title XIX Programs when provided in accordance with applicable Federal and State rules and regulations;

- Durable medical equipment and surgical and prosthetic appliances utilized on an ongoing basis;

- Hemodialysis treatments provided in a hospital or a

hemodialysis facility;

- All other medical services and supplies which are medically justifiable and included within the scope of services of the Rhode Island Medical Assistance Program, but not covered by Vocational Rehabilitation.

0320.10.15 Prior Authorization Required
REV:06/1994

All medical services and supplies paid for by the Medical Assistance Program will be provided in accordance with established methods of reimbursement, fee schedules and other applicable rules and regulations. Since certain hospital and outpatient department services provided in out-of-state hospitals require prior authorization, consultation between the two agencies will be required before authorization is granted for such services. All rehabilitative services will be provided within the scope of services of VR. Referrals between the two agencies will be administered as agreed upon by both agencies.

VR will take the initiative to evaluate and determine those services needed to return an individual to a remunerative occupation. Those medical services not directly connected with the individual's major disabling condition and vocational rehabilitation process will be included.

MA will be responsible for the ongoing medical needs not directly related to the vocational rehabilitation process.

VR will provide ongoing counseling and guidance and other non-medical services required to achieve the individual's vocational objective.

0320.10.20 Referral of MA Ineligible Indiv w/Disability
REV:01/2002

When an individual who is ineligible for MA has a disability, s/he may be referred to:

Office of Rehabilitative Services (ORS)
40 Fountain Street
Providence, RI 02903
Telephone: 421-7005

0320.15 VETERANS BENEFITS
REV:06/1994

Veterans Benefits are a resource for which increasing numbers of individuals may be eligible. These benefits and services are available to veterans and their dependents or survivors. They may be received instead of, or in addition to, Medical Assistance.

0320.15.05 Who is a Veteran
REV:01/2002

Service in any branch of the armed forces during the following periods designated for the various wars and specific periods of qualifying peacetime service qualifies an individual as a Veteran.

Mexican Border Period	May 9, 1916 to April 5, 1917
World War I	April 6, 1917 to November 11, 1918 Service in Russia, ending date: April 1, 1920
World War II	December 7, 1941 to December 31, 1946
Korean Campaign	June 27, 1950 to January 31, 1955
Vietnam	February 28,1961 to May 7, 1975

Verification by discharge papers (Form DD-214) is required upon application for benefits.

0320.15.10 Who is Eligible
REV:01/2002

Veterans Benefits are a possible source to any disabled veteran whether the disability is service-connected or not. Dependents and survivors may also be entitled to benefits. All applicants who are veterans (served during the specified periods) and who have a disability must apply for Veterans Benefits through the US Department of Veterans Offices. All widows of a veteran, or caretaker relative of the child(ren) of a deceased or disabled veteran must investigate the possible eligibility for Veterans Benefits. There are also benefits and services available to non-disabled veterans.

0320.15.15 Benefits Available
REV:06/1994

In addition to the regular Compensation (for service connected disabilities) or Pension (for non-service connected disabilities) that a veteran (and his/her dependents) or a widow pensioner receives, additional amounts are allowed when the individual:

- Is housebound;
- Has unusual medical expense (reimbursed expenditures above 5% of income which could reduce countable income below VA income limitation, thereby creating entitlement); or
- When the individual is in need of aid or attendance (this will be construed to include public or private nursing care facilities, foster homes and non-profit organizations).

0320.15.15.05 Death Benefits
REV:01/2002

Death benefits (gratuity) are available only to veterans who receive compensation or had active duty during wartime.

0320.15.15.10 Medical Benefits
REV:01/2002

Information about medical benefits available through the Veterans Administration Medical Centers for veterans whose benefits are service connected or non-service connected may be obtained from :

VA Medical Center
Davis Park
Providence, Rhode Island

0320.15.15.15 Cost of Living Increases
REV:06/1994

Whenever there is a cost of living increase in Social Security benefits the VA shall, effective the date the increase becomes effective, increase by the same percentage the maximum annual rates of the VA pension.

0320.15.20 How to Receive VA Benefits
REV:01/2002

All benefits must be applied for and substantiating data must be provided by the veteran or survivor.

Individuals potentially eligible may be referred directly to:

Veterans Administration Regional Office
380 Westminster Street
Providence, RI 02903
Telephone: 1-800-827-1000

If the individual questions whether there is eligibility for a specific program or benefit or needs help in making the application, referral may be made to:

Office of Veterans Affairs
600 New London Avenue
Cranston, RI 02920
Telephone: 462-0350

0320.20 RI PHARMACEUTICAL ASSIST FOR ELDERLY (RIPAE)
REV:01/2002

RIPAE is operated by the Rhode Island Department of Elderly Affairs. The program provides assistance to low and middle income individuals or couples, 65 years of age or older, to help pay for prescription medication for certain medical conditions.

0320.20.05 Eligibility for Coverage
REV:01/2002

To be eligible, an individual must:

- Be a resident of Rhode Island;
- Be sixty-five (65) years of age or older;
- Have income within program guidelines established by the Department of Elderly Affairs; and
- Have no coverage for prescription medication.

0320.20.10 Covered Medications
REV:01/2002

Current information about medications covered by RIPAE may be obtained from the Rhode Island Department of Elderly Affairs. In 2001, RIPAE covered a portion of the cost of prescriptions used to treat Alzheimer's disease, arthritis, diabetes, heart problems, depression, anti-infectives, Parkinson's disease, high blood pressure, cancer, urinary incontinence, circulatory insufficiency, high cholesterol, asthma and chronic respiratory conditions, glaucoma, and prescriptive vitamins and mineral supplements for renal patients.

0320.20.15 Application Process
REV:01/2002

Elderly individuals, ineligible for MA, should contact the Department of Elderly Affairs at 222-2880 for information concerning RIPAE and other programs for which s/he may be eligible.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES MANUAL

MEDICAL ASSISTANCE

EARLY INTERVENTION PROGRAM SECTION 0322

Early Intervention Program 0322
EFF:09/2005

RULES AND REGULATIONS PERTAINING TO THE PROVISION OF EARLY INTERVENTION SERVICES FOR INFANTS AND TODDLERS WITH DISABILITIES AND THEIR FAMILIES

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RHODE ISLAND DEPARTMENT OF HUMAN SERVICES MANUAL

MEDICAL ASSISTANCE

SECTION 0322 EARLY INTERVENTION PROGRAM

0322.05 Purpose the the Early Intervention Program
EFF:09/2005

Section 1.0 Purpose of the Early Intervention Program

1.1 Purpose:

The purpose of the Early Intervention (EI) Program is to provide comprehensive, coordinated, community based services that respond to the identified needs of eligible infants, toddlers and their families.

1.2 Statewide Equity:

Eligible children and families must have equal access to

comprehensive early intervention services, as defined in these regulations, irrespective of geographic location. These services must be fully compliant with all provisions of the regulations. Early intervention services must be made available to all eligible children irrespective of gender, race, ethnicity, religious beliefs, cultural orientation, citizenship, economic status, and educational or medical diagnosis.

Section 2.0 Definitions

Wherever used in these rules and regulations, the following terms shall be construed as follows:

2.1 "Act" means Chapter 23-13 of the RI General Laws, as amended.

2.2 "Assessment" means ongoing procedures used by qualified personnel throughout the child's eligibility period to identify the child's and family's unique strengths and needs, and the nature and extent of Early Intervention Services (EIS) needed by child and family.

2.3 "Children" means infants and toddlers from birth through age two (2), who need early intervention services.

2.4 "Council" means the state Interagency Coordinating Council.

2.5 "Days" means calendar days.

2.6 "Department" means the Rhode Island Department of Human Services.

2.7 "Destruction" means physical destruction or removal of personal identification from recorded information.

2.8 "Developmental delay" refers to significant delay in the developmental areas of cognition, communication development, and physical development, including vision and hearing, social or emotional development, and/or adaptive behavior.

2.9 "Director" means the Director of the Rhode Island Department of Human Services.

2.10 "Early Intervention System" means the total effort in the state that is directed at meeting the needs of eligible children and families.

2.11 "Early Intervention service provider" means a not-for-profit organization, certified by the Department, that has been

exempted from taxation pursuant to Internal Revenue Code Section 501(C)(3) [26 U.S.C. Section 501(c)(3)] formed for some charitable or benevolent purpose and which delivers

early intervention services as defined herein.

2.12 "Early Intervention Services" (here and after referred to as "EIS") means services that are designed to meet the unique developmental needs of the eligible child and the needs of the family related to enhancing the child's development.

2.13 "Education records" means the records covered by FERPA (the Family Education Rights and Privacy Act, 34 Code of Federal Regulations, Part 99).

2.14 "Evaluation" means the procedures used by qualified personnel to determine the child's eligibility.

2.15 "Health services" means services necessary to enable a child and family to benefit from other early intervention services during the time the child is receiving these services, and shall include, but not be limited to:

- Cleaning, intermittent catheterization, tracheotomy care, tube feeding, changing of dressings or colostomy collection bags, and other health services;
- Consultation by physicians with other early intervention service providers concerning the special health care needs of eligible children.

Health Services shall NOT include services that are:

- Surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); or purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose);
- Devices necessary to control or treat a medical condition; or
- Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children.

2.16 "IFSP" means the Individualized Family Service Plan defined in Section 12.0.

2.17 "Infants and toddlers with disabilities" means individuals from birth through age two (2) who need EIS because they:

- Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay;
- Are experiencing developmental delays as measured by appropriate diagnostic instruments and procedures in one

or more of the following areas: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, adaptive development;

- o Have multiple established conditions, whose circumstances may result in substantial developmental delays if EI services are not provided.

2.18 "Location of services" means services that are provided in natural environments, to the maximum extent appropriate to meet the child's needs, as determined by the parent and the IFSP team. These include the home and community settings in which infants and toddlers without disabilities participate.

2.19 "Multidisciplinary" means involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment and development of IFSP.

2.20 "Natural environments" means those home and community settings where EI services are provided, similar to those in which children without disabilities participate, to ensure that opportunities to enhance child development are incorporated into daily routines and activities typical for children under age three (3) and their families, as elaborated on in EI Certification Standards.

2.21 "Parent" means

a)General:

1. A natural or adoptive parent of a child;
2. A guardian;
3. A person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare);
4. A surrogate parent who has been assigned in accordance with section 16.0 herein.

b)Foster parent. If the natural parents' authority to make the decisions required of parent under the Act has been extinguished under state law; and the foster parent:

1. Has an ongoing, long-term parental relationship with the child;
2. Is willing to make the decisions required of parents under the Act; and
3. Has no interest that would conflict with the interests of the child; and/or
4. Is a surrogate parent who has been assigned in accordance with section 14.5 herein.

The term does not include the state if the child is a ward of the state.

2.22 "Participating agency" means any agency or institution that

collects, maintains, or uses personally identifiable information, or from which such information is obtained.

2.23 "Person" means any individual, trust or estate, partnership, corporation (including associations, joint stock companies), limited liability companies, state or political subdivision or instrumentality of a state.

2.24 "Qualified personnel" means personnel who provide Early Intervention services and who have met state approved or recognized certification, licensing, registration, or other comparable requirements that apply to the area in which the person is providing EIS.

2.25 "Service coordination " means the activities carried out by a service coordinator to assist and enable an eligible child and family to receive the services authorized under the Rhode Island EI program and contained in the IFSP, including all rights and procedural safeguards.

2.26 "Service coordinator" means a person from the profession most immediately relevant to the child's or family's needs (or who is otherwise qualified to carry out all applicable responsibilities), who will be responsible for the implementation of the IFSP and coordination with other agencies and persons.

2.27 "Transportation and related costs" means travel and other costs that are necessary to enable a child/family to receive EIS.

2.28 "Types of services" shall include EI services mandated by federal aw and as set forth in the EI Certification Standards.

0322.15 Lead Agency
EFF:09/2005

Section 3.0 Lead Agency

The Department is the lead agency responsible for early interventio services for infants, toddlers, and their families consistent with C of IDEA effective July 1, 1991, and section 23-13-22 of the RI General Laws, as amended.

Section 4.0 Interagency Coordinating Council (ICC)

4.1 Composition of ICC.

The composition of the Council is specifically determined by criteria set forth in Part C of IDEA. Members of the Council are appointed by the Governor. The Governor shall ensure that the membership of the Council reasonably represents the population of the state.

4.2 The Governor shall designate a member of the Council to serve as the chairperson of the Council. Any member of the Council who is a representative of the Department may not serve as the chairperson.

4.3 Appointments to the Council are for a two-year term. Composition of the Council shall include, but not be limited to:

a) At least twenty percent (20%) of parents of infants or toddlers including minority parents who have been enrolled in the Early Intervention Program within the past three (3) years [minimum 20%];

b) At least twenty percent (20%) of providers of early intervention services [minimum 20%];

c) One (1) representative from the legislature;

d) One (1) college or university member involved in personnel preparation;

e) One (1) pediatrician;

f) One (1) representative from each of the state human service agencies involved in the provision of or payment for EIS to infants and toddlers with disabilities and their families (Children, Youth and Families; Education; Health; Human Services; Mental Health, Retardation and Hospitals) having sufficient authority to do policy planning or implementation on behalf of the agency;

g) One (1) representative from the advocacy community for children with special needs and their families;

h) At least one (1) representative from the Department of Business Regulation, the agency responsible for state governance of health insurance;

i) At least one (1) Rhode Island Department of Education, Director of Special Education, responsible for preschool services to children with disabilities. This may or may

not be the same representative of the Department of Education as required in subsection (f);

j) At least one (1) member from Head Start;

k) At least one (1) member from a state agency responsible for child care. This may or may not be the same representative of the Department of Children, Youth, and Families as required in subsection (f);

l) At least one (1) member from the State Medicaid Agency;

m) At least (1) member from the Office of the Coordinator of Education for Homeless Children and Youth;

n) At least one (1) member from the state child welfare agency responsible for foster care. This may or may not be the same representative of the Department of Children, Youth, and Families as required in subsection (f)

o) At least one (1) member from the state agency responsible for children's mental health.

The Council may include other members selected by the Governor.

4.4 Duties and Responsibilities of the ICC

The Council shall assume the following responsibilities consistent with the provisions of Part C of IDEA

a) The Council will meet at least quarterly as stated in the by-laws;

b) The Council shall announce meetings in sufficient time as to ensure attendance;

c) Council meetings shall be open and accessible to the general public;

d) Interpreters for the deaf and other services needed to support participation of all interested parties will be provided as necessary;

e) No member of ICC may vote on any matter providing direct financial benefit to self or give appearance of conflict, and must conform to the provisions of Chapter 36-14 of the General Laws of Rhode Island, as amended, entitled "Code of Ethics";

f) Advise and assist the Department in the development and implementation of the policies that constitute the statewide system;

g) Assist the Department in achieving the full participation, coordination, and cooperation of all appropriate public agencies in the state;

h) Assist Department in implementation of the statewide system by establishing a process that includes seeking information from service providers, service coordinators, parents, and others about any federal or state or local policies that impede timely service delivery, and taking steps to ensure that policy problems are identified and resolved;

i) Assist Department in resolution of disputes to the extent deemed appropriate;

j) Advise and assist Department and state education agency (SEA) in obtaining appropriate services for children ages birth-5 inclusive;

k) Advise and assist SEA regarding transition of toddlers with disabilities to services under Part B to preschool and other appropriate services;

l) Advise or assist Department in the preparation of applications and amendments for applications;

m) Assist Department in the identification of fiscal sources of support for early intervention programs;

n) Assist in the assignment of financial responsibility to the appropriate agency;

o) Assist in the promotion of interagency agreements;

p) Submit an annual report to the Governor and to the Secretary of Education on the status of early intervention programs within the state.

Section 5.0 Certification of Early Intervention Service Providers

5.1 No person shall provide EI services as an EI service provider without first becoming certified by the Department.

5.2 In order to become certified as an EI service provider, a person shall submit an application along with the required documentation demonstrating compliance with the Act, rules and regulations herein, and Certification Standards.

5.3 Certification shall be granted for a three-year period. All certifications shall expire on December 31st of every third year commencing December 31, 2005.

5.4 The Department shall certify applicants as it deems appropriate and necessary in order to assure a viable statewide early intervention system that provides quality services to infants and toddlers with disabilities and developmental delay.

5.5 General Certification Requirements

An EI service provider shall comply with all federal IDEA (Individuals with Disabilities Education Act) requirements.

5.6 All EI service providers shall be capable of providing EI services on a statewide basis.

5.7 All infants and toddlers presumed eligible for EI services shall be promptly and accurately identified, located, and referred to EI and, if found to be eligible, shall have individualized family service plans (IFSPs) developed that accurately reflect their needs.

5.8 EI service providers shall provide care and services to children in accordance with the prevailing community standard of care.

5.9 It shall be the responsibility of the EI service provider to ensure timely referral for all children whose IFSP designates services provided by other agencies as needed. Further, those children who are evaluated by EI providers but are not eligible for EI services shall be referred for appropriate services (e.g., CEDARR Family Centers, Early Head Start, Starting Right) with family consent. Unmet needs of this population shall be documented and submitted in accordance with Department statistical reporting requirements.

5.10 EI service providers shall assess the child's and family's needs in the family's native language or other communication mode of the parent. If this is not feasible, an interpreter shall be provided.

5.11 EI service providers shall ensure that parents are actively involved in the preparation and implementation of the IFSP, including transition planning.

5.12 EI service providers shall ensure that there is an effective, ongoing quality improvement plan in place to evaluate the provision of EI services that is coordinated with the Department's quality assurance efforts. This plan shall be available for the Department's review. Program evaluation results shall be utilized to correct identified deficiencies

and to meet identified needs of children and parents.

5.13 EI service providers shall utilize evaluation and assessment procedures that are responsive to the unique demographic, cultural, racial, and ethnic characteristics of the families served.

5.14 Appropriate EI services shall be:

- Selected in collaboration with parents;
- Provided under public supervision;
- Provided by qualified personnel;
- Provided in conformity with an Individualized Family Service Plan (IFSP);
- Provided at no cost unless state law requires a system Of payments;
- Provided in accordance with state standards;
- Provided in natural environments to the maximum extent appropriate to the child's needs;
- Designed to enhance both the development of the child, as well as the family's capacity to meet the child's needs.

5.15 Certification Requirements Related to Organizational Capabilities

EI service providers shall have written memoranda of

understanding with community agencies where children are receiving EI services.

5.16 EI service providers shall have not-for-profit status.

5.17 EI service providers shall provide services in accordance with the Department's Certification Standards for Early Intervention.

5.18 EI service providers shall maintain appropriate and necessary staff to ensure timely fiscal management that maximizes collection of funds from available sources (e.g., Medicaid, private insurers).

5.19 Fees shall not be charged to families for the provision of child find services, evaluation and assessment, IFSP development, review and evaluation, service coordination, and implementation of procedural safeguards.

5.20 Under no circumstances shall EI services be withheld based upon a family's financial status or inability to pay for services.

5.21 No services that a child is entitled to receive shall be delayed or denied due to disputes between agencies regarding financial or other responsibilities.

5.22 EI fiscal services shall adhere to recognized standard accounting practices.

5.23 An annual certified audit, as prescribed by the Department, shall be maintained on file by the EI service provider for a period of no less than three (3) years. A copy of said annual audit shall be forwarded to the Department upon request.

5.24 EI service providers shall maintain management information systems, compatible with the Department's, to ensure timely billing, data reporting, and quality improvement activities.

5.25 Each EI service provider shall report to the Department statistical data on its operations and services. Such reports shall be made at such intervals and by such dates as determined by the Department.

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SECTION 0322 EARLY INTERVENTION PROGRAM

0322.30 Eligible Population
EFF:09/2005

Section 6.0 Definition of the Eligible Population

6.1 Children eligible for early intervention services shall include all infants and toddlers who have received a multidisciplinary team evaluation consistent with procedures described in sections 9.5--9.7 and who meet the criteria specified in section 6.0 or are eligible due to a designated single established condition.

6.2 Eligible children include those with:

6.21 Children with a Single Established Condition
Criteria: The child has a physical or mental condition known to impact development, including, but not limited to, diagnosed chromosomal, neurological, metabolic disorders, or hearing impairments and visual impairments not corrected by medical intervention or prosthesis. Evidence of diagnosis must be in the child's record.

6.22 Children with established developmental delays.
Criteria: The child exhibits a delay in one or more areas of development (that is, 2 standard deviations below the mean in one area of development, or 1.5 standard deviations below mean in two or more areas of development, or if using developmental age or age equivalents, a delay greater than or equal to 33% in one area or 25% in two

or more areas of development.)

6.23 Children with multiple established conditions.
Criteria: As a guideline, the identification of any one child characteristic and three (3) additional child or family circumstances. Evidence of these criteria should be documented in the child's record along with appropriate goals and treatment strategies as determined by the family and the IFSP team.

Central Directory of Services 0322.35
EFF:09/2005

Section 7.0 Central Directory of Services

7.1 The Department shall oversee a directory of local, regional, and statewide resources for infants, toddlers, and their families, which shall include:

a) Information on all health care, education, mental health, child care, developmental, financial, and other social service programs which are available for young children and families;

b) Information on research and demonstration projects in the state;

c) Professionals and other groups providing assistance to children and families;

d) Public and private early intervention services; and

e) Public and private resources and experts available to providers or families. This directory shall be updated at least annually and be accessible to the general public and be available in places in a manner that ensures accessibility by persons with disabilities.

0322.40 Comprehensive Child Find System
EFF:09/2005

Section 8.0 Comprehensive Child Find System

Child Find efforts shall be coordinated by the Department with

all state agencies and relevant community programs (e.g., Department of Education, Maternal and Child Health, Medicaid EPSDT, Department of Children, Youth and Families, Head Start and Family Outreach Program). Three methods, universal screening, direct referrals and public awareness, shall be implemented concurrently on a statewide basis to ensure that all infants and toddlers in the state who are eligible for services are identified, located, and evaluated.

8.1 Universal Screening

Universal screening shall mean that every child born in Rhode Island shall be screened at birth for risk factors related to developmental delay, or adverse developmental consequences. Follow-up screening shall occur at periodic intervals between birth and through age two (2). This initial screening may occur in the hospital and will continue via other health care providers in the community.

8.2 In-home screening, for all those identified as having risk factors in section 8.1, is a comprehensive process that is intended to identify children in need of additional services. After in-home screening is completed, and on-going risk factors have been identified, the child and family's needs will be addressed through a community based review process. Alternatively, children who are determined to have probable eligibility for EIS may be referred to an EI service provider.

8.3 Direct Referrals

All early intervention service providers certified by the Department in accordance with sections 5.0 and 10.0, shall implement a standard referral process which permits families and community-based agencies to refer infants and toddlers directly to programs for screening, evaluation and assessment to determine eligibility for EIS.

8.4 Referral will be made by primary referral services, (i.e.

hospitals, physicians, parents, child care centers, LEAs, public health facilities, other social service agencies and other health care providers) within two (2) working days after the child is identified.

8.4.1 All children under the age of three who are involved in a substantiated case of child abuse or neglect or are identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug explosive shall be referred to EI.

8.5 The standard referral process must include:

a)A form that minimally records the referral source, date

and reason(s) for referral, primary health care provider, services currently received, demographic information for the child and family, and final disposition of the referral;

b) Procedures to ensure that eligibility determination for all referrals shall be made and the initial IFSP meeting held within forty-five (45) days of referral;

c) Procedures to ensure that all referral sources and families are informed, in writing of the disposition of the referral, and any activities (with timelines) which will be instituted on behalf of the child and family with written parental consent;

d) Procedures to ensure that all ineligible children and families shall be informed of alternative community services and supports which coincide with identified needs.

8.6 Public Awareness

Public awareness is an ongoing, systematic approach to communication with the primary referral sources, health and human service professionals, and parents that focuses on the early identification of all children who are eligible to receive EIS.

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SECTION 0322 EARLY INTERVENTION PROGRAM

0322.45 Evaluation and Assessment Procedures
EFF:09/2005

Section 9.0 Evaluation and Assessment Procedures

9.1 Each EI service provider shall implement a timely comprehensive multidisciplinary evaluation of each child with unknown eligibility for EIS, birth through age two (2), referred for evaluation, and a family directed identification of the needs of each child's family to appropriately assist in the development of the child. Alternatively, families shall be offered the opportunity of an in home screening through the child outreach system, if probable eligibility for EI cannot be ascertained from the referral information. The evaluation and assessment will serve to determine:

- Program eligibility
- Initial IFSP content
- Process for ongoing IFSP monitoring
- Information for transition.

9.2 The assessment shall include, but not be limited to: resources, priorities, and concerns of family, and identification of supports and services necessary to enhance developmental needs of child, with parental consent.

9.3 Each provider shall implement a systematized process that tracks the sequence of all assessment activities and services from the date of referral through the child's discharge on or before three (3) years of age.

9.4 Multidisciplinary Team

For each initial team assessment and every reassessment thereafter, at least two members of the multidisciplinary team must be present, two (2) of whom must be qualified personnel and, in all instances, the service coordinator must be present.

9.5 Child Evaluation and Family Assessment--Child Level of Functioning

Each child referred to an early intervention program shall Receive a multidisciplinary team assessment within forty-five (45) days of the date of referral.

9.6 Such evaluations and assessments must be conducted by personnel trained to use appropriate methods and procedures and informed clinical opinion to evaluate a child's level of functioning in each of the following areas: cognitive, physical, (including vision and hearing), communication, social or emotional development, or adaptive development. A review of each child's current health records and medical history shall be included in this process.

9.7 The outcomes of the assessment process shall be the identification of the child's and family's unique strengths and needs as well as the identification of appropriate early intervention services to meet such needs.

9.8 Any person who has reasonable cause to know or suspect that any child has been abused or neglected shall report such information to the proper authorities at the state Department of Children, Youth and Families, in accordance with the requirements of Chapter 40-11 of the Rhode Island General Laws, as amended.

9.9 Family Concerns, Resources and Priorities

With the voluntary consent of the parent, the assessment process, shall also include:

- Specification of expressed family concerns, resources and priorities, related to enhancing the child's development, and
- Assessing all supports and linkages with other agencies to enhance the family's ability to provide for the child.

9.10 This information should be collected only if it serves a

specific decision making function. Parents and the service coordinator shall jointly determine the method(s) for gathering this information.

9.11 Nondiscriminatory Procedures

Each early intervention provider shall use a process that ensures that:

- Evaluation and assessment procedures are administered in the native language of the child and parent or other mode of communication;

- Procedures used are racially or culturally sensitive;
- Evaluation and assessment are conducted by qualified personnel.

9.12 Timelines

All initial evaluations to determine eligibility and assessment activities shall be completed within forty-five (45) days of provider referral.

9.13 An initial meeting to develop the IFSP and will be conducted within the forty-five (45) day time limit.

9.14 In exceptional circumstances wherein multidisciplinary team assessments cannot be completed within this forty-five (45) day timeframe, all children and families shall receive a comprehensive in-home screening for purposes of potential eligibility determination.

9.15 For children who are clearly eligible for services as determined by the screening process, but exceptional circumstances make it impossible to complete the initial evaluation within forty-five (45) days, the early intervention provider will document the circumstances which make an extension necessary and an interim IFSP shall be developed consistent with requirements specified in section 9.16, given informed written parental consent.

9.16 Interim IFSP's may also be developed if EIS are to begin before the evaluation and assessment are completed, with parents' informed consent. The interim IFSP must include the name of the service coordinator, the services immediately needed and proposed outcomes. In these cases, the initial evaluations and assessments must still be completed within forty-five (45) days.

9.17 Determination of Service Levels

The primary determinant of service levels--i.e., nature, frequency, intensity, location-shall be based on the IFSP process.

9.18 Decisions regarding service provision shall be derived from the child and family assessment process and shall result in an individualize family service plan for each

child and family

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SECTION 0322 EARLY INTERVENTION PROGRAM

0322.50 Individualized Family Service Plan (IFSP)
EFF:09/2005

Section 10.0 Individualized, Family Service Plan (IFSP)

10.1 Components of Plan

o The Department assures that each eligible child and family will receive an evaluation and assessment, IFSP service coordination services and access to procedural safeguards. An IFSP meeting will be conducted no later than forty-five (45) days of the referral. Each IFSP must be developed jointly by the family, service coordinator, at least one (1) member of the multidisciplinary team, and other persons deemed as necessary by the EI service provider or the family. Each IFSP will be based on the multidisciplinary team evaluation and assessment of the child and family and will include the appropriate services necessary to enhance the development of the child and the capacity of the family to meet the developmental needs of the child. The Department provides a standardized IFSP form that all EI providers must use. The following will be included in the IFSP:

o Child status that describes a child's current level of functioning within the areas of physical, (including vision and hearing), cognitive, communication, social or emotional and/or adaptive development. Present status of development will be based upon professionally accepted objective criteria and will focus on child strengths and needs to form the basis for goal development.

O With the concurrence of the family, the IFSP will include a statement of family resources, priorities, and concerns, related to enhancing the development of the child.

O A statement of the measurable results or outcomes expected to be achieved for the child and the family, including pre-literacy and language skills, as developmentally appropriate for the child, and the criteria, procedures, and timelines used to evaluate progress towards such outcomes shall be included. Services shall be modified, as necessary with family consent and prior notice.

O A statement of the specific early intervention services based

on peer-reviewed research, to the extent practicable, necessary to meet the unique needs of the child and family.

Such statements must include the frequency, intensity, location (i.e. home, center, hospital), method of service, and payment arrangements, if any. Also, services must be provided, to the maximum extent possible, in a natural environment as determined by the family and the IFSP team. A justification is needed when EIS cannot be achieved satisfactory for the infant or toddler.

- O A statement of medical, health and other services necessary to the child but not required under Part C, the methods used and persons responsible for accessing them.

- O Projected dates for the initiation and anticipated duration of all services listed.

- O Name of the service coordinator from a profession most immediately relevant to the child's or family's needs, or who is otherwise qualified to be responsible for implementing the IFSP. This may be the service coordinator assigned at the time of referral or a new one may be appointed at the IFSP meeting.

- O Specification of activities that will occur to support the smooth and effective transition of children from early intervention to other environments on or before three (3) years of age.

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MEDICAL ASSISTANCE

SECTION 0322 EARLY INTERVENTION PROGRAM

0322.55 Development, Review and Evaluation of IFSP
EFF:09/2005

Section 11.0 Development, Review, and Evaluation of the IFSP

11.1 Each IFSP meeting shall minimally include the following participants:

- o The parent or parents of the child;
- o Other family members, as requested by the parent;
- o Other persons, as requested by the parent;
- o An advocate or person outside of the family as requested b the parent;
- o Service coordinator;
- o Multidisciplinary team members who are directly involved in conducting evaluations or assessments and providing services.

Meetings must be held with sufficient written notice, at least seven (7) days prior to meeting, unless previously waived in

writing by the parent(s), and in settings and at times convenient to families to ensure attendance. They must be conducted in the native language of the family or other mode of communication used by the family, unless not feasible. If not feasible, an interpreter shall be provided.

In instances where services are needed immediately, an interim IFSP may be initiated for eligible children prior to the completion of the assessment process, provided:

- Written consent of parent is obtained;
- An interim IFSP is developed that includes the name of the service coordinator who will be responsible for implementation of the interim IFSP;
- Specific early intervention services that have been determined to be needed immediately by the child and child family are identified;
- Projected date of completion of the assessment process determined and agreed to by the parent(s);
- Documentation of the exceptional circumstances is required

11.2 Progress Review

Each IFSP must be formally reviewed every six (6) months, or more frequently if conditions warrant, or if a family requests such a review. Participants in this progress review shall minimally include the parent, service coordinator, and others as requested by the parent. The purpose of this meeting is to review the IFSP and to update or develop goals and determine progress toward the desired outcomes and whether or not modification to the IFSP is needed.

11.3 Annual IFSP

The annual IFSP meeting to evaluate the IFSP shall be consistent With results and findings derived from the annual multidisciplinary Team assessment and progress toward goals. Participants in this Meeting shall include those represented in the initial IFSP meeting or members of the multidisciplinary team.

11.4 Accessibility and Convenience of Meetings
IFSP meetings shall be conducted:

- In settings and at times that are convenient to families;
- In the native language of the family or other mode of communication used by the family;
- In accordance with written notification provided to the family and all other participants by the primary service coordinator at least seven (7) days prior to the date of the meeting.

0322.60 Transition of Children to Preschool Programs
EFF:09/2005

Section 12.0 Transition of Children to Preschool Programs

12.1 All programs shall include a description of policies and procedures to ensure a smooth transition of children from Early Intervention into other environments as outlined in the child's transition plan.

12.2 Transition of Children from Part C to Preschool Programs

When the child is 28 months old, EI providers shall notify the Local Educational Authority (LEA) where the child resides and other community services and supports. A transition meeting is requested by the service coordinator. A transition team shall convene to begin individual transition planning when the child is 30 months of age. The EI service coordinator shall be responsible for scheduling this meeting. The team shall include the parents, the service coordinator, the LEA representative, and other individuals as requested by the parents. The team shall develop a written plan outlining the activities to take place during the transition period, the persons responsible, and the timelines. The plan shall become part of the child's IFSP and shall reflect the individual needs of the child and the participation of the family.

12.3 All children exiting EI shall have a transition-planning meeting. As part of the transition plan, if a child is determined to be ineligible for special education services, the transition team shall refer the family and child to appropriate community resources.

Comprehensive System of Personnel Dev 0322.65
EFF:09/2005

Section 13.0 Comprehensive System of Personnel Development

13.1 All professional qualified personnel in early intervention programs, whether employed on a full-time or part-time basis, or under a contractual agreement, for whom certificates or licenses are required by state law and regulation, shall hold such certificates or licenses.

13.1.1 Copies of all current licenses, certificates, or registrations required by law or regulation shall

be maintained on file by the EI service provider for all professional qualified personnel.

13.1.2 All EI personnel shall meet qualifications as set forth in the EI Certification Standards.

13.2 Each EI service provider shall promptly notify the Department of any staffing changes that would materially affect the provision of EI services.

13.3 Personnel Standards

The EI service provider shall develop written policies and procedures that will ensure those personnel providing early intervention services to eligible children and their families are appropriately prepared and trained. Such written policies shall include the provision that staff shall attend all training for professional development activities mandated by the Department. This requirement may be met through the use of professional development plans. EI providers shall ensure appropriate supervision of qualified personnel. This shall include the employment of a full-time supervisor who shall participate in training or supervision as required by the Department.

13.4 Service Coordinator

Each eligible child and the child's family shall be provided with a service coordinator who is responsible for coordinating all services between agencies and serving as the single point of contact to obtain the services and assistance that parents require. There shall be a sufficient number of service

coordinators as defined by the Department available to plan and coordinate all EI services in natural environments in a timely manner including the multidisciplinary team evaluation and/or assessment, the initiation of an IFSP meeting within forty-five (45) days of referral, and all IFSP reviews. Service coordinators shall meet the required standards of Section 2.25 herein and shall be responsible for:

- Coordination of multidisciplinary evaluations and assessments;
  - Participation in development, review and evaluation of integrated Individualized Family Service Plan (IFSP) goals and outcomes;
  - Assisting families in identifying available service providers;
  - Coordinating and monitoring the delivery of services;
  - Informing families of advocacy services;
  - Coordinating with medical and health providers;
  - Facilitating the development of a transition plan to preschool services, when appropriate; or making referrals to appropriate community services and supports;
  - Facilitating the timely delivery of available

services
- Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.

Service coordinators shall serve as the single point of contact in helping parents to obtain the services and assistance they need. Service coordinators shall be persons who have demonstrated knowledge and understanding about eligible infants and toddlers, Part C of the Individual with Disabilities Education Act (IDEA) and the regulations, the nature and scope of services available under the state's Early Intervention Program as delineated in the Certification Standards, the system of payments for those services, and other pertinent information.

13.5 Training and Professional Development

Requirements for training and professional development of qualified personnel are outlined in EI Certification Standards. Certified providers must document evidence of trainings and Shall be maintained on file for all qualified personnel.

Section 14.0 Procedural Safeguards and Confidentiality

14.1 The intent of this section of the regulations is to ensure that:

- Parents are fully informed of all recommendations in the parent's native language or other mode of communication. If it is not feasible to provide information in the parent's native language or other mode of communication, an interpreter shall be provided;
- Recommendations and all direct services cannot be initiated without written parental consent;
- Parents are allowed the opportunity to inspect and review records; and
- In those instances in which disagreement occurs between EI service provider staff and parents regarding the nature of the assessment process, IFSP process, or service provision, impartial mediation and hearing procedures shall be available for resolving such issues.

14.2 Parent Consent and Notice

Definition of Consent

Consent means that:

- The parent(s) have been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication. If it is not feasible to provide information in the parent's native language or other mode of communication, an interpreter shall be provided.
- The parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom;
- The parent understands that the granting of consent is voluntary and may be revoked at any time;
- The parent has the right to determine whether the child or other family members will accept or decline an EIS under this part in accordance with state law, without jeopardizing other early intervention services under this part;
- The definition of "native language" (for persons with limited English proficiency) means language/mode of communication normally used by parents.

14.3 Prior Notice

- Written notice, typically through the IFSP process, must be given to the parent(s) of an eligible child prior to the provision or modification of early intervention services to the child or family. All communication must be in a language understandable to the parent(s), and/or must be conveyed in the parent's native language or normal mode of communication. Service providers shall be responsible for assuring availability of qualified foreign language interpreters and/or sign language interpreters.
- The notice must be provided within a reasonable time before the provider proposes or refuses to initiate or change the identification, evaluation, or placement of a child or the provision of early intervention services.
- If the parent is deaf or blind, or has no written language, the notice must be in the language or mode of communication normally used by the parent. An interpreter may be used.
- This notice must be in sufficient detail to inform the parent(s) about the evaluation or direct service activity being proposed or refused, must include the reasons for the actions proposed, and must include all procedural safeguards.

14.4 Parent Consent

Written informed parental consent must be

obtained before:

- Conducting an evaluation and assessment of a child;
- Initiating or changing the provision of early intervention services.

If consent is not given by the parent, the early intervention program shall make reasonable efforts to ensure that the parent:

- Is fully aware of the nature of the assessment or services that would be available;
- Understands that the child will not be able to receive the assessment or services unless consent is given.

14.5 Surrogate Parents

The Department shall ensure that the rights of eligible children are protected if:

- No parent can be identified;
- The early intervention provider, after reasonable efforts, cannot discover the whereabouts of a parent;
- The child is a ward of the State.

14.6 The Department shall be responsible for determining the need for a surrogate and the assignment of an individual to act as a surrogate for the child in accordance with existing state law. Such policies shall ensure that a person selected as a surrogate parent:

- Has no interest that conflicts with the interests of the child he or she represents;
- Has knowledge and skills that ensure adequate representation of the child.

14.7 A person assigned as a surrogate parent may not be an employee of any state agency or be involved or be an employee of someone involved in the provision of early intervention or other services to the child or to any family member of the child.

14.8 A surrogate may represent a child in all matters related to:

- The evaluation and assessment of the child;
- Development and implementation of the child's IFSP, including annual evaluations and periodic reviews;
- Procedural safeguards;
- The ongoing provision of early intervention services to the child;
- Any other matters contained in the Certification Standards.

14.9 A surrogate parent may be removed for any violation(s) of the surrogate parent agreement.

14.10 Opportunity to Examine Records

The parent(s) of eligible children must be afforded the opportunity to inspect and review their child's records, including information relating to evaluation and assessment, eligibility determination, development and implementation of IFSPs, and individual complaints dealing with the child. Parents must be informed in their native language of the nature, type, and purpose of information contained within their child's records, and must receive written notice of a program's policies and procedures regarding information collection, storage, disclosure, and destruction.

14.11 Access Rights

Each early intervention program shall permit parents to inspect their record. Requests for record reviews by parents shall be complied with promptly, and in no case shall exceed forty-five (45) days. Record reviews must be facilitated, upon request, prior to IFSP meetings, hearings related to the child's identification, evaluation, or placement, or at any time within the identification, evaluation, and IFSP planning process. Parents or their designated representative may also request copies of records; however, programs may not charge for retrieving or copying such records. Parents or their representatives have the right to a response to reasonable requests for explanations and interpretations of records. The agency will presume the parent has the authority to inspect and review his/her child's records unless the agency has been advised that the parent does not have that authority under state law.

14.12 Record of Access

All participating agencies which maintain confidential or personally identifiable information on children and their families must keep a record of parties obtaining access to those records (except access by the child's parents and authorized employees of the agency), including:

- The name of the party requesting access;
- The date of access; and
- The purpose for the access.

14.13 Records On More Than One Child

If any record includes information on more than one child, parents of those children have the right to inspect and review only the information relating to their child or to be informed of that specific information.

14.14 List of Types and Locations of Information

Agencies must provide parents, upon request, a list of the types

and location of records collected, maintained, or used by the agency.

14.15 Amendment of Record at Parent's Request

In those instances in which the parent believes that the record is inaccurate, misleading, or violates the privacy or rights of the child or family, the parent may request the agency to amend the information. Such amendments, if agreed to by the agencies, must occur promptly. The agency may, within a reasonable time, decide whether to amend the record. If an agency refuses to amend the record, the parent shall be so notified in writing and shall be informed of their right to an impartial hearing. In either case the agency must note in the record the parents expressed disagreement with the information.

14.16 Right to a Hearing Regarding Information Contained Within Records

Parents shall be entitled to an impartial hearing if they believe that the contents of their child's record is inaccurate, misleading, or violates the privacy or rights of the child or family. Such impartial hearings shall be subject to the same procedures as specified in section 15.8 of these regulations. If the impartial hearing finds that the record is inaccurate, misleading, or in violation, the agency must amend the record and so inform the parents of such amendments, in writing, within one (1) week of the decision. If the impartial hearing finds that the record is accurate, the agency must inform the parent of their right to insert a written statement into the record, commenting on information or expressing disagreement with the decision of the agency. Such statements must be maintained as part of the child's record as long as the child's record or contested portion is maintained by the agency, and must be disclosed if the record is reviewed by any party.

14.17 Hearing Procedures

Any hearing held under this part regarding a child's record must be conducted under the procedures in 34 CFR 99, the Family Education Rights and Privacy Act (FERPA).

14.18 Consent

Written parental consent must be obtained before personally identifiable information is disclosed to any individual not employed or placed by the Department, the Early Intervention service provider, or to any other agency, or for any other purpose than to comply with these regulations. The agency may not release information from the records to participating agencies without the consent of the parent unless authorized to do so under FERPA. In the event that the child's multidisciplinary team believes failure to release requested information would be harmful to the health or welfare of the child, the agency may request a due process hearing to determine if the information may be released without parental consent.

14.19 Safeguards

All early intervention programs are responsible to protect the confidentiality of personally identifiable information at the collection, storage, disclosure, and destruction stages. The administrator of the early intervention provider site shall assume responsibility for ensuring that confidentiality of personally identifiable information is maintained. Each provider must maintain a list of individuals who have access to personally identifiable information, and must provide instruction to these individuals regarding all sections of these regulations pertaining to maintenance of confidentiality.

14.20 Destruction of Information

Personally identifiable information (excluding permanent record information such as name, address, phone number, early intervention program and services) must be destroyed if the parent so requests. The agency must inform the parent when personally identifiable information is no longer needed or maintained by the agency.

14.21 Enforcement

Each service provider, agency, institution, and organization that provides services under Part C shall participate in a self-review process, as well as monitoring and on-site reviews by the Department to ensure that all policies and procedures are being followed.

14.22 Sanctions for failure to comply with the Part C requirements identified during the monitoring process and failure to correct identified deficiencies may include the withholding of Part C funds if determined appropriate by the Department.

14.23 If the Department determines that an EI service provider is not in compliance with the Act or the rules and regulations herein, certification status may be denied, revoked or suspended following notice and opportunity for hearing.

Section 15.0 Mediation and Impartial Hearing Process

15.1 Mediation Procedure

Mediation is a form of conflict resolution in which a "mediator" is called upon to attempt to reach a resolution of differences of opinion between parent(s) and early intervention service providers.

15.2 Either party to a disagreement may submit a written or verbal request to the Department for mediation. The Department has established and implemented procedures that ensure that the mediation process:

- Is voluntary on the part of both parties;
- Is not used to deny or delay a parent(s) right to a due process hearing or to deny any other parental rights afforded under Part C;
- Is conducted by a qualified and impartial mediator who is trained in effective mediation techniques; and
- Is completed within fourteen (14) days of request unless otherwise agreed to by the involved parties.

15.3 The Department shall maintain a list of individuals who are qualified mediators and are knowledgeable in laws and regulations relating to the provision of EI services.

15.4 The Department shall bear the cost of the mediation process.

15.5 Each session in the mediation process shall be scheduled in a timely manner and be held in a location that is convenient to the parties involved in the dispute.

15.6 An agreement reached by the parties to the dispute in the mediation process shall be set forth in a written mediation agreement that is legally binding and enforceable in a court of law. Discussions that occur during the mediation process are confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings. The parties to the mediation process shall be required to sign a

confidentiality agreement prior to the commencement of such process.

15.7 Either party may request a hearing, or reactivate a hearing, which was requested prior to mediation. In the event of reactivation, the hearing must be completed and decision rendered within thirty (30) days of the original request of the hearing if the mediation process fails to achieve a mutually agreeable resolution of the disagreement within the fourteen (14) day time line.

15.8 Impartial Due Process Hearing

A parent or public agency may initiate a hearing on any matter pertaining to prior written notice related to the

public agency's proposal or refusal to initiate or change the identification, evaluation, or placement of the child, or the provision of services. The procedures at 34 CFR Sections 300. 506-300. 512 has been adopted. A hearing shall be conducted by an impartial hearing officer who shall complete the proceeding, render a written decision, distributed to all parties, no later than thirty (30) days after the request for a hearing. The hearing officer shall not be involved in the education or care of the child, or be a person who has any personal or professional interest interfering with objectivity in the hearing. A person who qualifies as a hearing officer shall not be disqualified solely because he/she is paid by the public agency to implement the complaint resolution process. The hearing officer should have knowledge about the provision of complaint management requirements, the needs of the child/family and services available to the child/ family. It shall be the responsibility of the Department to assign and financially reimburse the hearing officer. The Department must keep a list of persons who serve as hearing officers and the list must include the qualifications of each of those persons.

15.9 Hearings Initiated by the Parent(s)

A hearing may be initiated by the parent(s) by filing a written complaint with the Department and/or the administrator of the early intervention program. The Department must inform the parent of any free or low-cost legal and other relevant services available in the area if the parent requests the information or the parent or the provider initiates a hearing under this section. Within ten (10) days of receipt of a written complaint, a hearing officer shall be designated.

15.10 Hearings Initiated by the Early Intervention Providers

A hearing may be initiated by the EI service provider Administrator by written notice to the Department with a copy of the notice mailed to the parent(s). Within ten (10) days of receipt of a written complaint, a hearing officer shall be designated. The Department will inform the parent(s) of any free or low cost legal and other relevant services available in the area. A form will be sent to the parents with information relating to legal counsel.

15.11 In the event either party requests a hearing, the hearing officer appointed will have knowledge about the provisions of the complaint management requirements, the needs of children and families, and the services available to children and families. The hearing officer shall perform the following duties:

- Listen to viewpoints about the complaint, examine information relevant to the issues, and seek to reach a timely resolution of the complaint.
- Provide a record of the proceedings, including the

written decision within sixty (60) days of the receipt of the written complaint.

15.12 Hearing Rights

Any party to an impartial due process hearing has the right to:

- Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to EIS for eligible children.
- Present evidence and confront, cross-examine and compel the attendance of witnesses.
- Prohibit the introduction of any evidence at the hearing that has not been disclosed to that party at least five (5) days before the hearing.
- Obtain a written or electronic verbatim record of the hearing.
- Obtain written findings of fact and decisions.

Parents involved in a hearing have the right to have the child who is the subject of the hearing present and to open the hearing to the public.

15.13 Hearing Decision: Appeal

A decision made in an impartial due process hearing is final unless a party to the hearing appeals this decision.

15.14 Administrative Appeal: Impartial Review

Any party aggrieved by the decision may appeal to the Department. The Director shall arrange for appointment of an impartial review officer who is not an employee of the Department. The review officer shall conduct an impartial review of the hearing. The official conducting the review shall:

- Examine the entire hearing record.
- Insure that the procedures at the hearing were consistent with the requirements of due process.
- Seek additional evidence, if necessary, applying all rights previously cited.
  Afford the parties an opportunity for oral or written argument, or both, at the discretion of the reviewing official.
- Make an independent decision on completion of the review, but no later than thirty (30) days after the request for the review.
- Give a copy of the written findings and the decision to the parties.

The decision made by the reviewing official is final unless a party brings civil action in a state or federal court. A hearing or reviewing officer may grant specific extensions of timelines beyond the thirty (30) day period at the request of either party.

15.15 Convenience of Hearings and Reviews

Each due process hearing and each review must be conducted at a time and place which is reasonably convenient to the parent. No later than thirty (30) days after receipt of the complaint, the impartial due process proceedings will be completed and a written decision will be mailed to each party.

15.16 Civil Action

Any party aggrieved by the decision of the reviewing officer has the right to bring civil action in state or federal court.

15.17 Child's Status During the Proceedings

During the pendency of any administrative or judicial proceeding regarding EI services unless the early intervention program and parent(s) of the child agree otherwise, the child involved must continue to receive the early intervention services defined in the most recent IFSP signed by both parties. If the complaint pertains to services to be provided under Part B after the child's third (3rd) birthday, Part B is responsible for the provision of all services.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES MANUAL

MEDICAL ASSISTANCE

SECTION 0322 EARLY INTERVENTION PROGRAM

0322.80 Resolving Complaints
EFF:09/2005

Section 16.0 Resolving Complaints

16.1 Any individual or agency, public or private, may file a written signed complaint to the Department which identifies an area of noncompliance with these regulations, as well as written facts supporting the complaint, by an early intervention service provider. The Department shall be responsible for investigating such complaints and, if necessary, for conducting on-site visitations, giving the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint; and reviewing all relevant information to make an independent determination as to whether the public agency is violating a requirement of Part C of the Act or of this Part; and written responses to the complainant shall be issued by the Department within sixty (60) days of receipt of the complaint. Such written correspondence shall include findings which indicate how the complaint was resolved, and the corrective actions, if any, including timelines required by the early intervention

program. Extensions of the sixty (60) day timeline may be granted by the Director only if exceptional circumstances exist with regard to the complaint. The family shall be notified if an extension is granted by the Director.

16.2 The Department shall include procedures for effective implementation of the Department's final decision, if needed, including:
- o Technical assistance activities;
- o Negotiations; and
- o Corrective actions to achieve compliance.

16.3 Complaints and Due Process Hearings Filed under this Section

If a written complaint is received that is also the subject of a due process hearing under this section, or contains multiple issues, of which one or more are part of that hearing, the state shall set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action shall be resolved within the sixty (60) day timeline using the complaint

procedures described in sections 16.1 and 16.2 herein.

16.4 If an issue is raised in a complaint filed under this section that has previously been decided in a due process hearing involving the same parties: (1) The hearing decision is binding; and (2) The Department shall inform the complainant to that effect.

16.5 A complaint alleging a public agency's or private sector provider's failure to implement a due process decision shall be resolved by the Department.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES MANUAL

MEDICAL ASSISTANCE

SECTION 0322 EARLY INTERVENTION PROGRAM

0322.85 Severability
EFF:09/2005

Section 17.0 Severability

17.1 If any provisions of these rules and regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of the rules and regulations which can be given effect, and to this end the provisions of the rules and regulations are declared to be severable.

0332 BUDGET PERIODS

0332.05 DEFINITION OF A BUDGET PERIOD
REV:07/1994

A BUDGET PERIOD is the period of time against which the applicant's income is measured for the purpose of determining income eligibili- ty. Categorically Needy cases have a one-month budget period.

Medically Needy cases have a six-month budget period.

When a change in circumstances occurs within a 6-month budget period, the current budget period is shortened and a new budget period begun.

0332.10 MEDICALLY NEEDY BUDGET PERIODS
REV:01/2002

An applicant who meets all other eligibility requirements, but has income in excess of the Medically Needy income limits for the size of his/her family may be eligible for MA in accordance with the Flexible Test of Income (See Section 0336 - Flexible Test of Income).

Flex Test cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) receipts for medical services incurred during the period of determination and/or 2) unpaid bills incurred either during the current period of determi- nation and/or prior to application for which the individual is still liable equal to the amount of such excess income. If the applicant is determined eligible via spenddown, the applicant is certified for six months or for the balance of the six (6) month budget period remaining when the excess income is absorbed.

FLEX CASES - Cases achieving Medically Needy eligibility because of having met a spenddown are initially approved for the balance of the original six-month budget period. Such case will automatically close on the last day of this six-month certification period. The new flex test six-month budget period will begin the next day.

For example, a case's original flex test 6-month budget period is January 1 through June 30th. The case meets spenddown on

March 22nd. The case is approved eligible beginning March 22nd and the certification period is for the balance of the six month period (March 22nd to June 30th). The case auto closes June 30th. The case begins new flex test 6-month budget period July 1st.

FIP CASE WITH CURRENT MONTH CLOSING - When a FIP case is closed due to excess income only, the FIP portion of the case is discontinued and eligibility for continued Medical Assistance is redetermined.

If the income is in excess of Medically Assistance Income Limits, the MA case is closed. The first month of the new flex test six month budget period begins the month of the MA closure.

0336 FLEXIBLE TEST OF INCOME

0336.05 USE OF EXCESS INCOME

REV:01/2002

An applicant who meets the other eligibility requirements, but has income in excess of the Medically Needy income limits may be eligible for Medical Assistance in accordance with the Flexible Test of Income.

Flexible Test cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) RECEIPTS FOR MEDICAL SERVICES INCURRED DURING THE PERIOD OF DETERMINATION and/or 2) UNPAID BILLS incurred either during the CURRENT PERIOD of determination AND/OR PRIOR TO APPLICATION for which the individual is STILL LIABLE equal to the amount of such excess income. The only exception to the requirement of applicant liability for the medical expenses is in the case of medical expenses which are paid by or are the liability of other medical care programs that are funded 100% with State funds. For example, an applicant's medical expenses that have been paid (or are to be paid) by the RIPAE program are considered to be the liability of the applicant, and if otherwise allowable, are deducted from the spenddown liability. Medical expenses that are subject to payment by any other third party payer are not considered the liability of the applicant and are not deducted from the excess income.

In some cases, current payments ON THE PRINCIPAL BALANCES of loans to pay off old medical bills (i.e., bills incurred prior to the current budget period) are incurred health care expenses if certain conditions are met.

The Flexible Test of Income may be used to establish eligibility in a retroactive period.

If the applicant is determined eligible under a flexible test of income, the applicant is certified for SIX (6) MONTHS OR FOR THE BALANCE OF THE SIX (6) MONTH BUDGET PERIOD remaining when the excess income is absorbed.

0336.05.05 When Eligibility Begins

REV:07/1994

The date of eligibility is the actual day of the month on which the applicant incurs a medical expense which reduces income to the income standard. THEREFORE, THE DATE OF ELIGIBILITY IS THE DAY THAT THE MEDICAL SERVICE IS PROVIDED AND NOT THE DATE OF THE BILLING, which may be a later date. The expense is incurred on the day of the service.

When an incurred medical expense is a hospital bill, the date of eligibility is the first day of hospitalization. An AP-758 is required to establish the amount of the hospital bill for which the individual is liable. The individual's liability is his/her excess income on the first day of hospitalization, providing there is no expense subsequently incurred which reduces such excess income to a lesser amount.

If the applicant has excess income and there is no indication of medical expenses by which the excess can be absorbed, the case is rejected. However, if the applicant should present medical expenses within the same six (6) month period, the original application is used in determining whether the excess income for this same six- month period has been reduced to the income standard.

0336.05.10 Whose Expenses Are Used
REV:07/1994

The construction of the Financial Unit provides the basis for determining the applicable Medically Needy standards for a family case and the amount of excess income, if any, to be absorbed via a spenddown. The Financial Unit may include persons who are not applying for MA. Medical expenses incurred by non-applicant members of the Financial Unit may be counted toward the applicant's spenddown liability. However, once the excess income is absorbed, only the applicant is MA eligible.

0336.10 DEDUCT LOANS TO PAY BILLS
REV:07/1994

A loan can be an incurred health care expense and, in some circumstances, may be applied against the CURRENT spenddown liability when the applicant has a CURRENT obligation under the loan. The objective of the policy is to allow the recipient to use his or her liability to the lender in place of his or her liability to the provider. However, since the applicant may apply only the amount that would have been deducted had the

provider's bill been used, the deduction of interest paid or payable on the loan is precluded.

A loan taken out in the current period or a preceding period to pay a provider's bill incurred in a PRECEDING PERIOD may be applied against current spenddown liability to the extent of any unpaid balance in certain cases. Current principal payments and any remaining unpaid principal balance on the loan may be applied against the spenddown liability to the extent that:

- The proceeds from the loan WERE actually used to pay the provider's bill (i.e., the loan payments are not deductible until after the proceeds have been paid to the provider); and,

- Neither the provider's charges nor the loan payments and the unpaid balance were previously applied against spenddown liability or deducted from income.

Loan proceeds that will not be used until after the current eligibility period may not be applied against the spenddown liability in the current period because only loan proceeds THAT HAVE BEEN USED to pay for health care expenses may be applied.

However, such proceeds could be used against any spenddown liability for the subsequent period in which they actually are used.

This policy gives the recipient the relief intended by the spenddown (i.e., application of the remaining liability for old medical expenses against the person's spenddown liability). The policy does not change the treatment of old bills that remain unpaid -- i.e., they are still deductible in the spenddown to the extent that a current liability continues to exist and the bills have not been previously deducted.

0336.15 DEDUCTING RECOGNIZED MEDICAL EXPENSES
REV:04/1995

In establishing financial eligibility, excess income is applied toward reasonable incurred medical expenses that are not subject to payment by a third party (other than those medical expenses which are the liability of or paid for by 100% State funded medical care programs).

Recognized medical expenses include medical insurance premiums, co-payments, deductibles and certain medical and remedial care

expenses recognized under state law (See section 0336.15.05 for recognized medical/remedial care expenses that are not provided within MA scope of services and which may be used to offset excess income). Incurred medical expenses may also include current payments on the principal of loans used to pay off old medical bills.

A loan that is taken out in the current eligibility period to pay a health care provider for services rendered in the same period (or, in the case of a new application, for services rendered in the month of application or within the 3 preceding months) may be applied against the spenddown liability for the current period IN PLACE of the provider's bill. (The loan expense and the provider's bill may not BOTH be applied against the spenddown liability.)

Determine the available excess income for the six (6) month period beginning with the month of application. Excess income can then be applied to recognized medical expenses incurred PRIOR to application and unpaid. If a medical expense is more than one (1) year old, it is necessary to ensure that the applicant is still liable for the payment. This can be done by presentation of a current billing. Apply the excess income to the medical expenses in the appropriate order.

Excess income is applied to the medical expenses in the following order:

FIRST: Deduct incurred medical insurance premiums, including any enrollment fee, Medicare premiums, capitation fees for enrollment in prepaid health care programs, and premiums for any other health insurance program which is primarily established for payment of medical costs. With the exception of Medicare premiums, the cost of such medical insurance must be actually incurred and MAY NOT BE PROJECTED over the six (6) months of the application period; Deduct any co-payments, co-insurance or deductibles under any health insurance program as they are incurred.

SECOND: Deduct necessary medical or remedial care recognized under state law but not provided within the Medical Assistance scope of services, such as chiropractic services, adult day care, respite care, or Home Health Aide/Homemaker services.

THIRD: Deduct necessary medical or remedial care provided

within the Medical Assistance scope of services.

FOURTH: Deduct current payments on the principal balances of loans used to pay off medical bills incurred prior to the current budget period.

0336.15.05 Deducting Recognized Medical/Remedial Care
REV:04/1995

Care which is not being provided within the MA scope of services and which may be used to offset excess income includes:

- Adult Day Care;
- Respite Care; and,
- Home Health Aide/Homemaker Services.

0336.15.05.05 Adult Day Care
REV:07/1994

The cost of adult day care services may be used to offset a flexible-test spenddown liability. In order to be considered a cost of "medical or remedial care", these conditions must be met:

- The service must have been rendered by a provider agency approved by the Department of Elderly Affairs (DEA); and,
- The service was required to assist an individual, who because of severe disability related to age or chronic illness, encountered special problems resulting in physical and/or social isolation detrimental to his/her well- being, or required close monitoring and supervision for health reasons.

0336.15.05.10 Respite Care
REV:07/1994

The cost of respite care may be used to offset a flexible-test spenddown liability if the applicant receives overnight respite care at a licensed nursing/convalescent facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).

0336.15.05.15 Home Health Aide/Homemaker Services

REV:07/1994

The cost of Home Health Aide services or Homemaker services may be used to offset a flexible-test spenddown liability under certain circumstances. In order to be considered a cost of "medical or remedial care", the following three conditions must be met:

- The service must have been rendered by an agency licensed by the Rhode Island Department of Health, and recognized as a service provider by DHS under the Homemaker Program (see Section 0530.35 for list); and,

- At least a portion of the service provided each month MUST be for personal care services (assistance with bathing, dressing, grooming, etc.). If the client does not (or did not) receive assistance with personal care during a month, no part of that month's cost of service may be used to offset the flexible-test spenddown liability; and,

- A physician must certify the client's need for personal care services, in writing, at least once in each flexible-test period (six (6) months). The certification must indicate the patient's diagnosis(es), and the type of services required.

If the foregoing three criteria are met, eligibility staff may recognize, without further review, the cost of up to 65 hours per month in Home Health Aide/Homemaker services to offset a flexible- test spenddown liability. Deductions in excess of this amount must be approved in writing by the Nurse/Consultant for Homemaker Services located at C.O. The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the eligibility technician, a copy of the individual's Plan of Service obtained from the provider agency, and a copy of the physician's certifica- tion of need for services. The Nurse/Consultant reviews the material to determine the extent to which the costs of service in excess of 65 hours per month may be recognized as a deduction from excess income. Only the cost of substantive services may be allowed as a deduction from excess income.

0336.20 EXAMPLES

REV:07/1994

EXAMPLE: The applicant has verified unpaid medical expenses for which the applicant is liable that were incurred prior to applica- tion but are still unpaid at the time of application. If the medical expenses absorb all the excess income, the applicant is eligible and is certified for a six (6) month period beginning with the month of application. The case must be redetermined at the end of the six (6) month period.

When the excess income is not absorbed by applying it to medical expenses incurred prior to the application and unpaid, the applicant must present receipts or bills for medical expenses incurred during the six (6) month period beginning with the month of application. The excess is then applied to those expenses. When the excess income is absorbed, ELIGIBILITY BEGINS ON THAT DAY WHICH IS THE DAY THE MEDICAL SERVICE WAS PROVIDED. The case is certified for the balance of that six (6) month period. At the end of this period, a new application must be submitted.

EXAMPLE: An applicant applies in July with countable income of $7,200 a year ($500 excess per year or $250 excess for six (6) months). The applicant cannot be certified as eligible until bills or receipts for incurred medical expenses totalling $250 are presented. If a receipt of $50 is presented in July, and a bill for $200 is presented in August, the applicant is then certified from the day in August that the medical service was provided, through December, the end of that six (6) month period.

If on the final day of the six (6) month period, the applicant has (1) no receipts or bills for incurred medical expenses; or (2) if the receipts and/or bills presented do not absorb the excess income; or (3) if the absorption of excess income in the exact amount of the excess income occurs on that final day, there is no eligibility.

EXAMPLE: An applicant applies in July with income of $7,200 a year ($500 excess per year or $250 excess for six (6) months). The applicant cannot be certified as eligible until bills and/or receipts for incurred medical expenses totalling $250 are present- ed. No bills or receipts for incurred medical expenses are presented.

EXAMPLE: An applicant applies in July with income of $7,200 a year ($500 excess per year or $250 excess for six months). A receipt for $50 is presented in July, $100 in September, and $50

in November - total $200. No further bills or receipts are presented.

EXAMPLE: An applicant applies in July with income of $7,200 a year ($500 excess per year or $250 excess for six months). A receipt for $50 is presented in July, $100 in September, $50 in November, and $50 on December 31 - total $250. However, the excess income is absorbed on the final day of the six (6) month period. There is no eligibility for that period since there is no medical coverage to be met.

Had the receipts and/or bills totaled more than $250, eligibility would have existed for MA coverage of the amount of any unpaid bills over $250. Also, had the applicant been hospitalized on December 31, eligibility would have existed for any expenses on December 31 which exceeded $250.

0336.25 CERT OF FLEXIBLE TEST CASES
REV:07/1994

Each individual determined to be ineligible for MA will receive notice of the basis of ineligibility. Those individuals ineligible on the basis of excess income will be informed of the amount of his/her spenddown liability.

When a recipient's case is discontinued on the basis of income exceeding the Medically Needy income standard, a review of the recipient's situation is completed under the Flex Test policy.

Such recipient is advised of the amount of excess income and the eligibility period during which such excess must be absorbed.

When such applicant/recipient presents unpaid bills (for which the individual remains liable) incurred at any time through the final day of the six (6) month period and/or receipts for bills incurred during the period for which eligibility is being determined which total or exceed the amount of the excess income, eligibility exists for the balance of the six (6) month period. A new application is not needed for that six (6) month period.

Any case certified, whether for a full six (6) month period or a balance of even only one (1) month, needs a new application at the end of each six (6) month period. The InRHODES system will trigger the mailing of a redetermination packet by sending a

notice to the field office. Each six (6) month period is determined separately.

Medical bills recognized in a previous Flexible Test period to reduce excess income must not be applied to reduce the excess income for the new application period. However, if the bills did not establish eligibility, then they were not used for spenddown and can be considered in a subsequent six (6) month period.

To certify a case where the recipient and Medical Assistance must share the expense, the InRHODES eligibility system will notify MMIS of the bills that were used to meet the spenddown. These bills will not be paid by MMIS and are the applicant's responsibility.

0336.25.05 Controlling Flexible Test Cases
REV:07/1994

The InRHODES on-line redetermination report lists all cases due for redetermination with flex-test cases highlighted. The system notifies workers two months before the month that certification ends that re-determination packets need to be sent out.

Flex-test cases by their nature are ineligible at the end of the certification period and will automatically close, and eligibility must be redetermined. The redetermination activities should be completed by the end of the six-month (or less) flex-test period.

0340 EVALUATION OF RESOURCES

0340.05 EVALUATION OF REAL PROPERTY
REV:07/1994

Real property is land, including houses or objects permanently attached to the land. The equity value of any non-excluded real property owned by the family must be counted toward the $1,000 Categorically Needy or $4,000 Medically Needy resource limit.

In determining the value of the resource, equity value is defined as the Current Fair Market Value (CFMV) minus encumbrances.

Evidence of ownership includes the deed, current mortgage statement, assessment notice, the recent tax bill, or a report of title search. If not available, the eligibility technician must obtain the information from the Recorder of Deeds, by telephone or other means.

The Regional Manager is available to the supervisor for consultation in assessing the value of property if the value is questionable in relation to the appropriate resource limit.

0340.10 EVALUAT OF PERSONAL PROPERTY
REV:07/1994

Personal property in a broad sense is everything that is subject to ownership that is not real property. Personal property includes liquid resources.

Liquid resources are those properties in the form of cash or other financial instruments which are convertible to cash and include savings accounts, checking accounts, stocks, bonds, mutual fund shares, time deposits shares, money market certificates, promissory notes, mortgages, cash value of insurance policies and similar properties.

The value of any liquid resources must be counted toward the $1,000 Categorically Needy or $4,000 Medically Needy resource limit.

0340.10.05 Life Insurance
REV:07/1994

In determining eligibility as Categorically Needy, the cash surrender value of all life insurance policies of the assistance

unit is counted toward the $1,000 resource limit. Each assistance unit may retain insurance where the total cash surrender value of all the policies, when combined with all other countable resources, does not exceed $1,000.

Medically Needy resource limits allow up to $4,000 cash surrender value in life insurance policies for each adult, and up to $1,500 cash surrender value in life insurance policies for each dependent child under 18.

Term insurance and group insurance have no cash surrender provisions and are, therefore, not counted as resources.

Procedures to determine eligibility include the following:

- Determine the cash value of each policy that has a cash surrender provision;

- If the total cash surrender value is under the $1,000 limit, this amount must be added to all other countable resources to determine whether the total resources are within the $1,000 limit;

- If the total cash surrender value, when added, exceeds the $1,000 limit, the applicant does not meet Categorically Needy eligibility and eligibility under the Medically Needy limit should be determined.

- If the total cash surrender value, when added, exceeds $4,000 for an adult or $1,500 for a dependent child under 18, the applicant is ineligible for Medically Needy MA.

The specific information required on the insurance policies is identified on the Statement of Need for each member in the family.

The information is obtained from the applicant or recipient by examining the insurance policies or premium books. The insurance information is reviewed and the value updated for purposes of continuing eligibility at each redetermination. If insurance coverage changes by adjustment, termination or purchase, the Statement of Need is updated.

Life insurance held on any or all assistance unit members by an individual outside the assistance unit shall not be counted as a resource.

0340.10.10 Medical Insurance
REV:07/1994

If a family has any medical insurance, such as Blue Cross/Blue Shield, Major Medical, Federal Medicare (Part A, Part B), Harvard Community Health Plan, Ocean State, Delta Dental or other medical insurance, this is identified as a resource for medical payment on the DHS-2 and on the InRHODES Insurance (INSU) panel. The insurance information is transferred from InRHODES to the MMIS at eligibility approval and with each change.

0340.10.15 Automobiles
REV:07/1994

Automobile means a passenger car or other motor vehicle used to provide transportation of persons or goods.

In determining eligibility, one automobile, valued at $1,500 or less, is excluded. However, the equity value over $1,500 of the one excluded automobile and any other automobile(s) owned by the assistance unit must be added to the value of all other resources owned by the assistance unit, and counted toward the $1,000 resource limit for Categorically Needy eligibility or the appropriate resource limit for Medically Needy eligibility.

Equity value is the wholesale/average trade-in value of the automobile less the amount of total encumbrances (legal debts).

- To assess the equity value of an automobile, the eligibility technician determines the wholesale/average trade-in value of the car (truck, van, motorcycle), as listed in the Used Car Guide Book (NADA "Blue Book") minus any encumbrances.

  Encumbrances are verified from documents submitted by the applicant/recipient or from contact with collateral sources. (If a motor vehicle is specially equipped with apparatus for the handicapped, the value of the apparatus is excluded from the assessment in applying the resource policy);

- If the automobile is not listed in the Blue Book, or the recipient disputes the value as stated because of physical damage, the appraisal of a registered automobile dealer is accepted as evidence of the average trade in/wholesale value.

Assistance Unit With One Automobile

For assistance units with one automobile, the first $1,500 of the automobile's equity value is excluded. If the automobile's equity value is $1,500 or less, then no further determination is needed.

The equity value in excess of $1,500 is counted toward the Categorically Needy or Medically Needy resource limit.

Assistance Unit With Two or More Automobiles

For assistance units with two or more automobiles, exclude up to the first $1,500 of equity value from the first automobile. The recipient/applicant can choose which automobile is to be excluded.

Count the amount of equity value in excess of $1,500 of the first automobile plus the total equity value of all other automobiles owned by the assistance unit toward the Categorically Needy or Medically Needy resource limit.

0340.10.20 Non-Essential Items
REV:07/1994

Usually accepted household items are excluded. However, when there is evidence that the applicant possesses household or personal items of unusual or exceptional value, there should be verification of this resource by establishing its fair market price and equity value. Items of unusual value are those not normally used to maintain an adequate standard of comfort and convenience for the household.

The value of recreational boats, art objects or valuable collections of luxury items of unusual value represent resources that must be added to all other total resources to determine whether the resources are within the appropriate limit. It is the current fair market value of the item rather than the item itself that determines the unusual value.

The statement on the DHS-2 (indicating the applicant does not own items of unusual value) referring to other resources owned by the applicant/recipient will be accepted without further development unless there is evidence to the contrary (e.g.,

information from other sources, or answers to other questions on the application that cast doubt on the validity of the response).

If the applicant/recipient owns a valuable resource, then the CFMV must be determined. Any reliable and reasonable method may be used to establish and verify the CFMV, e.g., sales slips, insurance, prior appraisals, or contacts with local merchants.

If the total equity is under the resource limit, this amount must be added to all other countable resources to determine whether the total resources are within the resource limit.

If the total equity exceeds the resource limit, eligibility is not established.

0342 Medicaid Coverage for Children and Families

0342.01 Applicability

October 2013

The provisions in this section do not apply to the individuals and families in the Medicaid affordable coverage groups identified in Medicaid Code of Administrative Rules (MCAR) section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid affordable coverage groups included in section 1301 are located in MCAR section 1303; eligibility requirements for Medicaid-eligible individuals and families in these groups are set forth in MCAR section 1305. Accordingly, the provisions of this section, MCAR 0342, are applicable on and after January 1, 2014 only to the extent indicated in each subsection.

0342.05 RI Works Program Families and Section 1931

REV: June 2014

RI WORKS PROGRAM (RIW)

In Rhode Island, eligible families receive temporary cash assistance through the RI Works Program (RIW). Medicaid benefits for RIW eligible families will be established through a separate determination of eligibility for Title XIX, Section 1931 coverage in accordance with all of the rules and regulations of the Medicaid Program. Effective January 1, 2014, eligibility for RIW participants will be governed by the provisions set forth in the MCAR sections 1301.03.01(01) pertaining to families covered through Section 1931 of Title XIX of the U.S. Social Security Act – the federal Medicaid law. Any families receiving coverage on January 1, 2014 who were initially determined eligible under section 0342.05 will be subject to the provisions applicable to the Medicaid Affordable Care Coverage (MACC) group for families at the time of their next redetermination or, as the process is called now, "Medicaid renewal." Such redeterminations will entail use of the web-based eligibility system (MCAR section 1301 and 1303), including evaluating income eligibility based on the modified adjusted gross income standard (MAGI) in MCAR section 1307.

0342.25 Pregnant Women

REV: June 2014

Effective January 1, 2014, Medicaid eligibility for pregnant women is governed by the provisions set forth in the MCAR section 1301.03.01(2). Eligibility requirements are set forth in MCAR section 1305. Any pregnant women receiving coverage on January 1, 2014 who were initially determined eligible under this section will be subject to the provisions applicable to the Medicaid Affordable Care Coverage (MACC) group for pregnant women at the time of their Medicaid renewal or if there is a change in eligibility status for any reason prior to the date they renew. Such redeterminations will entail use of the web-based eligibility system (MCAR section 1301 and 1303), including evaluating income eligibility based on the modified adjusted gross income standard (MAGI) in MCAR section 1307.

0342.40 Newborn Child of Medicaid Eligible Mother

REV: October 2013

Effective January 1, 2014, Medicaid eligibility for newborn children of Medicaid-eligible pregnant women is governed by the provisions set forth in the Medicaid Code of Administrative Rules (MCAR) section 1305.14 and below as indicated.

0342.40.10.05 Hospital Record of Birth

REV: June 2014

Certain in-state hospitals with maternity units have agreed to assist the Medicaid agency in establishing eligibility for newborns (for Medicaid Only, or RIW/Medicaid) by completing a hospital birth record form. The hospital record of birth contains:

- Newborn's name, date of birth and sex;
- Mother's name; and
- Information regarding whether the child was discharged in the mother's care.

The document must bear the original signature of the hospital's representative authorized to sign the hospital record of birth.

The authorized representative must be an individual designated as keeper of the facility's official records.

The original of the hospital birth record is given to the mother at the point of discharge from the hospital, and a copy is attached to the hospital bill for the newborn that is sent to the Medicaid agency.

This document is reliable alternate evidence of:

- The age of the child;
- The relationship of the child to the mother; and
- The U.S. citizenship of the child.

The birth record serves as initial documentation for the field staff to add a child to the cash assistance and/or Medicaid case.

Note: This document does not establish paternity for a child born out of wedlock. Paternity for eligibility determination purposes is established only when an adjudication is made by Family Court, or when the official birth certificate issued by the Department of Health Division of Vital Statistics lists the father's name.

0342.50 Extended or Transitional Medicaid

REV: June 2014

The Family Support Act of 1988 created a special Medicaid program, known as “transitional Medicaid,” for families in which parents are making the transition from welfare to work.

In Rhode Island, this eligibility category is referred to most often as "extended Medicaid." Under current federal law, extended Medicaid is available to families covered under Section 1931 of Title XIX for a period of up to twelve (12) months. Section 1931 eligibility covers families participating in the RI Works Program and any families who choose to forego cash assistance for any reason who have income up to 110% of the Federal Poverty Level (FPL) at the time initial eligibility was determined. Extended Medicaid is available to these families only when the requirements set forth in section 0342.50.05 below have been met.

0342.50.05 Extending Medicaid Section 1931

REV: June 2014

Extended Medicaid may be provided to families enrolled in RIte Care or RIte Share for up to twelve (12) months following the loss of eligibility for health care under Section 1931 families.

Medicaid eligibility may continue only if section 1931 eligibility is closed because of increased earned income due to:

- employment; or
- increased hours from employment; or
- an increase in wages.

0342.50.10 Initial Criteria for Extending Medicaid

REV: June 2014

At the time a family becomes ineligible for Section 1931 Medicaid benefits, the Medicaid agency must verify and confirm, whether:

- The family has a child living in the home who is under the age of eighteen (18) or between the age of eighteen (18) and nineteen (19) if the child is a full-time student in a secondary school, or at the equivalent level of vocational or technical training, and is reasonably expected to complete the program before or in the month of his/her nineteenth (19th) birthday. A student attending summer school full time, as defined by school authorities, is considered a full-time student for these purposes; and

- Eligibility for Section 1931 Medicaid coverage was discontinued because of earned income of a parent /caretaker or other member of the family due to:

    - employment;
    - increased hours of employment; or
    - an increase in wages.

NOTE: Extended Medicaid is not provided to any individual who has been legally determined to be ineligible for cash assistance because of fraud at any time during the last prior six months in which the family received benefits. Families who meet these criteria are eligible to receive extended Medicaid if they meet the requirements set forth below.

0342.50.15 Additional Requirements

REV: June 2014

When earned income contributes to the loss of eligibility for Section 1931 Medicaid, a notice is sent informing the family of the right to extended Medicaid for up to the maximum of 12 months. The notice also sets forth the following requirements:

The family must:

- submit a report which includes an accounting of the family's earned income and the "necessary child care" expenses;
- enroll in an employer's health plan (whether individual or family coverage) if it is offered at no cost to the parent / caretaker; and
- report circumstances which could result in the discontinuance of extended benefits (e.g., no age appropriate child in the family or a move out-of-state).

0342.50.20 Loss of Benefits Due to Employment

REV: June 2014

A required element for eligibility to receive extended Medicaid is employment of a parent / caretaker or other member(s) of the family whose earned income contributes to the family's loss of eligibility for Section 1931 Medicaid.

Often employment linked with other changes, such as a parent returning to the home or a child turning eighteen, may combine to cause the loss of eligibility. While there must be a relationship between earned income and the loss of eligibility for Section 1931 Medicaid to qualify for extended Medicaid, the advent or increase in earned income need not be the only factor causing the loss.

0342.50.25 Individuals Eligible to be Included

REV: June 2014

The first month of extended Medicaid is the first full or partial month in which the family loses eligibility for Medicaid health care coverage under Section 1931, but only in those instances in which eligibility under any other Medicaid coverage group is unavailable. If the family is eligible for Medicaid State Plan or waiver coverage, extended Medicaid will be denied.

Extended Medicaid is provided to those individuals:

- who are living in the household, and whose needs and income were included in determining Section 1931 eligibility of the assistance unit at the time such benefits were discontinued;
- whose needs and income would be taken into account in determining Section 1931 Medicaid eligibility of the assistance unit if the family were applying for either of these programs in the current month.

Under the above definition, a child born after Section 1931 benefits are discontinued, or a child, parent or step-parent who returns home after Section 1931 benefits are discontinued, is included as a member of the family for purposes of providing extended Medicaid.

0342.50.30 Initial Receipt of Extended Medicaid

REV: June 2014

Extended Medicaid continues throughout the first seven months following the loss of Section 1931 Medicaid eligibility unless:

- no age-appropriate child is living in the family; or
- the parent / caretaker refuses to apply for health coverage offered by the employer.

When it is determined that a family no longer has a child who meets the age requirements living in the home, Medicaid for all family members ends the last day of the month in which the family no longer includes such child.

The Medicaid program requires beneficiaries to utilize all resources available to them to pay for all or part of their health care coverage. If the parent / caretaker fails to avail her/himself of an employment related health plan (either individual or family membership) that is approved for RIte Share purposes, extended benefits must be discontinued.

0342.50.35 Continuing Receipt of Extended Medicaid

REV: June 2014

To continue to receive the remaining months of extended Medicaid, up to the limit of the full twelve months of the transitional medical program, families must:

- include a child who meets the age requirement living in the household; and
- timely file the earned income report when due in the seventh (7th) month; and
- pass the 185% FPL earned income test; and
- pass the parent / caretaker employment test.

Additionally, an employed parent / caretaker must enroll in an employment-related health plan, if such plan is offered.

0342.50.40 Earned Income Report - Requirement

REV: June 2014

During the period of extended Medicaid, the family is required to file one (1) report due in the seventh (7th) month of extended Medicaid.

The report is filed in the seventh month of extended Medicaid coverage and is an accounting of the family's total earnings and necessary child care expenses incurred during month six (6) of extended Medicaid.

The following information is reported.

- the family's gross monthly earnings received in the specified month, including the earnings of any individual who is eligible to be included in the coverage, but who may not be included in the coverage because of a statutory exclusion (e.g., an individual who fails to comply with child support requirements); and

- the necessary child care expenses for the specified month.

Necessary child care is defined as the child care expenses which allow a parent / caretaker to be employed.

0342.50.40.10 Family's Total Gross Earnings Defined

REV: October 2013

The total gross earned income of family receiving extended Medicaid is defined as the total countable earned income of all the members of the family without the application of any earned income disregards.

0342.50.40.15 Necessary Child Care Expenses Defined

REV: June 2014

For an extended Medicaid family, necessary child care expense is defined as a reasonable child care expense necessary for the employment of a parent / caretaker.

'Reasonable' refers to a child of an age or of a dependency plausibly needing child care. Additionally, child care expenses paid by the Medicaid agency or another third-party are not recognized as an allowable deduction. A necessary child care expense can be incurred, it need not be paid.

0342.50.45 Submitting the Earned Income Report

REV: June 2014

The extended Medicaid earned income reports are:

- an accounting of the family's total gross earned income and a parent / caretaker's necessary child care expenses for month six (6) of extended benefits;

- due by the 5th day of month seven (7) respectively of extended benefits.

On the 15th of each month, a reporting form is sent to any family who has reached month six (6) of extended Medicaid. Such a family must report the required income and necessary child care information by the 5th day of the following month.

On the 7th day of each month, a reminder notice is sent to all extended Medicaid cases scheduled to report in the month. This is to encourage compliance by any family that has neglected to return the report by the due date (5th of the month). Instructions direct those who have complied to disregard the reminder notice.

All reports due in the month must be received by the Medicaid agency prior to the close of business on the 21st day of the month. Medicaid is discontinued on the last day of the month for any family who fails to submit the report by the 21st of the month.

0342.50.45.05 Employment Test for the Parent / Caretaker

REV: June 2014

For families to remain eligible beyond the seventh (7th) month of extended benefits, a parent / caretaker must meet an employment test. Unless there is good cause, a parent / caretaker must be employed. The parent / caretaker must claim good cause on the income report form in order to have the circumstances of a lack of employment considered. (See Section 0342.50.60.10 for Good Cause.)

A parent / caretaker must have earnings under the employment test even if the loss of benefits from Section 1931 Medicaid was caused by the earnings of another family member.

If a parent / caretaker fails the employment test without good cause, extended Medicaid benefits are discontinued on the last day of the seventh (7th) month of extended Medicaid.

0342.50.50 Failure to Meet Requirements

REV: June 2014

If the family fails to pass the income test, the Medicaid agency discontinues extended Medicaid benefits on the last day of a reporting month. In addition failure to pass the employment and income tests in month seven (7) of extended benefits, eligibility will end in any month during extended Medicaid when it is determined that:

- the family ceases to include a child who meets the age requirement living in the household; or
- an employed parent / caretaker failed to enroll in a employment-related health plan.

The maximum amount of time under the extended Medicaid program is limited to twelve (12) months. The Medicaid agency must provide a notice of closing if eligibility is discontinued prior to the receipt of the maximum time allowed under the program's twelve (12) months time-limited benefits. Eligibility is always discontinued on the last day of a month.

0342.50.60 Good Cause

REV: June 2014

A family may have reason to claim good cause for failure to comply with required action.

- Good cause may exist for a failure to timely submit an earned income report;
- Good cause may exist for a failure of the parent / caretaker to be employed.

Good cause may not be claimed for failure to comply with any extended Medicaid requirements other than the above.

0342.50.60.05 Failure to Submit Earned Income Report

REV: October 2013

Good cause for failure to submit the earned income report or to include appropriate verifications, may exist if circumstances beyond the recipient's control prevent the requirement from being met when due. Circumstances in which good cause may exist include, but are not limited to, the following:

- hospitalization or documented serious illness of the recipient or a member of the recipient's family;
- lost or stolen mail confirmed by the U.S. Postal Service;
- a catastrophe caused by fire, flood, or a severe weather condition.

0342.50.60.10 Parent / Caretaker Failure to be Employed

REV: June 2014

The parent / caretaker may have good cause for lack of employment if loss of employment was caused by illness or other factors beyond the parent / caretaker's control. Extended Medicaid may continue if the parent / caretaker can show good cause for being unemployed. Good cause includes circumstances beyond the recipient's control, such as, but not limited to:

- involuntary loss of employment;
- illness or incapacity;
- unanticipated household emergency;
- work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule.

0342.50.70 Discontinuing Extended Medicaid - Notice Required

REV: June 2014

When a family becomes ineligible for Section 1931 Medicaid for reasons related to employment, the family is advised in writing of their continuing eligibility for medical coverage. The Medicaid agency must provide timely notice informing the family of the extended Medicaid program's eligibility requirements; the time-limited nature of the program (12 months maximum), and the exact date coverage will end when the maximum period of benefits has passed. The notice also explains that family members may qualify for Medicaid under other provisions of the program when eligibility for extended Medicaid ceases.

When extended Medicaid is discontinued for any reason prior to the end of the maximum twelve-month period, a separate notice of adverse action is sent.

0342.70 Adoption Subsidy/IV-E Foster Child

REV: June 2014

This coverage group includes foster children, children in kinship guardianship care and adopted children whose Medicaid eligibility is based on eligibility for the Title IV-E Foster Care Maintenance Program, Kinship Guardianship Assistance Program or Adoption Assistance Program.

The Foster Care Maintenance Program provides federally funded foster care payments on behalf of the following children:

- Children previously eligible under the Title IV-A Foster Care Maintenance Program;
- Certain children voluntarily placed or involuntarily removed from their homes;
- Children in public non-detention type facilities housing no more than 25 children.

Children for whom a cash payment is made under the foster care program are deemed eligible for Medicaid. Medicaid eligibility for children in the Foster Care Maintenance program exists as long as the Title IV-E payment continues to be made for them or up to age twenty-six if still in foster care age eighteen (18).

The Adoption Assistance Program provides Federal funding for continuing payments for hard to place children with special needs. The special needs adoptive children must be SSI beneficiaries at the time of adoption. A cash payment is not a Medicaid eligibility requirement for Title IV adoption assistance children. These children continue to be eligible for Medicaid as long as a Title IV-E adoption assistance agreement is in effect. An interlocutory order or final decree need not exist.

0342.70.05.05 Medicaid Eligibility, State of Residence

REV: October 2013

Title IV-E adoption assistance children, kinship guardianship assistance children and Title IV-E foster care children are eligible for Medicaid in their states of residence.

0342.70.05.10 DCYF Certification Responsibility

REV: October 2013

Primary certification responsibility for Title IV-E children resides with the Department of Children, Youth and Families (DCYF).

When a parent or guardian of a IV-E foster child, child in a kinship guardianship care or adopted child, who is now residing in Rhode Island contacts a local district office to apply for Medicaid for his/her child, referral is made to the IV-E Unit at the DCYF.

0342.75 Non IV-E Foster Child Under 18

REV: October 2013

This coverage group is children under age 18, or if 18, will complete high school before his/her 19th birthday, who are in foster family care or in a kinship guardianship care and are not eligible for Title IV-E.

0342.80.10 Continuing Responsibility, DCYF

REV: October 2013

DCYF has the continuing responsibility to notify the Medicaid Foster Care Unit of any change in circumstances for the Foster Care, Kinship Guardianship Care, or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, DCYF must notify the Medicaid agency of the child's date of closure.

If a child is returned to his family, the agency worker informs the family about Medicaid. If the family is potentially eligible, the worker helps the family apply for Medicaid coverage.

0342.85 Non IV-E, State Sub Adopt Assistance

REV: October 2013

This coverage group is hard-to-place children for whom the state provides adoption/guardianship assistance and who are not eligible for Title IV-E. The basis of eligibility for Medicaid is deprivation of parental support occasioned by the child's separation from his/her family.

The determination of financial need of a child not living in a home maintained by the child's parents considers only the child's own income and resources.

Medicaid under this coverage group may be provided until the child reaches age 21.

0342.90 Refugee Medical Assistance

REV: June 2014

This coverage group is refugees who have resided in the United States for eight (8) months or less, and who are ineligible for one of the categorical programs due to lack of a characteristic.

To be eligible for Refugee (RMA) Medicaid, a refugee must:

- Meet the refugee immigration and identification requirements or be the dependent child of such refugees;
- Meet the non-financial requirements and conditions of eligibility for Refugee Cash Assistance (RCA). (Receipt of RCA is not an RMA eligibility requirement);
- Not have been denied or terminated from RCA due to voluntary termination from a job or a refusal of employment;
- Not be full-time students except as allowed in Section 0906.20;
- Be beneficiaries of RCA or, for certain refugees prohibited from receiving a cash payment for a limited period of time, be eligible for some form of RCA;
- Have income and resources within the Categorically Needy limits.

0342.90.05 Treatment of Income

REV: 07/1994

In-kind services and shelter provided by a sponsor or resettlement agency are not considered as income to the refugee when determining financial eligibility for RMA.

Direct cash payments to the refugee from a sponsor or resettlement agency are counted as unearned income.

0342.90.10 Eight Month Limitation for RMA

REV: 07/1994

Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months in the United States, beginning with the month the refugee initially entered the United States, or the entrant was issued documentation of eligible status by the Immigration and Naturalization Service.

0342.90.15 Extended RMA Coverage

REV: 07/1994

If a refugee receiving Refugee Cash Assistance becomes ineligible solely due to increased earnings from employment, the refugee's RMA is extended, at the same level of care, for four months or until the end of the eight month limitation, whichever comes first.

0342.90.20 Termination of Eligibility for RMA

REV: June 2014

A refugee who is terminated from RCA because of failure or refusal to participate in the employment-related requirements is also terminated from RMA. The RMA termination applies only to the sanctioned individual.

0342.95 Closed Family-Related MA-HMO Enroll

REV: June 2014

This coverage group is individuals who would be ineligible if not enrolled in an HMO. These individuals are closed family-related beneficiaries locked in for the enrollment period by managed care.

0342.96 Post Foster Care Coverage Group

REV: October 2013

The Foster Care Independence Act of 1999 established the John H. Chafee Foster Care Independence Program. Participants in this Medicaid coverage group consist of children who are at least eighteen (18) years old but are not yet twenty-six (26) years old and who meet the following criteria:

1. They were in foster care under the responsibility of the Department of Children, Youth and Families (DCYF) on their eighteenth (18th) birthday; and

2. They have been closed to foster care services from DCYF; and

3. They are residents of Rhode Island.

A post foster care adolescent may be residing independently or with others (including family members).

A redetermination must be completed once in a twelve (12) month period to ensure that the post foster care adolescent is a resident of Rhode Island. If the child establishes residency in another state, s/he would not be eligible for medical coverage through the State of Rhode Island.

0342.96.05 Continuing Responsibility, DCYF

REV: October 2013

DCYF has the continuing responsibility to notify the Medicaid Foster Care Unit of any change in circumstances for the Independent Foster Care Adolescent which might cause him/her to be ineligible based on the above criteria.

0342.100 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

0346 MEDICALLY NEEDY AFDC-RELATED COVERAGE GROUP

0346.05 FAMILIES WITH AFDC CHARACTERISTICS

REV:07/1994

Families with characteristics of AFDC and income and resources within the limits established for the Medically Needy (InRHODES Category Code 80)include:

- AFDC-related families to include children under 18 and their caretakers;
- AFDC-related pregnant women with no other eligible children;
- AFDC-related children age 18 who are full time students in a secondary school or in the equivalent level of vocational or technical training, and who will complete school before their 19th birthday.

0346.10 QUAL PREG WOMEN--NO DEPRIV FACTOR

REV:01/2002

A pregnant woman in a one or two parent family, without regard to the existence of a deprivation characteristic, whose income and resources are within appropriate limits at the time of the eligibility determination, is eligible for Medical Assistance as an individual for the duration of the pregnancy.

Eligibility exists provided that:

- The pregnancy has been medically verified; and,
- The family income and standards do not exceed the Medically Needy standards for the size of the family including the newborn.

Once the pregnant woman has been determined eligible, she remains eligible throughout the pregnancy and post partum period regardless of changes in family income.

0346.15 QUALIFIED PREGNANT WOMEN

REV:01/2002

This coverage group is women whose pregnancy has been medically verified, and who would be eligible for FIP cash payment if the child had been born and living with her. Family size includes the unborn. Once the pregnant woman is determined eligible, she remains eligible regardless of any change in family income.

0346.20 QUALIFIED POST PARTUM WOMEN

REV:01/2002

This coverage group is women who, while pregnant, were eligible for and received MA. The woman continues to be eligible, as though she were pregnant, for all pregnancy related and post partum medical assistance for a 60 day period beginning with the last day of her pregnancy.

Eligibility for this coverage extends to the last day of the month in which the 60th post partum day falls.

0346.25 NEWBORN CHILD OF MA ELIG MOTHER

REV:01/2002

This coverage group is children born to a woman who is eligible and receiving MA as Medically Needy on the date of the child's birth (InRHODES Category Code 90). The mother's basis of eligibility may be family or SSI-related.

The child is deemed eligible for one year from birth as long as:

- The child resides continually in the mother's household;
- The mother remains eligible for MA, or would have remained eligible if she were pregnant.

To determine if the newborn is living in the mother's household, the eligibility technician will use the rules of the cash assistance program related to the mother's eligibility.

Changes in the mother's family income never effect the newborn's deemed eligibility because, if still pregnant, the mother would remain eligible regardless of changes in income. If the mother loses eligibility because of changes other than income, the eligibility technician must determine whether she would have remained eligible on any basis if she were still pregnant.

An infant born to an eligible pregnant woman has automatic MA enrollment for the first year of life whether the mother qualifies through a cash assistance program (FIP or SSI) or through Medical Assistance only. This eligibility exists even if the mother becomes ineligible for FIP or SSI, provided the mother is currently eligible for MA or would be if she were still pregnant.

0346.25.05 Newborn Enumeration Requirement

REV:01/2002

Although the mother need not file a separate application for coverage for the newborn, she is required to cooperate with the agency in the enumeration process. Enumeration is a requirement of eligibility for the newborn. However, failure to enumerate the child results in a sanction against the mother, not the child.

The child will remain eligible even if lacking a social security number because of mother's failure to cooperate.

Medical Assistance coverage under this group is the "last resort" for newborns. Whenever possible, staff should determine a child eligible under the Section 1931 or under another coverage group before certifying the child for Medical Assistance as a newborn.

0346.25.10 Newborn Case Processing

REV:01/2002

Although the newborn is deemed eligible at birth, the birth itself is a change in household composition which has substantial eligibility ramifications. The introduction of a new household member(s) requires the worker to redetermine eligibility for the family unit as a whole, as well as the newborn. The redetermination process is completed within thirty (30) days from the date the district office receives notification of the birth.

Operating procedures vary, depending on how the district office becomes aware of the birth and on whether the mother is enrolled in managed care. In some instances the hospital or HMO may inform DHS of the birth, or the mother, or guardian of the infant, may inform the district office of the birth directly.

For a newborn child born to a mother not enrolled in managed care, the district office will receive a copy of the hospital birth record from the hospital where the birth occurs. Subsection 0346.25.10.05, below, describes the function of the hospital birth record.

For a newborn born to a mother enrolled in managed care, the hospital will notify the mother's HMO through their billing process and the HMO will subsequently send a Health Plan Status Change Reporting Form (RC-80HP) to the Center for Child and Family Health (CCFH). The birth hospital may also issue a hospital birth record to the mother which will allow the mother to report the birth to DHS directly. Refer to section 0348.75.10 for guidance relative to newborn enrollment into managed care.

Either the Health Plan Status Change Reporting Form or the hospital birth record is acceptable verification of the birth.

Upon notification, the worker evaluates the change in circumstances brought about by the birth by redetermining eligibility for the family unit.

0346.25.10.05 Hospital Record of Birth

REV:01/2002

Certain in-state hospitals with maternity units have agreed to assist DHS in establishing MA eligibility for newborns by completing a hospital birth record form.

The hospital record of birth contains:

- Newborn's name, date of birth and sex;

- Mother's name; and,
- Information regarding whether the child was discharged in the mother's care.

The document must bear the original signature of the hospital's representative authorized to sign the hospital record of birth.

The authorized representative must be an individual designated as keeper of the facility's official records.

The original of the hospital birth record is given to the mother at the point of discharge from the hospital, and a copy is attached to the hospital bill for the newborn that is sent to the Division of Medical Services.

This document is reliable alternate evidence of:

- The age of the child;
- The relationship of the child to the mother; and,
- The U.S. citizenship of the child.

The birth record serves as initial documentation for the field staff to add a child to the Medical Assistance case.

Note: This document does not establish paternity for a child born out of wedlock. Paternity for eligibility determination purposes is established only when an adjudication is made by Family Court, or when the official birth certificate issued by the Division of Vital Statistics lists the father's name.

0346.25.15 Determination of Newborn Elig

REV:07/1994

When the eligibility technician determines if the child is eligible for inclusion in the mother's Medical Assistance case, there are two possible resolutions:

- The child is eligible as a "Poverty Level" child; or,
- The child remains eligible as a newborn.

0346.25.15.05 Newborn Inclusion in Mother's Case

REV:01/2002

The newborn is added via InRHODES for Medical Assistance Only recipients. The fiscal unit will be notified electronically by InRHODES of the inclusion of the newborn in the mother's FIP case.

0346.25.15.10 Newborn not in Mother's Case

REV:07/1994

The eligibility technician determines eligibility for the child as a "Poverty Level" or "Ribicoff" child (Section 0344). If eligibili-

ty under one of these groups exists for the child, Medical Assistance is authorized via InRHODES in the normal manner.

0346.25.15.15 Elig Remains as a Newborn

REV:07/1994

If eligibility cannot be determined to exist in any other group, it continues to exist for the child as a newborn for as long as the mother:

- Remains eligible for and receiving Medical Assistance, or would be eligible for Medical Assistance if she were pregnant;
- The child remains living with her; and,
- A reasonable effort is made to fulfill newborn enumeration requirements.

At a minimum, the child must be authorized Medical Assistance coverage for the period from the date of birth until the expiration of the ten-day notice period.

When the mother becomes ineligible, and/or eligibility for the newborn terminates, the client must be given a ten-day notice of impending termination.

0346.25.15.20 Example of Newborn Elig

REV:01/2002

Example: Mother is eligible at the child's birth as a Medically Needy pregnant woman. Her eligibility continues to the end of the month in which the 60th postpartum day falls. The mother takes no action to secure continuing assistance for herself and/or the child, ignoring a contact letter sent to there by the district office upon receipt of the hospital notification of birth.

Because the mother takes no action the child cannot be determined eligible in his/her own right under any provision other than as a newborn. Medical Assistance eligibility for the mother continues only until the end of the month in which the 60th postpartum day falls.

A notice of impending termination must be sent to the mother at least ten days prior to the date eligibility for mother terminates.

Failure of the mother to cooperate does not result in termination of coverage of the newborn since an infant eligible under the newborn provision is eligible for the first year of life. If recertification is unsuccessful, or if recertification is successful and eligibility under another provision is not found, eligibility remains for the newborn until the first birthday.

Example: Mother, a MA only Medically Needy recipient, gives birth on November 11, 1994. The agency becomes aware of the birth from the hospital bill, accompanied by a hospital birth record.

The hospital birth record is forwarded to the district office attached to the MA-526NB. The eligibility technician contacts the mother, who declines to file a formal application on behalf of the child. The mother does cooperate in the enumeration process by completing an application for a Social Security Number for the child. The child remains Medically Needy for Medical Assistance as long as s/he remains living with the mother and the mother remains Medically Needy. An interim redetermination must be conducted after six months to ascertain that the mother is still eligible for MA, or would be eligible if pregnant, and the child is still living with the mother.

0346.25.20 Newborn's Loss of Eligibility

REV:07/1994

Events which result in the child's loss of eligibility under the newborn provision are:

- The mother loses eligibility for a reason that would result in her ineligibility even if she were pregnant, or there is a break in her eligibility;
- The child moves from the mother's house;
- The child is placed with potential adoptive parents either directly from the hospital or subsequent to discharge;
- The child attains one year of age.

Notification must be sent to the mother ten days prior to terminat- ing Medical Assistance for the newborn.

0346.30 RIBICOFF CHILD

REV:01/2002

This coverage group is children who are born after September 30, 1983, are under age 19, and whose family meets Medically Needy resource and income standards. A deprivation characteristic does not exist. Ribicoff coverage does not qualify the child's caretaker relative for Medical Assistance.

0346.35 NON IV-E FOSTER CHILD UNDER 18

REV:01/2002

This Medically Needy coverage group is children under age 18 or if 18, will complete high school or technical training before their 19th birthday, who are in foster family care and are not eligible for Title

IV-E. The basis of eligibility for Medical Assistance is deprivation of parental support by the child's separation from his/her family.

This coverage group includes:

- Children placed in foster care by the Department of Children, Youth and Families (DCYF);
- Children placed in foster care by private, non-profit child caring agencies; and,
- Children in group care serviced by private, non-profit child caring agencies.

The determination of financial need of a child not living in a home maintained by the child's parents or other relatives considers only the child's own income and resources. A child is determined to be Medically Needy if his/her non-excluded resources are within the Medically Needy resource limit and income is less than the Medically Needy limit for one.

0346.35.05 MA Foster Care Case Processing

REV:01/2002

Within ten days of the child's placement in foster/group care, DCYF Medical Benefits Unit completes the MA application for subsequent referral to the MA Foster Care Unit.

The MA FOSTER CARE UNIT located in the DHS Regional Office in Providence, is responsible for:

- Processing MA applications for children placed in foster family care or group care by DCYF or private, non-profit child caring agencies;
- Determining the basis for MA eligibility (Categorically Needy or Medically Needy);
- Maintaining records, files, controls and reports for this coverage group.

0346.35.10 Responsibility of Child Care Agency

REV:10/2007

The child care agency has the continuing responsibility to notify the MA Foster Care Unit of any change in circumstance for the Foster or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, DCYF must notify DHS of the child’s date of closure.

If a child is returned to his/her family, the agency worker informs the family about Medical Assistance. If the family is potentially eligible, the worker helps the family apply at the appropriate district office.

0346.40 NON IV-E AGE 18 BUT NOT YET 21

REV:07/1994

This coverage group is children age 18 but not yet 21 who are in foster family care and are not eligible for Title IV-E (InRHODES Category Code 88). The basis of eligibility for Medical Assistance is deprivation of parental support by the child's separation from his/her family.

This coverage group includes:

- Children placed in foster care by the Department of Children, Youth and Families (DCYF);
- Children placed in foster care by private, non-profit child-caring agencies; and,
- Children in group care serviced by private, non-profit child-caring agencies.

The determination of financial need of a child not living in a home maintained by the child's parents or other relatives considers only the child's own income and resources. A child is determined to be Medically Needy if his/her non-excluded resources are within the Medically Needy resource and income limits.

0346.40.05 MA Foster Care Case Processing

REV:07/1994

Within ten days of the child's placement in foster/group care, DCYF Medical Benefits Unit completes the Statement of Need for subse- quent referral to the MA Foster Care Unit.

The MA FOSTER CARE UNIT, located in the Regional Office at 111 Fountain Street, Providence, Rhode Island 02903 is responsible for:

- Processing MA applications for children placed in foster family care or group care by DCYF or private, non-profit child caring agencies;
- Determining the basis of MA eligibility (Categorically Needy or Medically Needy);
- Maintaining records, files, controls and reports for this coverage group.

Prior to the final determination of eligibility, the MA Foster Care Unit will transmit a temporary ID for medical benefits to DCYF Medical and Benefits Unit.

0346.40.10 Responsibility, Child Care Agency

REV:10/2007

The child care agency has the continuing responsibility to notify the MA Foster Care Unit of any change in circumstances for the Foster or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, DCYF must notify DHS of the child’s date of closure.

If a child is returned to his family, the agency worker informs the family about Medical Assistance. If the family is potentially eligible, the worker helps the family apply at the appropriate district office.

0346.45 NON IV-E, STATE SUB ADOPT ASSIS

REV:07/1994

This coverage group is hard-to-place children for whom the State provides adoption assistance and who are not eligible for Title IV-E (InRHODES Category Code 89). The basis of eligibility for Medical Assistance is deprivation of parental support by the child's separation from his/her family.

The determination of financial eligibility of a child not living in a home maintained by the child's parents considers only the child's own income and resources. A child is determined to be Medically Needy if the value of his non-excluded resources and income are within Medically Needy limits.

Under this coverage group, Medical Assistance is available until the child reaches age 21.

0346.50 REFUGEE ASSISTANCE

REV:07/1994

This coverage group is refugees who have resided in the United States for eight (8) months or less, and who are ineligible for one of the categorical programs due to lack of a characteristic (InRHODES Category Code 92).

To be eligible for Refugee Medical Assistance (RMA), a refugee must:

- Meet the refugee immigration and identification requirements or be the dependent child of such refugees;
- Meet the non-financial requirements and conditions of eligibility for Refugee Cash Assistance (RCA). (Receipt of RCA is not an RMA eligibility requirement);
- Not have been denied or terminated from RCA due to voluntary termination from a job or a refusal of employment;

- Not be full-time students except as allowed in Section 0906.20;
- Have income and resources within the Medically Needy limits.

0346.50.05 Treatment of Income

REV:07/1994

In-kind services and shelter provided by a sponsor or resettlement agency are not considered as income to the refugee when determining financial eligibility for RMA.

Direct cash payments to the refugee from a sponsor or resettlement agency are counted as unearned income.

0346.50.10 Eight Month Limitation for RMA

REV:07/1994

Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months in the United States, beginning with the month the refugee initially entered the United States, or the entrant was issued documentation of eligible status by the Immigration and Naturalization Service. (See 0908.10.05)

0346.50.15 Extended RMA Coverage

REV:07/1994

If a refugee receiving Refugee Cash Assistance becomes ineligible solely due to increased earnings from employment, the refugee's RMA is extended, at the same level of care, for four months or until the end of the eight month limitation, whichever comes first.

0346.50.20 Termination of Elig for RMA

REV:07/1994

A refugee who is terminated from RCA because of failure or refusal to participate in the employment-related requirements (Sections 0906.10 ad 0906.20) is also terminated from RMA. The RMA termina- tion applies only to the sanctioned individual.

0350 RITE SMILES DENTAL PLAN

0350.05 Program Overview

REV:09/2006

The RIte Smiles Program is a statewide dental benefits managed care delivery system established under a 1915(b) waiver. The program's goal is to improve access to oral health services for Rhode Island children who receive Medical Assistance. Emphasis is placed on preventive and primary care dental services and education.

Children born on or after May 1, 2000 who are receiving dental benefits through Medical Assistance are enrolled in a RIte Smiles dental plan. The Department of Human Services (DHS) contracts with one or more dental plans to provide oral health services to these MA eligible children.

0350.10 Legal Authority

REV:05/2006

Title XIX of the Social Security Act provides the legal authority for the Medical Assistance Program. RIte Smiles Program operates under a waiver under the authority of Section 1915(b) of the Social Security Act.

0350.15 Coverage Groups

REV:05/2006

Participation in the RIte Smiles Program is mandatory for all children in the following populations who were born on or after May 1, 2000 and who are receiving Medical Assistance:

1. Section 1931 Children and Related Populations (Including Poverty Level Groups and Family Independence Program Cash Recipients)

2. Blind and/or Disabled Children

3. Foster Care Children who are receiving foster care or adoption subsidy assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

4. Section 1115 Waiver Children.

0350.20 Excluded Coverage Groups

REV:05/2006

The following groups are excluded from participation in the RIte Smiles Program:

1. Children born on or before April 30, 2000;

2. Children who have access to third party dental benefits;

3. Children who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

4. Children who reside outside of the State of Rhode Island.

Those children who are not eligible to participate in the RIte Smiles Program receive dental benefit coverage under the Fee For Service System.

0350.25 Retroactive Eligibility

REV:05/2006

If a member is eligible for retroactive eligibility, the dental plan does not provide coverage to Medical Assistance beneficiaries during the period of retroactive eligibility.

0350.30 Enrollment Process

REV:09/2006

All children determined eligible for Medical Assistance starting May 1, 2006 who were born on or after May 1, 2000 must enroll in a RIte Smiles Program dental plan. The parent(s) or guardian(s) of the eligible children may have a choice of dental plans, if more than one plan is available, in which to enroll.

The enrollment process insures that applicants/beneficiaries are provided with sufficient information (if a choice of dental plan is available) in order to make an informed choice when deciding upon which RIte Smiles plan to chose.

0350.35 Voluntary Selection of a Dental Plan

REV:05/2006

Effective May 1, 2006, newly eligible children for RIte Care, RIte Share, or fee-for-service MA will be given a choice of RIte Smiles plans on their application for Medical Assistance (MARC-1 application or the DHS-2).

0350.45 Auto Re-Enrollment Following Resum of Elig

REV:09/2006

Members of Medical Assistance families who are disenrolled from a dental plan due to loss of eligibility are automatically re-enrolled, or assigned, into the same plan should they regain eligibility within sixty (60) calendar days. If more than sixty (60) days have elapsed, the family is permitted to select a plan from those open for enrollment at that time.

0350.50 RIte Smiles Lock-In

REV:09/2006

After initial enrollment into a RIte Smiles plan, enrollees are restricted to that dental plan until the next open enrollment period, unless disenrolled under one (1) of the conditions described below:

- O Loss of Medical Assistance eligibility including for non-payment of applicable premium shares for RIte Care or RIte Share;
- o Selection of another dental plan during open enrollment, if another plan exists;
- o Death;
- o Relocation out-of-state;
- o Adjudicative actions;
- o Change of eligibility status;
- o Eligibility determination error;
- o As the result of a formal grievance filed by the member against the dental plan or by the dental plan against the member;
- o Just cause (as determined by the State).

0350.55 Open Enrollment

REV:09/2006

During open enrollment members have an opportunity to change RIte Smiles dental plans, if more than one dental plan is available.

0350.60 Voluntary Disenrollment

REV:09/2006

RIte Smiles members seeking disenrollment during the lock-in period must first file a formal appeal pursuant to grievance and appeal procedures with the dental plan (with the exception that members are permitted to disenroll without cause during the ninety (90) days following the effective date of the individual's initial enrollment, if more than one dental plan is available).

Disenrollment can only be ordered by CCFH after administrative review of the facts of the case. In order for disenrollment to occur, CCFH must first find in favor of the member, and then determine that the appropriate resolution to the member's complaint is the member's disenrollment.

0350.65 Member Disenrollment

REV:09/2006

Unless the member's continued enrollment in the dental plan seriously impairs the dental plan's ability to furnish services to either the particular member or other members, a RIte Smiles dental plan may not request disenrollment of a member because of:

- An adverse change in the member's health status;
- The member's utilization of medical services; or,
- Uncooperative or disruptive behavior resulting from the member's special needs.

All disenrollments are subject to approval by the DHS/CCFH.

0360 RESOURCE TRANSFER

0360.05 LEGAL BASIS

REV:12/2000

The Omnibus Budget Reconciliation Act (OBRA) of 1993 provides a penalty for institutionalized individuals who transfer or have transferred assets for less than fair market value on or after 8/11/93 when the transfer was made:

- within 36 months immediately prior to or anytime after the date the individual was both institutionalized and applied for MA; or,

- if the transfer involves a trust, within 60 months immediately prior to or anytime after the individual was both institutionalized and applied for MA.

The penalty is a period of RESTRICTED MA ELIGIBILITY during which payment is denied for Long Term Care Services, including nursing facility services, Intermediate Care Facility Services for the Mentally Retarded, administratively necessary days in a hospital, and home and community based waiver services.

See Section 0384 for a detailed discussion of this topic.

0376 OVERVIEW OF MA

0376.05 MANUAL ORGANIZATION

REV: 06/1994

Sections 0376 through 0398 of the Manual set forth policies and procedures to determine Medical Assistance eligibility and Medical Assistance payment for services to INSTITUTIONALIZED INDIVIDUALS.

Institutionalized persons in this context refers to individuals who reside in institutional settings, or who receive home and community based services under a Waiver.

The remainder of this section, OVERVIEW OF MA, describes who is considered to be institutionalized for the purpose of determining MA eligibility and the sequence of determinations. This section also lists the terminology for institutionalized persons, the coverage groups and Waiver programs to which they may belong, and services for the relocation of institutionalized individuals;

Section 0378, PRIOR AUTHORIZATION FOR INSTITUTIONALIZED CARE, sets forth the provisions governing prior authorization for institutionalized care, which is a requirement for MA payment of care in certain medical facilities;

Section 0380, RESOURCES GENERALLY, contains general provisions which apply to an institutionalized individual's resources - resource limits, definitions, distinguishing resources from income, determining the countable resources of an institutionalized individual with a community spouse or dependents, resource reduction, and deeming of resources;

Section 0382, EVALUATION OF RESOURCES, sets forth the First Moment of the Month Rule (FOM) and the policies for evaluating specific types of resources;

Section 0384, RESOURCE TRANSFERS, defines resource transfers and when a prohibited transfer may result in a period of ineligibility for MA payment of long term care;

Section 0386, INCOME GENERALLY, contains general provisions which apply to an institutionalized individual's income -- limits, deeming considerations, definitions, and when income is counted;

Section 0388, TREATMENT OF INCOME, describes the various income exclusions and the evaluation of specific types of income such as rental property income and VA payments.

Section 0390, FLEXIBLE TEST OF INCOME, contains the policies governing the spenddown of excess income to achieve Medically Needy eligibility;

Section 0392, POST-ELIGIBILITY TREATMENT OF INCOME, describes how the amount of income that an institutionalized individual must allocate to the cost of his or her care is determined;

Section 0394, SSI-RELATED COVERAGE GROUPS, describes the eligibility requirements and other provisions of the specific SSI- related coverage groups to which an institutionalized individual may belong;

Section 0396, WAIVER PROGRAMS - GENERAL PROVISIONS, contains the eligibility

requirements and other common provisions governing home and community-based services; Section 0398, SPECIFIC WAIVER PROGRAMS, describes the program goals, eligibility requirements, and services of the specific Waiver programs.

0376.10 ELIGIBILITY REQUIREMENTS

REV: 07/2006

The rules regarding determinations of eligibility for institutionalized individuals differ from the rules for community residents with respect to:

- Income limits;
- Consideration of the income of an institutionalized individual with a community spouse;
- The procedures utilized in the flexible test of income;
- Evaluation of the resources of an institutionalized individual with a community spouse; and
- The impact of resource transfers.

In addition to income and resource eligibility, institutionalized applicants for MA must meet the technical and characteristic requirements of the program and require an institutionalized level of care.

The technical requirements for eligibility are:

- Level of care;
- Residency;
- Enumeration;
- Citizenship/Alienage;
- Identity;
- Accessing potential income and resources; and
- Cooperation in making income/resources available.

An individual must have a characteristic. The characteristics are:

- Age (65 years or older);
- Blindness;
- Disability; and/or
- An AFDC-related characteristic.

The Long Term Care Unit within the Division of Medical Services at CO and Long Term Care/Adult Services (LTC/AS) field staff are responsible for determinations involving institutionalized individuals who apply for MA. An institutionalized individual who receives SSI or FIP is automatically Categorically Needy and receives the full scope of services. However, if an eligible institutionalized individual has made a prohibited transfer of resources, the transfer may render the individual ineligible for MA payment of nursing facility care for up to thirty (30) months.

Once eligibility for Medical Assistance and eligibility for payment of nursing facility services is determined, LTC/AS staff evaluate the individual's income to determine the amount the individual must pay toward the cost of care in the institution.

0376.15 CONSIDERED INSTITUTIONALIZED

REV: 06/1994

For purposes of determining eligibility for Medical Assistance, the following individuals are considered to be institutionalized from the first day in the medical institution:

- Individuals who receive care, or who are likely to receive care for at least thirty (30) consecutive days in nursing facilities, i.e., Skilled Nursing Facilities, Intermediate Care Facilities (SNF/ICFs), Intermediate Care Facilities for the Mentally Retarded (ICF/MRs), or public medical facilities such as the Eleanor Slater Hospital and Zambarano Hospital;

- Individuals in acute care hospitals who are likely to be in the hospital (or another medical institution) for at least thirty (30) consecutive days, and have applied for nursing or public medical facility placement;

- Individuals in acute care hospitals who are likely to be in the hospital (or other institutional setting) for at least thirty (30) consecutive days, who no longer require acute care and for whom Administratively Necessary Day (AND) payment has been requested by the hospital;

- Individuals who entered the acute care hospital setting from a nursing or public medical facility to receive acute care and who plan to return to a nursing or public medical facility subsequent to the episode of acute care hospitalization. The following individuals are also considered to be institutionalized for the purpose of determining MA eligibility:

    - Individuals who receive home and community-based services under a Waiver; and

    - Children under age eighteen who require an institutional level of care, but who receive services at home (Katie Beckett children).

0376.20 SEQUENCE OF DETERMINATIONS

REV: 06/1994

Prior to Medical Assistance payment for the cost of institutional care, it must be determined that the individual requires care in an institutional setting, and that the specific institution is appropriate for that individual's needs. (See Section 0378, PRIOR AUTHORIZATION FOR INSTITUTIONALIZED CARE).

Three separate financial determinations must be made in order to determine the Medical Assistance benefits for individuals who are institutionalized. The financial determinations are made in the following order:

- First, a determination of eligibility for Medical Assistance as either Categorically or Medically Needy is completed. Because of the broader scope of benefits, a determination of eligibility for the Categorically Needy Program is completed first. If the individual is not eligible as Categorically Needy, a determination of Medically Needy eligibility is completed;

- Second, the impact of resource transfers is evaluated. Eligibility for nursing facility payment (or an equivalent level of care) may be effected by a resource transfer which occurs on or after 10/1/89. (See Section 0384, RESOURCE TRANSFER);

- Third, if eligibility for both Medical Assistance and nursing facility payment exists, the institutionalized individual's income is evaluated to determine how much income must be used to help pay for the cost of care in the nursing facility or public medical facility. The Medical Assistance payment for care in these institutions is reduced by the amount of the institutionalized individual's applied income. This determination is known as the post-eligibility treatment of income. (See Section 0392, POST-ELIGIBILITY TREATMENT OF INCOME).

0376.25 NOTICE OF AGENCY ACTION

REV: 06/1994

Each application for Medical Assistance results in a determination of eligibility or ineligibility. If eligible, the scope of services to be provided is determined, i.e. Categorically Needy, Medically Needy, restricted services only for aliens, non-payment for nursing facility services due to resource transfers, etc.

Applicants must be notified of agency decisions regarding:

- Medical Assistance eligibility and the effective dates thereof, including the months of eligibility/ineligibility resulting from the application;

- The scope of services, including eligibility for payment for nursing facility services;

- The amount of income to be applied to the cost of care, and how it was calculated, including the income allocation to the community spouse and/or dependents; and

- The amount of resources attributed to an institutionalized spouse and to his/her community spouse.

0376.25.05 TIMELINESS

REV: 06/1994

Applicants must receive adequate notice at the time the decisions pertinent to their applications are made. Unless the timely decision time frame has been extended by consent of an individual who is rebutting the presumption of ownership of a joint account, decisions on applications for disabled individuals are made within sixty (60) days. Decisions on applications for all others are made within thirty (30) days.

Recipients must receive adequate and timely (10-day) notice of decisions which result in an adverse action. Adverse actions include closing, reduction in the scope of services, and ineligibility for payment of institutional care services.

0376.25.10 NOTICE STRUCTURE

REV: 06/1994

LTC/AS cases frequently require a complex series of decisions relating to eligibility date(s), resource determinations, income to be applied to the cost of care, and allocations to community spouses. A series of attachments supplements the system- generated notices of the Medical Assistance program.

The LTC/AS staff utilize the additional special notices:

- Individuals must be notified of the results of the initial determination of total joint resources for couples when the evaluation is conducted in advance of the eligibility determination;
- Applicants must be notified of the attribution of resources between the institutionalized and community spouses at the time of application;
- Applicants must be notified that there may be a period of ineligibility for Medical Assistance as a result of a resource transfer. Recipients must be notified of the period of ineligibility for payment for nursing facility care that results from a prohibited transfer.

0376.30 TERMINOLOGY

REV: 06/1994

The following terms, which are listed alphabetically, are used in determining MA eligibility and payment for services:

ADVANCED DETERMINATION OF SPOUSAL SHARE: The determination of the Spousal Share of a couple's Total Joint Resources, conducted prior to the MA application and on the first day of the month in which one member of a couple begins a Continuous Period of Institutionalization.

COMMUNITY SPOUSE: The spouse of an individual in a medical institution whose separation from the institutionalized spouse is due solely to the spouse's institutionalization. For a spousal relationship to exist, there must be a legal marriage under Rhode Island law. A legal marriage may be a ceremonial marriage, or a common-law marriage. For a common-law marriage to exist under Rhode Island law, the following conditions must be met:

- Both parties must be of age;
- Both parties must be otherwise free to marry;
- The parties must hold themselves out to the community to be married; and
- The parties must have cohabited at some point.

COMMUNITY SPOUSE RESOURCE ALLOWANCE: The amount of a couple's combined Total Joint Resources which is attributed to the Community Spouse at the time Medical Assistance

eligibility is determined for the Institutionalized Spouse.

CONTINUOUS PERIOD OF INSTITUTIONALIZATION: A period of institutionalization which lasts (or is expected to last) at least thirty (30) consecutive days. A continuous period of institutionalization ends when the institutionalized individual is absent from an institutional setting for thirty (30) consecutive days.

DEPENDENT: For purposes of determining the post-eligibility allocation of income, a dependent is defined as:

- The financially dependent minor child of either the institutionalized or community spouse;
- The financially dependent parent of either the institutionalized or community spouse;
- The financially dependent sibling of either the institutionalized individual or the community spouse.

Financial dependency is established if the sibling, parent or child meets the criteria for dependency for federal income tax purposes for either the institutionalized or the community spouse. The dependent must reside with the community spouse in order to receive a dependent's allocation.

INSTITUTIONALIZED SPOUSE: An individual who is in a medical institution and who is married to a spouse who is not in a medical institution or nursing facility.

SPOUSAL SHARE: One half (1/2) of the couple's Total Joint Resources computed as of the beginning of a Continuous Period of Institutionalization. The Spousal Share remains fixed until the institutionalized spouse is determined to be eligible for Medical Assistance, regardless of any changes in the resources of either the institutionalized spouse or the community spouse. At the time of eligibility determination, the Spousal Share is used as one component in the calculation of the Community Spouse Resource Allowance.

TOTAL JOINT RESOURCE: The combined resources of the Community Spouse and the Institutionalized Spouse owned jointly and/or severally, to the extent that either has an ownership interest in the resource(s). Total Joint Resources are normally calculated at two points in the eligibility determination process as follows:

- The first evaluation (referred to as Advance Determination) is conducted as of the first day of the month in which the institutionalized spouse begins a Continuous Period of Institutionalization. The Total Joint Resources are those existing on the first day of the month in which the Continuous Period of Institutionalization begins, regardless of when the evaluation is actually conducted. The Total Joint Resources of the couple (as of the first day of the month in which a continuous period of institutionalization begins) are divided in half to determine the Spousal Share;
- The second calculation of Total Joint Resources occurs at the point the institutionalized spouse applies for Medical Assistance. At the time of application, as part of the eligibility determination process, the Total Joint Resources of the couple are established as they exist on the first day of the month(s) for which eligibility is being determined.

0376.35 COVERAGE GROUPS
REV: 04/2007

The following is a summary listing of the Medical Assistance coverage groups applicable to institutionalized individuals.

Following each listing is a reference to the section where the requirements of that specific coverage group may be found:

- Institutionalized Individuals - SSI Eligible in Community (0394.05)
- Institutionalized Individuals - Not SSI Eligible in Community (0394.10)
- December 1973 Residents of Title XIX Facility (0394.15)
- Continuing Eligibility - Short Term Confinement (0394.20)
- Employed Individuals Receiving SSI under Section 1619 - Institutionalized in State Operated Facilities (0394.25)
- Institutionalized Individuals AABD Eligible in December, 1973 (0394.30)
- Qualified and Specified Low-Income Medicare Beneficiary (0394.35)
- Qualified Disabled Working Individual (0394.40)
- Disabled Children Receiving Care at Home (Katie Beckett - 0394.45)

Coverage groups also include individuals receiving home and community- based services under one of the following Waiver programs approved by the Centers for Medicare and Medicaid (CMS) of the U.S. Department of Health and Human Services:

- Home Based Services for the Elderly and Disabled (A&D Waiver) (See Section 0398.05)
- Home Based Services for the Mentally Retarded (MR Waiver) (See Section 0398.10)
- PersonalChoice Program (See Section 0398.40)
- Home Based Services for Deinstitutionalizing the Elderly (DEA Waiver) (See Section 0398.20)
- The Assisted Living Waiver (See Section 0398.30.05)
- The Habilitative Waiver (See Section 0398.35.05)

0376.40 RELOCATION OF INSTIT IND
REV: 06/1994

The LTC/AS staff has the responsibility to:

- Determine initial and/or continuing eligibility of applicants and/or recipients who reside in a Long Term Care (LTC) facility or who reside in the community under Long Term Care

Alternatives (see Section 0396, WAIVER PROGRAMS);

- Provide required medical and social facts to Division of Medical Services for providing care to such recipients; and,
- Report to the LTC/AS Unit Supervisor any questions of quality of care or any indicated deviations from the standards set by the Licensing Authority.

The LTC/AS workers have an ongoing responsibility to provide service to recipients in nursing facilities and individuals receiving home-based services under the Long Term Care Alternatives Program.

Individuals receiving services under Long Term Care Alternatives are Group I and Group II. Group I is active SSI recipients who, as of January 1, 1982, had been previously diverted from entering a nursing facility through Home Maker Services, and meet the financial and non- financial eligibility criteria for Categorically Needy MA. No new beneficiaries may be added to Group I. Group II is individuals who qualify for nursing facility care, meet the financial and non-financial criteria for Categorically Needy MA and the criteria for Long Term Care Alternatives Program, and who choose home-based services in lieu of institutional care. When home-based care is no longer needed, it is the responsibility of the LTC/AS worker to plan with the recipient concerning his/her discharge from the home.

0376.40.05 INVOLUNTARY RELOCATION

REV: 06/1994

The relocation of patients necessitated by the decertification of a nursing or ICF/MR facility for Title XIX funds requires detailed social service planning in order to minimize the disruptive effect of the transfer. The Department will, upon request, provide social services necessary to plan and complete relocation. Every effort must be made to achieve a solid plan based on the patient's individual needs. The planning considers several factors. These factors include nursing facility and ICF/MR vacancies, location of the facility, the patient's medical condition, and proximity to visiting relatives and friends. Relevant planning data should be consolidated from all potential authority, relatives, etc.

The following activities occur:

- The patient and patient's family must be notified in writing immediately as to the status of the facility with respect to decertification. The letter should indicate the inability of DHS to pay for the care thirty days following decertification, and also inform the patient and family that LTC staff will provide service for relocation at any time during the thirty day period that the patient and/or family requests it.

- Since the patient's case record contains all current and pertinent medical and social data, it must be carefully reviewed to identify all factors necessary for a sound relocation plan. If it is determined from this review, from consultation with the patient, the patient's family or attending physician that a change in level of care is appropriate, the LTC/AS supervisor will request that the case be re-evaluated by the DHS Review Team.

- Sufficient casework service will be provided to reduce as much as possible the anxiety

level of the patient and assure that the patient understands to his/her capacity the necessity for relocation. Staff must be sensitive to the potential impact of the relocation on the patient. The patient's attending physician will be notified of the pending relocation and requested to provide information regarding any special medical considerations related to the relocation. Involvement of the patient, and the patient's family is paramount. The significance of the family's involvement in the planning should be emphasized. At least one contact, or as many as necessary to effect the relocation plan, will be made with the patient's family, where available. In most instances where the patient is competent and wishes that the family not be involved, the patient's wish is to be honored.

- Care should be taken to sensitize the staffs at the current and prospective facilities to the seriousness of the impact of relocation. They should be encouraged to provide whatever additional support the patient may require in dealing with the stress of uncertainty about the future.

- The caseworker should prepare the patient by providing as much information about the new facility as the patient needs and/or can absorb. Information may include the prospective facility's policies with respect to personal needs, money, laundry, visiting hours, etc. If brochures or photographs are available, they should be shown to the patient. In those instances where a group of patients from a decertified facility will all be transferring to the same facility, group meetings can be held to answer questions about the new facility.

- To the maximum extent possible, the prospective facility selected should be in close geographical proximity to the decertified facility, to avoid disrupting visiting patterns of the patient's relatives and friends. Every effort will be made to relocate together patients who wish to be placed in the same facility.
- Planning for mentally retarded patients must be coordinated with appropriate MHRH field staff in order to ensure that no disruption of other related special services occurs.

- All activities with respect to relocation, including date, time, place and details for planning must be included in the case record.

- LTC staff will undertake the activities set forth in the preceding bulleted paragraphs before concluding that the patient has knowingly refused to accept relocation planning from LTC staff.

- If medically feasible and if a family member or other appropriate person is available to bring the patient for an on-site visit, it can be very helpful in reducing the patient's anxiety.

- Several appropriate alternatives for transporting patients to the new facility are available. The responsible attending physician should be consulted to determine if the patient requires an ambulance. Voluntary transportation resources in the community should be mobilized, where appropriate, to effect the actual move. Suitable plans for a relative or other appropriate person to transport the patient can be arranged. Unusual problems with

transportation should be referred to the Supervisor of LTC services for resolution.

- Appropriate follow-up casework service, after the transfer, is imperative. The social worker must provide whatever support is necessary to ensure adjustment to the new facility.

- Before planning begins, each patient should be notified of the planning process and informed that, if s/he is dissatisfied with any aspect of the contemplated plan, s/he has a right to appeal through the fair hearing process.

0376.40.05.05 INVOLUNTARY RELOCATION RESTRICTIONS

REV: 06/2000

The Nursing Home Resident Protection Amendments of 1999 prohibit the transfer or discharge of residents from a nursing facility as a result of the facility's voluntary withdrawal from participation in the Medicaid Program.

Individuals residing in a nursing facility on the day before the effective date of the facility's withdrawal from MA participation may not be transferred or discharged as a result of the facility's withdrawal. This includes residents receiving MA benefits at the time, as well as individuals who are residents but not yet eligible for MA.

To continue receiving MA payments, the nursing facility must comply with all Title XIX nursing facility requirements related to treating patients residing in the facility in effect at the time of its withdrawal from the program.

Involuntary relocation of a resident patient is permitted when the basis for discharge or transfer is:

- to meet the resident's welfare and that welfare cannot be met in the facility;
- the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- the safety of individuals in the facility is endangered;
- the health of individuals in the facility would otherwise be endangered;
- the resident has failed, after reasonable and appropriate notice, to pay (or have paid by Medicare or Medical Assistance) for a stay at the facility; or
- the facility ceases to operate.

Individuals admitted to the nursing facility on or after the effective date of the facility's withdrawal from the MA program must be provided with notice that:

1) the facility no longer participates in the MA program with respect to that individual; and,

2) the individual may be discharged or transferred if unable to pay the facility's charges

even though the individual may have become eligible for MA.

This information must be provided to the individual both verbally and in a prominent manner in writing on a separate page at the time of admission. A written acknowledgment of the receipt of the notice, signed by the individual (and separate from other documents signed by the individual) must be obtained.

0376.40.10 NF PATIENT APPEAL RIGHTS

REV: 06/1994

Section 1919 (e) (3) of the Social Security Act requires States to provide appeal hearings for all nursing facility residents who wish to challenge their transfers or discharges. By statute, the appeals process cannot be limited to only Medical Assistance eligible nursing facility residents. Therefore, DHS will conduct administrative hearings for any NF resident who wishes to appeal a transfer or discharge from the facility, whether Medical Assistance or Medicare eligible, or private pay.

0376.40.10.05 TRANSFER DISCHARGE CRITERIA

REV: 06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- The health of individuals in the facility would otherwise be endangered.

The basis of the transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.10 DOCUMENTATION REQUIREMENTS

REV: 06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

- The health of individuals in the facility would otherwise be endangered;

The basis or transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.15 PRE-TRANSFER/DISCHARGE NOTICE

REV: 06/1994

Before effecting a transfer or discharge of a resident, a nursing facility must:

- Notify the resident (and, if known, an immediate family member or legal representative of the resident) of the transfer or discharge and of the reasons for the move; and
- Record the reasons in the resident's clinical record (including any required documentation).

The nursing facility must notify the resident by use of a PRE- TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF) at least thirty (30) days in advance of the resident's transfer or discharge. At the time the patient receives the Pre-Transfer or Pre-Discharge Notice, s/he receives at the same time a NOTICE OF YOUR TRANSFER AND DISCHARGE RIGHTS (DHS-200NF) and a copy of REQUEST FOR A HEARING (DHS-121NF).

Thirty (30) day advance notice is not required under the following circumstances:

- In the event of danger to the safety or health of the individuals in the facility;
- When the resident's health improves sufficiently to allow a more immediate transfer or discharge;
- Where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs;
- When the resident has not resided in the facility for a period of at least 30 days.

In the case of such exceptions, notice must be given as many days before the date of the move as is practicable, and include:

- The right to appeal the transfer or discharge through the administrative appeals process;
- The name, mailing address, and telephone number of the State long-term care ombudsman.

In the case of residents with developmental disabilities, the pre- transfer or pre-discharge notice must include:

- The mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

The resident must request an appeal within thirty (30) days of the date of the pre-transfer/discharge notice.

0376.40.10.20 Administ Appeals Process
REV: 06/1994

The Department of Human Services will conduct administrative hearings for any nursing facility resident who wishes to appeal a transfer or discharge from the facility. The patient or patient's representative may request a hearing by completing Sections I and II of DHS form, REQUEST FOR A HEARING (DHS-121NF). The hearing request form should then be routed promptly to the Department of Human Services, Hearing Office, Hazard Building, 74 West Road, Cranston, RI 02920. Upon receipt, the Hearing Office will date stamp the form and send a copy with a letter to the nursing facility instructing the facility to complete Section III and return the form to the Hearing Office within seven (7) days.

The request for a hearing must be submitted within 30 days of the date of the PRE-TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF). If the request is submitted within 10 days of the date of the PRE- TRANSFER OR PRE-DISCHARGE NOTICE (DHS-100NF), the patient will remain in the facility pending the decision of the Hearing Officer.

The administrative hearing generally will be conducted at the resident's nursing facility unless otherwise requested by the patient or the patient's representative. Official notice of the hearing is sent to all parties involved at least five (5) days prior to the scheduled hearing date.

September 10, 2015
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0378 INSTITUTIONAL CARE

0378.05 PURPOSE OF PRIOR AUTHORIZATION

REV: 08/1998

Prior authorization is required for the Rhode Island Medical Assistance Program to provide payment for the care of Categorically and Medically Needy recipients in certain medical facilities. The purpose of prior authorization is to insure that the individual is placed in a facility appropriate to his/her service needs. Therefore the authorization process includes:

- Evaluating the recipient's needs for institutional care and the type of facility required;
- Screening potential nursing facility candidates for mental illness and mental retardation (PASRR);
- Authorizing Medical Assistance and vendor payments;
- Conducting periodic evaluations of the patient's needs.

0378.05.05 Authorization Responsibilities

REV: 08/1998

The district office Long Term Care/Adult Service (LTC/AS) units:

- Determine financial eligibility for MA;
- Determine patient income to be allocated to the cost of institutional care;
- Authorize vendor payments to nursing facilities;
- Assist in the evaluation of medically necessary care;
- Assist in placement of eligible individuals; and,
- Provide social services for applicants and recipients of long term care.

The Office of Medical Review (OMR):

- Establishes the need for nursing facility care by an applicant or recipient prior to authorizing payment; and,
- Ensures that the PASRR Preadmission Screening requirement is completed.

0378.10 TYPES OF FACILITIES

REV: 08/1998

The Medical Assistance Program provides payment for the care of MA recipients in the following types of nursing facilities:

- Nursing Facilities (NF)
  A patient qualifies for nursing facility care if s/he requires the services of professional or qualified technical health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, audiologists, or s/he requires assistance with activities of daily living. Activities of daily living include

walking, bathing, dressing, feeding and toileting. The facility must provide these services under the supervision of licensed nursing personnel.

- Intermediate Care Facility for the Mentally Retarded (ICF/MR)
  A patient qualifies for an ICF/MR level of care if s/he is mentally retarded, and requires supervision and/or assistance with activities of daily living.

The Medical Assistance Program also provides payment for medically necessary care in the following Public Medical Facility:

- Eleanor Slater Hospital.

Patients in NFs, ICF/MRs, the Public Medical Facility and certain Waiver programs are considered to be institutionalized for purposes of determining eligibility for Medical Assistance. The Medical Assistance payment for institutional care is reduced by the amount of the individual's income after certain allowable expenses are deducted.

0378.15 DETERMINING CARE REQUIREMENTS

REV: 08/1998

Procedures for evaluating the type of care required by an individual will vary, depending on whether the individual requests placement from a community setting or while a hospital in-patient.

0378.15.05 Evaluating Needs, Hospital Patients

REV:03/1999

This policy section applies to the following individuals seeking nursing facility placement from a hospital:

- Individuals seeking initial NF placement;
- Individuals who left a NF to enter assisted living, and are now seeking readmission to a NF;
- Individuals who left a nursing facility to return to the community for other than short term social or therapeutic stays, and are now seeking readmission to a NF.

Discharge staff at Rhode Island acute care hospitals have been delegated the authority to make preliminary evaluations of the need for nursing facility care. At the time of discharge to a nursing facility, the hospital social worker or nurse:

- Completes the CP-1 evaluation instrument;
- Sends the original CP-1 and a copy to LTC/Office of Medical Review unit at C.O., along with the PASRR ID screen (See Section 0378.25), a notification of recipient choice (CP-12) and an Inter-agency Referral form;
- Sends a copy of the CP-1, the PASRR forms, and the interagency referral form with the patient to the facility.

Upon approval of the CP-1 evaluation by the Nurse Consultant in the DHS Office of Medical Review (OMR), nursing facility payment is authorized. Copies of the CP-1 and CP-12 are sent to the DHS district office.

Out-of-state hospitals send the PASRR required forms, copies of the medical (72.1) and social worker(70.1) forms, and/or other comprehensive assessments to the DHS Nurse Consultant in the DHS Office of Medical Review. Upon approval, the MA-510 (Authorization for a Level of Care in a Nursing Facility) is completed by the DHS Nurse Consultant and forwarded to the appropriate DHS district office.

When the approved CP-1 or MA-510 is received in the district office, the worker notifies the applicant or recipient of the decision and, if necessary, assists in the placement.

The level of care information is entered to the InRhodes system via the STAT/CARE panel.

Note: MA recipients who have been admitted to the hospital from a nursing facility and are being discharged to the same or another NF are considered to be continuously institutionalized and a new evaluation (CP-1) is not required at the time of their readmission to the NF.

0378.15.10 Evaluating Needs, Community Applicants

REV: 08/1998

When a person residing in the community requests direct placement into a nursing facility, the following documentation is assembled by LTC/AS staff and transmitted to the OMR unit at CO:

- A medical evaluation of the applicant by a physician, Form AP-72.1;
- An evaluation completed by the LTC/AS unit social worker establishing the applicant's functional abilities, living arrangements and service needs, Form AP-70.1;
- PASRR ID Screen (MA/PAS-1). (See Section 0378.25);

If an emergency placement is indicated, the worker contacts the LTC/OMR Unit for emergency authorization of nursing facility placement. Otherwise, as soon as the documentation is received by the LTC/OMR Unit, the Nurse Consultant reviews the evaluations and determines the need for nursing facility care. The decision is transmitted to the LTC/AS staff on Form MA-510, Authorization for Care in a Nursing Facility.

When the MA-510 is received in the district office, the worker notifies the applicant or recipient of the decision and, if necessary, assists in locating a suitable facility. If space is not available, the worker places the individual's name on a waiting list.

The level of care information is entered to the InRHODES system via the STAT/CARE panel.

0378.15.15 Evaluating Needs, ICF-MR Care

REV: 08/1998

Caseworkers at the Department of Mental Health, Retardation, and Hospitals are authorized to determine an individual's need for ICF/MR level of care. The caseworker completes the CP-1 form, and forwards it and the PASRR ID Screen to the LTC/OMR Unit at C.O. for review and approval.

The level of care information documented on the CP-1 is entered to the InRHODES system via the STAT/CARE panel.

0378.15.20 Re-Evaluation of Needs

REV:04/2006

When the Office of Medical Review (OMR) in the Center for Adult Health determines that an individual meets a nursing facility level of care and/or that a full Identification Screen has been received, the OMR Nurse Consultant designates those instances in which the individual's medical information indicates the possibility of significant functional and/or medical improvement within two (2) months. The OMR maintains all records of pending and completed reviews including all cases requiring future review.

Notification is sent to both the individual, his/her authorized representative and the Nursing Facility by the OMR that a Nursing Facility level of care has been approved, but functional and medical status will be re- reviewed in thirty (30) to sixty (60) days. At the time of the review, the OMR Nurse Consultant must first confirm that the individual remains a resident of the nursing facility. For clients remaining in a nursing facility, the Nurse Consultant reviews the most recent Minimum Data Set and requests any additional information necessary to make one of the following determinations:

1. The individual no longer meets a nursing facility level of care. In this instance, the Long Term Care Office is notified of the Level of Care denial, and the individual, his/her authorized representative if one has been designated, and the nursing facility are sent a discontinuance notice by the Long Term Care Unit. Any fair hearing appeal requests resulting from this Level of Care discontinuance notice will be defended by the Office of Medical Review.

2. The individual continues to meet a level of care, and no action is required.

0378.20 AUTHORIZATION OF MA PAYMENT

REV:08/1998

Level of care information (and PASRR information for individuals whose authorized level of care is a nursing facility) is entered to InRHODES and maintained via the STAT/CARE panel.

LTC/AS unit staff approve MA eligibility for institutionalized individuals and authorize vendor payments on behalf of the individual via the InRHODES ELIG/AUTH panel, provided a prohibited resource

transfer does not prevent Medical Assistance payment for the cost of nursing facility care.

If payment to the nursing facility will be made, the worker determines the amount of the patient's income which must be applied to the cost of nursing facility services. The Medical Assistance payment for care in a nursing facility is reduced by the amount of the patient's applied income. See Section 0392, POST-ELIGIBILITY OF INCOME, for policy regarding allocation of income to the cost of institutional care.

0378.20.05 Payment for Nursing Facility Services

REV: 08/1998

Special attention must be paid when a recipient who has Medicare coverage is a resident of a nursing facility. If Medicare coverage is authorized, then Medicare payment for the NF services must be utilized before Medical Assistance payment will be made.

For patients requiring "skilled" services, Federal Medicare helps pay for up to a maximum of 100 days in a participating nursing facility per spell of illness. For persons enrolled in Part A of Medicare, hospital insurance pays for all covered nursing facility services for the first 20 days, if approved. Medically necessary care for the balance of 80 days requires a co-insurance payment. Medical Assistance will pay a recipient's "co-insurance" for approved skilled nursing days if the patient has insufficient income, and no "Medigap" coverage.

0378.20.05.05 Payment to Long Term Care Facilities

REV: 09/2010

Each nursing facility has a per diem rate established by the Rate Setting Unit within the Division of Medical Services, determined on the basis of the cost of operating the facility, and on the need of its residents for nursing care (acuity). The payment to the facility is made for all persons authorized to receive service in the facility.

Payment is made for the day of admission to the facility, regardless of the hour, but is not made for the day of discharge, regardless of the hour.

0378.20.05.10 Bed-Hold Days

REV: 08/1998

When a patient goes to the hospital or otherwise temporarily leaves a LTC facility, the Agency makes no payment to retain a bed for the patient's return to the facility.

0378.20.10 Notice of Patient Placement or Discharge

REV: 08/1998

When a patient has been placed directly from his/her home into a nursing facility, the LTC/AS worker identifies the facility on the AP-510 or CP-1 form, sends one copy of the AP-510 or CP-1 to the facility, and files a remaining copy in the case record.

0378.20.10.05 Facility's Notice of Admission or Discharge

REV: 08/1998

Each facility administrator is required to send a Notice of Admission (MA-602) to the appropriate DHS district office LTC unit whenever a recipient is admitted. The Admission Notice contains identifying data about the person and information pertaining to his/her eligibility for Medicare benefits.

The facility administrator is required to send a Notification of Discharge (MA-603) to the appropriate DHS district office LTC unit when care is no longer required and/or the person is discharged from the facility. Payment is not made to the facility for the day of discharge, regardless of the hour.

0378.20.15 Payment to Other Vendors or Facilities

REV: 01/2002

The district office LTC/AS units authorize vendor payments through MMIS to other types of vendors/facilities via InRHODES. Medicare does not provide payment for other than nursing facility services.

0378.25 PREADMISSION SCREEN/RESIDENT REVIEW (PASRR)

REV: 12/2008

All new candidates for admission to a nursing facility (NF) Licensed as a Medicaid provider must be screened for serious mental illness and mental retardation/developmental disabilities prior to admission. The procedure is known as the Preadmission Screening and Resident Review (PASRR).

PASRR has three major purposes which are:

- To assure that all candidates for admission to nursing facilities are properly screened for the existence of serious mental illness or mental retardation/developmental disabilities;
- To prevent the inappropriate admission to nursing facilities of individuals with mental illness or mental retardation/developmental disabilities; and,
- To assure that proper treatment plans for inpatients in nursing facilities who have serious mental illness and/or mental retardation/developmental disabilities are formulated and adjusted when necessary to meet treatment needs.

Medical Assistance cannot authorize a payment to a facility on behalf of an individual if the PASRR process is out of compliance. It is the responsibility of the nursing facility to assure that the preadmission screen requirements are complete on admission of the individual. Otherwise eligible Medicaid recipients cannot be billed for services for which federal financial participation is unavailable due to failure to comply with PASRR requirements.

For individuals seeking admission or readmission to a nursing facility from a hospital, the PASRR and level of care requirements must be completed by qualified hospital personnel.

An individual cannot be admitted to a nursing facility if it is determined by the Level II evaluation process that the individual's needs for specialized services for serious mental illness and/or mental retardation/developmental disabilities cannot be appropriately met in the nursing facility.

0378.25.05 Preadmission Screen - Levels of Evaluation

REV: 12/2008

Preadmission screening has two levels of evaluation--the Level I PASRR ID Screen and the Level II evaluation.

0378.25.05.05 PASRR Level I Evaluation - ID Screen

REV: 12/2008

The PASRR ID screen is the Level I evaluation instrument to screen for serious mental illness or mental retardation/developmental disabilities, and must be completed by a qualified health professional who is qualified to assess and diagnosis serious mental illness and mental retardation/ developmental disability; or the form must be reviewed and signed by a physician prior to admission to a nursing facility.

Completion of the ID Screen is required for all nursing facility initial admissions except for those individuals meeting the ID screen exemption condition.

0378.25.05.10 PASRR ID Screen Exemption

REV: 12/2008

Thirty (30) Day ID Screen Exemption-The Level I PASRR process is required on all nursing facility applicants unless the applicant is an individual:

a) who is admitted to a NF directly from a hospital after receiving acute inpatient care at the hospital, and;
b) who requires NF services for the condition for which the individual received care in the hospital, and;
c) whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of NF services.

Such an individual is EXEMPT from the pre-admission screening aspects of PASRR. It is not necessary to complete either an ID screen or a Level II PASRR on these individuals. The exemption portion of the ID screen must be submitted with the level of care application.

An individual likely to reside in a nursing facility longer than 30 days; admitted for medical conditions secondary to a serious mental illness or for treatment of a serious mental illness, is not eligible for a 30-day exemption.

If at any time the exemption no longer applies, an ID Screen must be completed. If the patient is found to require longer than 30 days, an ID screen is due prior to the 25th day. When this ID screen indicates or

suggests a serious mental illness, arrangements must be made for an immediate Resident Review (RR).

The PASRR evaluation stops at the Level I for those individuals who do not have identified or suspected serious mental illness or mental retardation/developmental disability.

0378.25.05.15 PASRR LEVEL II Exemptions

REV: 12/2008

The Level II PASRR evaluation process must be completed for individuals who have serious mental illness or mental retardation/developmental disability UNLESS one of the following three conditions exists:

Delirium-If the individual has delirium to the extent that an accurate psychiatric diagnosis cannot be made until the delirium clears, the delirium exemption applies. For all delirium exemptions, recommendations for medical and psychiatric follow-up at the nursing facility must be made prior to admission and must be included in the evaluation packet;

For the individual admitted under the delirium exemption, an ID Screen is required at the point that the delirium clears but no later than 30 days after admission. If this identifies or suspects serious mental illness, arrangements should be made for Resident Review; or

Dementia-If the individual has a PRIMARY diagnosis of dementia according to the DSM IV criteria (including Alzheimer's Disease or related disorders); or the individual has a primary diagnosis of an illness other than serious mental illness and a diagnosis of dementia (including Alzheimer's Disease or related disorder); AND a serious mental illness is not a primary problem. If the dementia exemption applies, the name of the physician confirming the diagnosis must be on the ID Screen. Supportive documentation to confirm the diagnosis must be included in the ID Screen evaluation packet. The Dementia exemption does not apply for the MR PASRR process; or

Respite Care - If the individual is admitted for respite care and is projected to require a stay of less than 30 days, the respite exemption applies.

Completion of the ID Screen ends the PASRR screening for these individuals during the duration of the level II exemption.

0378.25.05.20 PASRR Level II Evaluation

REV: 12/2008

In addition to the above 3 categories, some individuals who have suspected or identified serious mental illness will also have a serious illness with somatic medical needs which indicate a categorical determination of NF level of care. These Serious Illness Exception Conditions include:

Terminal Illness-The patient is being admitted to the nursing facility for care of a terminal illness, and has a life expectancy of less than six (6) months; or

Serious Illness-The patient is being admitted to the nursing facility for care of an illness so severe that specialized services as defined in Medicaid state plan for serious mental illness or mental retardation, is precluded.

If one of these exception conditions exists, a *portion* of the Level II evaluation must be submitted to the State Department of Mental Health Retardation & Hospitals (MHRH) for determination prior to the nursing facility admission.

0378.25.05.25 PASRR Level II Process

New: 12/2008

Those individuals identified by the Level I evaluation as having serious mental illness or mental retardation/developmental disability and not meeting one of the exemption conditions must be further evaluated to assure that nursing facility placement is appropriate with a PASRR level II evaluation. If the ID Screen indicates that an individual has both conditions, both processes are required.

PASRR-MI
With respect to the PASRR-MI process, the following procedural points should be noted. When an I.D. Screen identifies or suggests MI, a complete PASRR-MI screen includes:

- A Level I PASRR Identification Screen;
- Individual Notification of PASRR level II requirements;
- PASRR-MI Level II Screen requirements including:
- PASRR Level II Physical Health Screen requirements;
- PASRR Level II Psychiatric evaluation requirements; and
- also include the Rhode Island HEALTH Continuity of Care Form containing name of admitting nursing facility and update to recommendations for care planning for individuals being admitted to a nursing facility after a hospital admission.

PASRR-MR/DD
With respect to the PASRR-MR/DD process, the following procedural points should be noted. When an I.D. Screen identifies or suggests MR/DD, a complete PASRR-MR/DD screen includes:

- An Identification Screen, which is completed by the referring agency;
- Individual Notification of PASRR level II requirements;
- A PASRR-MR/DD Level II Data Sheet for those clients who are NEW referrals to the DD office. This form is completed by the referring agency and includes the results of cognitive testing and a social history, if available;
- Include the Rhode Island HEALTH Continuity of Care Form for individuals being admitted to a nursing facility after a hospital admission

- A PASRR-MR/DD Level II Resident Assessment Form for those clients who are open to DD and receiving services. This form is completed by the referring agency.
- A PASRR-MR/DD Level II Screen - to be completed by the DDA PASRR representative.

The dementia exemption does not pertain to the MR/DD PASRR process. A Level II Screen will be necessary for individuals who have a dementia and a MR/DD diagnosis.

Emergency Nursing Facility Placement
All Level II pre-admission requirements must be completed prior to admission unless the individual is admitted under emergency protection services. Individuals who are admitted under emergency protection services must have a PASRR Level II completed within 7 days of admission. In these cases, the nursing facility must have documentation of the need for protective services in addition to the materials required for a routine pre-admission Level II or for an initial Resident Review.

Individual Notification
Individuals (or a responsible party) will receive written notification of their referral for PASRR level II review prior to the actual review process. The notification will inform the individual or responsible party that a more detailed patient assessment instrument will be completed.

Community Level II Evaluations
All individuals in the community whose ID Screens suggests the presence of mental illness and/or mental retardation/developmental disabilities, will need level II PASRR forms completed by a health care provider unless the individual is admitted under the emergency service or level II exemption provision. If the ID Screen indicates both mental illness and mental retardation/developmental disability, both processes are required. The PASRR level II forms must be forward to MHRH for appropriate review prior to admission. The nursing facility must assure that a decision is made prior to nursing facility admission. Nursing facility staff may not complete the entire level II PASRR-MI **or** MR/DD evaluation.

Initial Level II Evaluations in Hospital
Individuals applying for initial placement to a nursing facility from a hospital whose ID Screens indicates or suspects mental illness and/or mental retardation/developmental disabilities require level II PASRR forms completed by qualified hospital staff. If the ID Screen indicates both conditions, both the Mental Illness and Mental Retardation/Developmental Disabilities processes are required prior to the nursing facility admission unless the individual is admitted under the level II exemption provision. The PASRR level II forms must be forward to MHRH for appropriate review prior to discharge. The referring agency must assure that decision is made prior to nursing facility admission.

Level II Interagency Coordination
Prior to the nursing facility accepting the individual, the individual’s health care provider completing the PASRR screen must

provide the nursing facility information on the PASRR report, including the history of illness and treatment issues along with current symptoms and treatment needs, to assure that the NF can meet the needs of the individual.

The Mental Health Agency and/or Developmental Disability Agency must provide **verbal** approval prior to NF admission. The PASRR contact person is responsible for forwarding notification of the PASRR determination to the individual, and/or responsible persons, individual physician and admitting nursing facility. The complete Level II PASRR report, including consultation reports that require follow-up in the nursing facility, must be sent to the facility at the time of the admission. The Mental Health Agency will forward the determination letter to the PASRR contact person and the admitting nursing facility. The Developmental Disability Agency will forward the determination letter to the admitting nursing facility.

The Medicaid Agency is responsible for reviewing the nursing facility level of care portion of the PASRR determination and for providing notice of Level of Care approvals or denials as deligated by the MHA and/or DDA authority.

Level II Determination

The Mental Health Agency (MHA) is the state agency charged with making the final determination of whether serious mental illness exists, and the Developmental Disabilities Agency (DDA) is the state agency responsible for determining if mental retardation/developmental disabilities exists. MHA and DDA may also make the final decision regarding placement at a particular facility.

The Level II evaluation procedure varies, depending on the individual's diagnosis. Both procedures must be followed for persons diagnosed as having serious mental illness and mental retardation/developmental disability.

Both MHA and DDA may require additional evaluation material prior to making a final determination. When a decision on the diagnosis is made, MHA or DDA will notify the referring agent and the Medicaid Agency. The referring agent then notifies the evaluated individual (or the responsible party), and the admitting or retaining nursing facility. This notification will include the determination of serious mental illness or mental retardation/developmental disabilities, the need for specialized services, treatment recommendations and the individual’s rights to appeal. Nursing facility placement cannot occur until the notification has been made.

The Medicaid Agency is delegated to provide the nursing facility level of care determination by the State Authority for Behavioral Health and Developmental Disabilities. Any denial must be authorized by the MHA/DDA consistent with federal regulations and the nursing facility level of care Medicaid Agency policy promulgated in the RI Medical Assistance Manual.

Specialized Services for Mental Illness

Specialized services do not have to be provided by nursing facilities. The term “Specialized Services” is equated with the level of care provided in psychiatric hospitals, or other intensive programs staffed

with trained mental health professionals on a 24-hour/day basis. The patient’s care follows the aggressive implementation of a treatment plan developed by an interdisciplinary team including a physician and other qualified mental health professionals and incorporates therapies supervised by these professionals. Treatment is aimed at diagnosing and reducing behavioral symptoms to improve the patient’s level of functioning to a point that permits a reduction in intensity of services as soon as possible. While some of these services may be the same as those required to be provided by the nursing facility, it is their intensive level that sets them apart.

Specialized Services for Mental Retardation/Developmental Disabilities
A continuous program for each client, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward: 1) the acquisition of the behaviors necessary for the person to function with as much self determination and independence as possible; and, 2) the prevention or deceleration of regression or loss of current optimal functional status. Specialized Services does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous specialized services program.

DDA is responsible for the provision of specialized services, those services that will enhance the quality of life for persons with developmental disabilities as well as for the maximization of their potential for inclusion and participation in community life. The role of PASRR within the framework of services provided by DDA is to ensure the quality of care of those residing in nursing facilities with the diagnosis of MR/DD and to certify that a nursing facility is the most appropriate and least restrictive residential setting.

0378.25.10 RESIDENT REVIEW (PASRR)

REV: 12/2008

Amendments to the Social Security Act no longer require annual reviews for all nursing facility residents with SMI or MR/DD. The latest regulations emphasize resident reviews for a "Significant Change”. This provides the flexibility to time evaluations and determinations when they are needed. However, Significant Change Resident Review, Change in Condition Resident Reviews, Periodic Resident Reviews and other Resident Reviews are still required under certain conditions.

0378.25.10.05 Resident Review (PASRR) for Serious Mental Illness

REV: 12/2008

PASRR Level II–MI Evaluations for Hospitalized NF Residents

Hospitalized nursing facility residents also require PASRR screens for certain conditions. A medical hospitalization for medical and /or psychiatric care that has a bearing on mental health needs requires a review for the need of a PASRR evaluation prior to returning to a nursing facility. Hospitalization for a condition primarily or secondarily related to an identified or suspected serious mental illness requires a level II PASRR evaluation.

Medical or psychiatric hospitalization for a change in mental status related to a mental disorder that does not require PASRR evaluation requires documentation of the mental disorder(s) to be treated in the nursing facility.

Significant Change Resident Reviews

Situations that require the nursing facility to provide prompt notification to MHA and the PASRR Review Evaluator for need of a Significant Change Resident Review include a decline or improvement in the resident's status identified by the MDS that impacts behavioral health needs. The individual requiring the significant change RR may or may not have had a PASRR Level II Evaluation prior to the nursing facility admission.

This significant change will not normally resolve itself without further intervention; and has an impact on two or more areas of the resident's health status. This change may require further staff intervention, implementation of standard disease-related clinical interventions; interdisciplinary review; and/or revision of the care plan.

Significant Change Resident Reviews are also required for a significant change resulting in hospitalization in which the individual has not responded to hospitalization and/or nursing facility treatment.

Change in Condition Resident Reviews

Other situations also require the nursing facility to provide prompt notification to MHA and the PASRR Review Evaluator for need of a Change in Condition Resident Review when the situation impacts behavioral health needs and will not normally resolve itself without further intervention. The situation may require further staff intervention; implementation of standard disease-related clinical interventions; interdisciplinary review; and/or revision of the care plan.

Change in Condition Resident Reviews are required for situations including:

- Notice of nursing facility eviction related to the individual's mental illness;
- Use of police assistance, or other emergency services such as emergency room visits and regular use of PRN medication for at risk, dangerous or illegal behaviors that have not resolved with treatment;
- Refusal of treatment resulting in a significant risk to an individual's health status; and
- Alternative placement disposition issues where the individual or nursing facility is unable to arrange alternate placement; such as an alternative level of care.

Other Conditions Requiring a Resident Review

It is the responsibility of the nursing facility to complete the nursing facility PASRR Level II requirements for other situations that require a resident review including:

- Newly identified or suspected serious mental illness;

- A recurrence of a serious mental illness in an individual whose last PASRR did not specifically determine the individual as having a serious mental illness;
- Identification of PASRR level II exemption expirations or non compliance with Preadmission Screening Resident Review Requirements; and
- Department of Mental Health and Retardation, Department of Health, Department of Human Service and Department of Elderly Affairs (DEA) Nursing Facility Ombudsman request for Resident Review for suspected serious mental illness, a significant change or change in condition.

Periodic Resident Reviews

Periodic Resident Reviews are required for individuals with serious mental illness under certain conditions described in PASRR procedures.

0378.25.10.10 Resident Review (PASRR) for MR/DD

REV: 12/2008

PASRR Level II-MR/DD Evaluations for Hospitalized NF Residents

If a person should require hospitalization after admission to a nursing facility, a new PASRR will not be needed unless the hospital admission is the result of the individual’s developmental disability.

Significant Change Resident Review

If there is a question of a significant change in a resident's physical or mental status or if an individual or his/her representative requests a less restrictive environment or alternative, the nursing facility is instructed to contact the MHRH Division of DD PASRR representative to determine if a resident review is necessary.

Given the nature of DDA services, significant change has other considerations in addition to a change in an individual's physical or mental status. The purpose of the PASRR MR/DD program is to assure the quality of care of individuals with developmental disabilities who reside in nursing facilities. In addition, the program ascertains that nursing facility care is necessary as well as the choice of the resident. Less restrictive residential options, if appropriate, are offered for consideration. Resident reviews are warranted in order to ensure quality care as well as to determine the need for residential alternatives.

Change in Condition Resident Reviews

Other situations also require the nursing facility to provide prompt notification to the PASRR-MR Evaluator for need of a Change in Condition Resident Review when the situation impacts needs for a developmental disability and will not normally resolve itself without further intervention. The situation may require further staff intervention; implementation of standard disease-related clinical interventions; interdisciplinary review; and/or revision of the care plan.

Change in Condition Resident Reviews are required for situations including:

- Notice of nursing facility eviction related to the individual's mental retardation or developmental disability related issues;
- Use of police assistance, or other emergency services such as emergency room visits and regular use of PRN medication for at risk or dangerous behaviors that have not resolved with treatment;
- Refusal of treatment resulting in a significant risk to an individual's health status; and
- Alternative placement disposition issues where the individual or nursing facility is unable to arrange alternate placement; such as an alternative level of care.

Other Conditions Requiring a Resident Review
It is the responsibility of the nursing facility to complete the nursing facility PASRR Level II requirements for other situations that require a resident review including:

- Newly identified or suspected mental retardation and/or developmental disability;
- Symptoms of a developmental disability as defined by MHRH in an individual whose last PASRR determination did not specifically determine the individual as having mental retardation and/or developmental disability;
- Identification of PASRR level II exemption expirations or non compliance with Preadmission Screening Resident Review Requirements; and
- Department of Mental Health and Retardation, Department of Health, Department of Human Service and Department of Elderly Affairs (DEA) Nursing Facility Ombudsman request for Resident Review for suspected mental retardation and/or developmental disability or a related significant change or change in condition.

Periodic Resident Review
Resident reviews for MR/DD individuals are also conducted on a periodic basis. The PASRR MR/DD representative will contact the nursing facility and make arrangements for visitation and consultation. It is the responsibility of the nursing facility to complete the PASRR Level II Resident Assessment Form prior to the visit, unless the resident review is conducted during an unannounced nursing facility survey.

0378.25.10.15 Client in Crisis

REV: 12/2008

In addition to the Resident Review (RR), an intensified level of services may be indicated. If, however, a client is in a crisis situation that needs more care than the nursing facility can provide, it is the nursing facility's responsibility to transfer the client to a more appropriate setting.

0378.25.10.20 Summary of Nursing Facility Responsibility

REV:12/2008

Nursing facilities are responsible for the maintenance of all PASSR forms, including the ID Screen, within the individual's record. In

order to ensure documentation compliance, nursing facilities are required to maintain an active list of individuals within the PASRR MI and MR/DD programs.

Facilities must also consider the PASRR; other related assessments and treatment recommendations within the care planning process. During the resident's annual care planning process, the nursing facility will complete an annual assessment and care plan update for individuals in the PASRR –MI and/or PASRR MR/DD tracking programs.

If the facility decides that a resident review is or might be necessary for a significant change, change in condition or other situation requiring a resident review, the nursing facility must promptly provide state notification in the form of a Notification of Need for Resident Review.

When there is a significant change in a resident's condition, a nursing facility is required to initiate treatment to meet immediate needs and begin a comprehensive reassessment. Treatment is geared to help the resident meet his/her highest practicable level, improve when possible and prevent avoidable decline.

The nursing facility is responsible for:

- Completing a comprehensive assessment by the 14th day after noting a significant change;
- Revising the care plan based on the reassessment within 7 days after its completion;
- Assure that specialized service needs, if any are identified, are met;
- Concurrently making a clinical judgment based on the person's response to treatment and current treatment needs, on whether the change in the resident's physical or mental condition warrants a Resident Review by the State within this 21 day time period.

When there is a need for periodic resident reviews to be conducted, the PASRR evaluator will contact the nursing facility and make arrangements for completion of required evaluations, visitation and consultation. The nursing facility is responsible for identifying those residents needing periodic reviews as defined in PASRR procedures; unless the review is requested by MHRH.

The nursing facility is responsible to complete the nursing facility PASRR Level II requirements prior to the visit; unless the review is performed during an unannounced survey visit.

In cases of inter-facility transfers, the transferring nursing facility is responsible for ensuring that the individual's PASRR evaluations accompany the individual.

0378.25.10.25 The PASRR Evaluator for Mental Illness

REV: 12/2008

The PASRR Evaluator will complete all PASRR level II evaluations in RI nursing facilities within the prescribed time frames. The PASRR Review Evaluator will receive notification of need for resident reviews along

with the Department of Mental Health and Retardation. MHRH may determine the need for a delayed resident review, an abbreviated resident review or a resident review reevaluation. MHRH will also determine the need for additional evaluations and information updates in collaboration with the PASRR review evaluator and notify the nursing facility accordingly.

Each PASRR evaluation will include verbal communication with the nursing facility staff, an interview with the resident and family member, if applicable, record review and a written report that includes recommendations for care planning. The nursing facility will be provided with a copy of the PASRR evaluation and resident review-tracking list signed by a nursing facility contact person. All evaluations completed by the PASRR Evaluator will be forwarded to MHRH for review and determination along with the resident review-tracking list.

In addition to requested reviews, the PASRR Evaluator will schedule appointments with each nursing facility for the purpose of conducting periodic resident reviews unless the review is performed during an unannounced survey visit.

0378.25.10.30 Interdepartmental Responsibilities

REV: 12/2008

Department of Human Services has the overall responsibility for the PASRR program and is accountable to assure that the process is followed.

MHRH Division of Behavioral Healthcare Services (State Mental Health Authority) reviews all level II PASRR evaluations for identified or suspected mental illness to make the final determination on whether a mental illness is present and if special services are required.

MHRH Department of Developmental Disabilities (State Mental Retardation Authority) conducts the Level II PASRR evaluations and determinations for residents with mental retardation/developmental disabilities.

The PASRR Review Evaluator is responsible for completing timely level II PASRR reviews within Rhode Island nursing facilities.

The Department of Health will continue their role as the state survey agency by sampling residents with serious mental illness and mental retardation/developmental disability for timely documentation completion and care plan requirements. =

0378.25.10.35 Quality Assurance Survey Program

REV: 12/2008

A quality assurance program is geared to assure the quality of services for nursing facility (NF) residents with mental illness and mental retardation/developmental disability. The program is a collaborative effort between the Department of Human Services, Department of Mental Health, Retardation and Hospitals, and Department of Health. The program is geared to reduce symptoms and behaviors, prevent regression

and loss of functioning; maximize independence, improve abilities and capacity to transition from nursing facility back into the community. The program may include survey of residents previously determined to have or suspected of having a serious mental illness and/or mental retardation/developmental disability, review of the PASRR Evaluation, Plan of Care, and services provided. Training, consultation and limited technical assistance along with tools such as protocol, forms, and guidance to nursing facilities or evaluators may be provided to assure that treatment is geared to address the resident's needs.

0380 Resources Generally

0380.05 Resource Limits

REV: 06/1994

For Medicaid Resource eligibility to exist, the institutionalized individual's countable resources cannot exceed the following basic limits:

- For Categorically Needy eligibility - $2000
- For Medically Needy eligibility - $4000

The evaluation of resources of an institutionalized individual with a community spouse first determines:

- The total joint resources of a couple;
- The spousal share of resources; and
- The community spouse resource allowance.

The computation of the community spouse resource allowance is based on the couple's total joint resources and the spousal share of those resources as of the first moment of the month in which the period of continuous institutionalization begins.

Except for the community spouse resource allowance, the total joint resources of a married couple with an institutionalized spouse are deemed available to the institutionalized spouse for purposes of Medicaid eligibility.

Each determination of eligibility (new, reopening or redetermination) requires a review of resources, which includes sending three bank statements (AP-91). Resources are also reviewed at the time of a reported change, or when information is received which indicates a change has occurred, or that unreported resources may exist (Income Eligibility Verification System match, etc.).

Resources must be verified by a review of documents related to the resource, with copies of the documentation kept for the case file.

0380.10 **Resource Definitions**

REV: 07/2006

A RESOURCE is either real or personal property which the applicant/recipient can use (either directly or by sale or conversion) to provide for his/her basic needs for food, clothing, shelter or medical care. Third Party Resources for medical care, such as health insurance, are not countable resources in eligibility determinations.

REAL PROPERTY is land and generally whatever is erected or growing upon or attached to land. Real property also includes any interest in land. Examples of real property and interests in land include a lot with or without a house, a life estate, a remainder estate, mineral rights, easements, and leaseholds.

PERSONAL PROPERTY in a broad sense is everything that is subject to ownership that is not real property. It includes tangible and intangible personal property.

TANGIBLE PERSONAL PROPERTY includes movable and tangible things such as animals, furniture, automobiles, jewelry, boats, and merchandise.

INTANGIBLE PERSONAL PROPERTY includes such rights as stock, bonds, savings accounts, checking accounts, certificates of deposit, cash, and promissory notes.

Resources are further defined based upon whether they are countable or excluded in the process of determining eligibility for Medicaid .

COUNTABLE RESOURCE: A resource, whether real or personal property, that is counted toward a resource limit. Countable resources are available to the recipient, and are not excluded.

EXCLUDED RESOURCE: A resource that is not counted toward the resource limit because of a specific exclusion in policy. Some resources are totally excluded regardless of value (e.g., an automobile used for transportation for medical care); some resources are excluded to the extent they do not exceed a specific threshold amount (e.g., a certain amount of the equity of the home of a recipient, life insurance face value limit). See Section 0382, EVALUATION OF RESOURCES.

Other definitions pertaining to the evaluation of an institutionalized individual's countable resources are set forth below.

TOTAL JOINT RESOURCES is the combined resources of the community spouse and the institutionalized spouse, to the extent that either has an ownership interest in the resources. Total joint resources are normally calculated at two points in the eligibility determination process - 1) advance determination when the institutionalized spouse begins a continuous period of institutionalization, and 2) at the time of application for Medicaid (total joint resources as they exist on the first day of the month for which eligibility is being determined).

SPOUSAL SHARE is one-half (1/2) of the couple's Total Joint Resources computed as of the beginning of a continuous period of institutionalization. The spousal share remains fixed until the institutionalized spouse is determined eligible for Medicaid, regardless of any changes in the resources of the institutionalized spouse or the community spouse. At the time of Medicaid eligibility determination, the spousal share is used as one component in the calculation of the community spouse resource allowance.

COMMUNITY SPOUSE RESOURCE ALLOWANCE is the amount of a couple's total joint resources which is attributed to the community spouse at the time Medicaid eligibility is determined for the institutionalized spouse.

A RESOURCE TRANSFER is the conveyance of right, title, or interest in either real or personal property from one person to another.

The conveyance may be by sale, gift, or other process.

COMPENSATION/CONSIDERATION is all real and/or personal property, or any other right or item of value that is received by an applicant/recipient pursuant to a binding contract in exchange for a resource. The recipient may receive the consideration or compensation prior to, at the time of, or after the transfer.

Items of value that serve as consideration or compensation include money, food, shelter, services, stocks, bonds, etc.

FAIR MARKET VALUE (FMV) of property (real and personal) is the amount for which the property can be expected to sell on the open market in the geographic area involved and under existing economic conditions at the time of the determination.

EQUITY VALUE is the FMV less the amount of any legal encumbrances.

UNCOMPENSATED VALUE (UV) is the equity value of a transferred resource minus the amount of compensation/consideration received by the applicant/recipient in exchange for the resource.

THE HOME is an individual's principle place of residence. An individual may possess many houses but only one home.

0380.15 **Differentiating Resources from Income**
REV: 06/1994

Resources are items such as property, cash, bank accounts, other financial instruments, real estate, buildings, etc. that are owned by or available to individuals. Resources must be distinguished from income. The general rule is: A RESOURCE is that which is owned at the beginning of the month. INCOME is that which is received during the month. Income that is not spent within the month in which it is received becomes a resource at the beginning of the next month.

0380.20 **Conversion/Sale of a Resource**
REV: 06/1994

A resource that is converted from one form to another does not result in income to the individual. A previously excluded resource may become a countable resource if converted into another form (e.g., an excluded auto is sold for $400 in cash. The cash received becomes a countable resource - not income). Conversely, a countable resource may become excluded (e.g., an excludable auto is purchased with $400 in cash), but in no event does income result from the transaction.

0380.25 Replacement of a Resource
REV: 06/1994

When an individual sells a home and the proceeds are used to purchase a new home within three months, the money obtained from the sale of the home cannot be considered a resource.

Cash (e.g., an insurance settlement) received for the purpose of repairing or replacing an excluded resource that is lost, damaged, or stolen is excluded as a resource for a period of nine months with an additional nine-month extension for good cause. Similarly, in-kind replacement of a lost, damaged, or stolen excluded resource is also an excluded resource.

0380.30 **Availability of a Resource**
REV: 06/1994

In order to be countable in the determination of Medicaid eligibility, a resource must be available to the individual. The individual must be able to use the resource to provide food, shelter, clothing, or convert it into a form in which it can be used to meet needs:

- A resource is considered to be available both when actually available, and when the applicant has the legal ability to make such sum available for support and maintenance;

- Resources are not available when a legal impediment exists which precludes the applicant from making the resource available for support, maintenance or medical care.

Applicants/Recipients are required, as a condition of eligibility, to cooperate with the Medicaid agency in making resources available. See Section 0308, COOPERATION REQUIREMENTS.

0380.35 **Excluded Resources**
REV: 07/2008

In determining eligibility for both Categorically Needy and Medically Needy Medicaid for an institutionalized individual, the following resources, subject to certain rules discussed in Section 0382, EVALUATION OF RESOURCES, are EXCLUDED:

- THE HOME AND ASSOCIATED LAND up to an equity value as set forth in section 0382.10.05;

- HOUSEHOLD GOODS AND PERSONAL EFFECTS, regardless of value;

- ONE AUTOMOBILE, regardless of value;

- LIFE INSURANCE with a face value less than $1,500 for Categorically Needy; less than $4,000 for Medically Needy;

- BURIAL SPACES;

- IRREVOCABLE BURIAL CONTRACTS OR TRUSTS;

- FUNDS SET ASIDE FOR BURIAL, up to a maximum of $1,500;

- RETROACTIVE RSDI AND SSI BENEFITS, for a limited period;

- RESOURCES NECESSARY FOR SELF EMPLOYMENT;

- RESOURCES DESIGNATED BY SSA FOR A PLAN OF SELF SUPPORT for a blind or disabled individual;

- RESOURCES EXCLUDED BY SPECIFIC STATUTES;

- RESOURCES DISREGARDED DUE TO PAYMENTS TO AN LTSS FACILITY UNDER A QUALIFIED STATE LONG TERM CARE INSURANCE PARTNERSHIP POLICY (see Sec. 0382.80ff).

0380.40 **Countable Resources, Institutional Spouse**
REV: 06/1994

The evaluation of resources of an institutionalized spouse with a community spouse first determines:

- The total joint resources of the couple; then

- The spousal share of the resources; and

- The community spouse resource allowance.

The computation of the community spouse resource allowance is based on the couple's total joint resources at the beginning of the period of continuous institutionalization.

The total joint resources of the married couple with an institutionalized spouse are deemed available to the institutionalized spouse for the purpose of eligibility determination.

0380.40.05 **Total Joint Resources**
REV: 06/1994

The total joint resources of an institutionalized spouse and community spouse are ALWAYS EVALUATED AS OF THE FIRST OF THE MONTH IN WHICH A CONTINUOUS PERIOD OF INSTITUTIONALIZATION BEGINS, regardless of the actual date on which the evaluation is conducted. The total joint resources are equal to the combined resources of the couple, regardless of whether they are owned partly or wholly by either spouse. The evaluation of specific resources follows the policies set forth in Section 0382.

The procedures for evaluating total joint resources differ depending on whether the initial evaluation is conducted in advance of a Medicaid application at the individual's request (Advance Determination), or is conducted as part of a Medicaid application.

0380.40.05.05 Advance Determination
REV: 07/2008

The LTSS/AS unit conducts evaluations of total joint resources when requested by an institutionalized or community spouse in advance of a Medicaid application. When a request for an Advance Determination is received, the LTSS/AS unit forwards a packet containing the MA-2 and

MA-2a to the requesting spouse. The completed forms are returned to the LTSS/AS unit with supporting documentation which includes a copy of the couple's most recent income tax returns.

Upon receipt of the MA-2, a file/case number is assigned.

If all relevant documentation is provided, the LTSS/AS unit determines the total joint resources and spousal share. If the information provided is not sufficient for a determination, the LTSS/AS unit requests that the additional information be provided within a reasonable period of time.

Within 45 days of receipt of a completed MA-2 and all relevant supporting documentation, both spouses are notified of the results of the advance determination of total joint resources and spousal share via an MA-3.

All documents related to the advance determination of the total joint resources are retained in the district office case record until:

- A Medicaid application is filed; or
- The institutionalized spouse ends the continuous period of institutionalization by residing outside the institutional setting for at least thirty consecutive days; or
- The death of one spouse.

At the time of a Medicaid application, the file is used as the Medicaid case record.

No disregard based on a Qualifying LTSS Insurance Partnership policy is made at time of Advance Determination, as the statute states that this disregard is based on the payments made by that policy as of the time of application.

0380.40.05.10 Determination at Time of Application

REV: 06/1994

When a Medicaid application is filed by an institutionalized individual with a community spouse, the LTSS unit determines if an advance determination has been completed. If so, the file is requested from the LTSS/AS unit which conducted the initial determination.

If an advance determination has not been completed, the LTSS/AS worker conducts both the evaluation of total joint resources as of the time of institutionalization, and the determination of total joint resources as they exist at the time of application.

The determination of total joint resources at the beginning of the period of institutionalization is needed to calculate the spousal share and the community spouse resource allowance. The determination of total joint resources at the time of the Medicaid application is needed to determine the countable resources of the institutionalized spouse. (The countable resources of the institutionalized spouse, for purposes of Medicaid resource eligibility, is the couple's joint total resources at the time of application LESS the community spouse resource allowance).

0380.40.10 Spousal Share

REV: 06/1994

The spousal share is equal to one-half of the value of the couple's total joint resources as of the beginning of a period of continuous institutionalization. The value of the spousal share remains fixed at the value computed as of the beginning of the period of continuous institutionalization, regardless of changes in resources which may occur between the beginning period of institutionalization and the time of the Medicaid eligibility determination.

0380.40.15 Community Spouse Resource Allowance

REV: April 2015

The community spouse resource allowance, to the extent such resources are available, is equal to the greater of:

- $23,844 or
- The spousal share, up to a maximum of $119,220.

0380.40.25 Segregating the Resources

REV: 01/1996

The total joint resources of the couple should be divided as soon as practicable to segregate in the community spouse's name the funds permitted as a community spouse resource allowance.

Resources transferred to the community spouse in order to segregate the funds permitted as a community spouse resource allowance are exempt from the rules pertaining to transfer of resources set forth in Section 0384.

Any resource acquired by the community spouse after the month in which an institutionalized spouse is determined to be eligible will not be deemed available to the institutionalized individual.

Conversely, any resource acquired by the institutionalized spouse in the month after the determination of eligibility is fully countable, and cannot be transferred to the community spouse as part of the community spouse resource allowance.

Resources transferred by an individual to a community spouse under a court order are also exempt from the rules pertaining to transfer of resources in Section 0384.

0380.40.30 Assignment of Rights, 3rd Party Resources

REV: 06/1994

Under Rhode Island law, rights to spousal support are automatically assigned to the EOHHS upon application for and receipt of Medicaid. In the event the community spouse does not make the couple's joint resources (less the community spouse resource allowance) available to the institutionalized spouse, the institutionalized spouse is not determined to be ineligible on the basis of such resources. When a community spouse has refused to make resources available, and eligibility has been established, the Medicaid agency is empowered to take action to obtain said

resources to reimburse the state for the cost of medical care paid for on behalf of the institutionalized spouse.

The institutionalized spouse is required, as a condition of eligibility, to assist the Medicaid agency in the process of obtaining such support from the community spouse.

Resources obtained as a result of action taken against the community spouse that are in excess of the incurred cost of institutional care are distributed to the institutionalized spouse, and are considered to be countable resources of the institutionalized spouse.

0380.40.35 Fair Hearing
REV: 06/1994

If either the institutionalized spouse or the community spouse is dissatisfied with the spousal share of the joint resources, the attribution of resources, or the determination of the community spouse resource allowance, and if an application for Medicaid has been made on behalf of the institutionalized spouse, the dissatisfied spouse is entitled to a fair hearing.

Section 1924 (e) (2) (C) of the Social Security Act provides State Hearing Officers authority to raise the community spouse resource allowance (CSRA) under certain circumstances. If either the community spouse or the institutionalized spouse establishes that the community spouse resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, an amount adequate to provide such a minimum monthly maintenance needs allowance (under the post-eligibility formula) shall be substituted for the current community spouse resource allowance. In determining how much more income must be generated by the additional resources in order to raise the community spouse's income to the minimum maintenance allowance, the Hearing Officer considers the community spouse's existing income. Existing income for this purpose includes the monthly income allowance which the institutionalized spouse has made available to the community spouse under the post-eligibility formula. There can be no substitution for the current community spouse resource allowance if the institutionalized spouse does not actually make a monthly income allowance available to the community spouse under the post- eligibility formula.

The additional resource(s) above the CSRA which may be protected under this section of the Social Security Act must be income-producing. To be protected, the income producing resource must be providing a reasonable rate of return.

The hearing must be held within thirty days of receipt by the agency of a written request for a hearing.

0380.45 Resource Reduction
REV: 06/1994

If an applicant or recipient is found to be ineligible due to excess countable resources as of the first moment of the month, s/he is notified that eligibility does not exist. Included with the Notice is a description of the possibility of resource reduction (form MA-6).

An applicant whose countable resources exceed the basic resource limitation may establish eligibility on the basis of resources if:

- S/he incurs (or has incurred) outstanding allowable medical bills or other allowable expenses that equal or exceed his/her excess resources; AND

- S/he reduces the excess resources to the appropriate resource limit by actually paying the allowable expenses or fees, and submitting verification thereof within thirty days of the date of the rejection or closing notice. Both the expenditure of the resource and submission of verification of the expenditure and the reduced resource must occur within the thirty day time period.

The bills used to establish eligibility cannot be incurred earlier than the first day of the third month prior to the date of an application that is eventually approved. Allowable bills, which the applicant has paid and used to reduce resources, may not be the same bills that have been used to meet an income spenddown.

The agency representative must see the bills that have been actually paid in order to verify that resources have been properly reduced.

0380.45.05 Date of Eligibility
REV: 06/1994

An individual who reduces resources and is otherwise eligible will be eligible as of the date the incurred allowable expenses equaled or exceeded the amount of his or her excess assets, subject to verification that the excess resource was actually expended on the allowable expense. In no event shall the first day of eligibility be earlier than the first day of the month of application.

Although an applicant may reduce excess resources by paying an allowable expense that was incurred up to the first day of the third month prior to the date of an application, an applicant cannot establish eligibility by resource reduction in the retroactive period.

The applicant will be required to verify that:

- S/he incurred the necessary amount of expenses; and

- His or her excess resources were reduced to the allowable resource limit by expenditure of the excess resource on the allowed expense.

0380.45.10 Allowable Expenses
REV: 04/2001

Only certain expenses may be used to establish eligibility by reduction of excess resources. These expenses are as follows:

- Medical expenses that would be allowed under the policy on the Flexible Test of Income. See Section 0390, FLEXIBLE TEST OF INCOME.

- Certain fees required for: a) an individual to make income or resources available; or b) an incompetent individual, who needs a court-appointed guardian, to access or consent to necessary medical treatment, including applying for Medicaid. Only the fees indicated in Sections 0380.45.10.05 through 0380.45.10.15 are allowable under this provision.

0380.45.10.05 Guardian/Conservatorship Costs
REV: 04/2001

Applicants who have court-appointed guardians or conservators are generally required to pay court-approved guardian/conservator's fees. Such fees include but are not limited to court filing fees, the cost of a Probate Bond, court-approved guardianship/conservatorship fees, and court-approved legal fees.

Allowable court-approved expenses not covered by other sources for items listed in Section 0380.45.10, subject to the Rhode Island Supreme Court approved fee schedule (currently $30 per hour under "Executive Order" Number 95-01), may be considered.

When such guardianship fees have been approved by Probate Courts, related guardian ad litem fees not exceeding $250 may also be recognized. The applicant must submit a copy of the Probate Court Order and any supporting documentation, including an itemized bill for allowable guardianship expenses.

The case is referred to the Office of Legal Services by the Long Term Services and Supports Administrator (or his designee) for a decision on the amount of the allowable deduction. The referral must contain a brief description of the case, a copy of the Probate Court Order, an itemized bill from the guardian, and any other supporting documentation submitted by the applicant. The total amount allowed must be reasonable and shall be based on the hours approved by the particular Probate Court for items listed in 0380.45.10 at the rate of compensation paid for guardians ad litem in Family Court as specified in the then-current Rhode Island Supreme Court Executive Order on fee schedules.

0380.45.10.10 Legal Fees
REV: 06/1994

Individuals who incur legal fees resulting from legal action to obtain income or resources for their support may expend excess resources to pay such fees.

0380.45.10.15 Tax Assessments
REV: 06/1994

Individuals ordered by the Internal Revenue Service, the Rhode Island Division of Taxation, or other State or municipal taxing authority to pay income taxes may expend excess resources to pay the taxes.

0382 Evaluation of Resources

0382.05 First Moment of the Month Rule
REV: 06/1994

Countable resources are determined as of the FIRST MOMENT OF THE MONTH (FOM). The determination is based on the resources the individuals own, their value, and whether or not they are excluded as of the first moment of the month. The FOM rule establishes a point in time at which to value resources; what a person owns in countable resources can change during a month but the change is always effective with the following month's resource determination.

The kinds of changes that can occur are:

- CHANGES IN VALUE OF EXISTING RESOURCES

The value of an existing resource may increase or decrease. For example, the value of a share of stock may decrease by $30 or increase by $20.

- DISPOSITION OR ACQUISITION OF RESOURCES

An individual may dispose of an existing resource (e.g., close a savings account and purchase an item) or may acquire a new resource (e.g., an inheritance which is subject to the income-counting rules in the month of receipt).

- CHANGE IN EXCLUSION STATUS OF EXISTING RESOURCES

An individual may replace an excluded resource with one that is not excluded (e.g., sell an excluded automobile for non-excluded cash) or vice versa (use non-excluded cash to purchase an excluded automobile). Similarly, a time-limited exclusion (such as the period for exclusion of retroactive Title II benefits) may expire.

Changes such as SSI, SSA, and Lump Sums do not affect the countable value of resources in the month in which they occur. Any change does not affect countable resources until the first moment of the following month.

If countable resources exceed the limit as of the first moment of a month, the recipient is not eligible for that month, unless the resources are reduced by expenditure on certain allowable expenses, see Section 0380.45, RESOURCE REDUCTION.

Resources are evaluated using the methodologies set forth in the remainder of Section 0382 for the various types of resources. Each type of resource has its own unique deductions, exclusions, and methods for evaluation to determine its countable value. If not otherwise indicated, the countable value of a resource is the equity value (fair market value less legal encumbrances).

Once the countable value of each resource (after the appropriate exclusions/deductions) is determined, the countable values of all resources (including deemed resources) are added together to determine the total countable resources for the institutionalized individual.

0382.10 Real Estate
REV: July 2014

The policies and procedures set forth in the following sections will be used to determine Medicaid eligibility and Medicaid payments for services to institutionalized individuals.

The equity value of real property owned by an individual that is neither excluded (up to a certain amount) as the home nor determined unavailable is a countable resource.

Real property may consist of land, buildings, and objects permanently attached to the land, (including "mobile" homes permanently sited).

Real property includes the value of certain interests in real estate such as life estates, mineral rights, easements, and life leaseholds. Life estates with enhanced powers shall be evaluated for Medicaid eligibility in accordance with section 0382.56 herein.

0382.10.05 Home and Associated Land Exclusions
REV: April 2015

Definitions
For the purposes of this section, the following definitions apply:

APPLICANT: New applicants for Medicaid as well as current recipients at any point in which eligibility is redetermined.

DEPENDENT CHILD: An unmarried child of the applicant and/or the applicant's spouse who is dependent upon the applicant and/or the spouse for financial support, and is either under eighteen (18) years of age; or over eighteen (18) years of age and living with a disability which began before age twenty-two (22).

HOME: Any residential property in which the applicant and/or applicant's spouse possess an ownership interest that also serves as the principal place of residence of the applicant and/or, in the instances specified in this section, the applicant's spouse or dependent child. A home may be a fixed or mobile residential property. A cooperative or condominium apartment, townhouse, mobile house, and houseboat are all examples of residential properties that may serve as home. An applicant and spouse may have an ownership interest in several residential properties, but only one (1) shall be considered a home for the purposes of this section.

HOME EXCLUSION: The treatment of a residential property as a non-countable resource when the property serves as the home of an applicant/spouse as specified in this section. Regardless of whether one or both spouses in the household are applicants, only one residential property is considered to be a home, and as such, is treated as an excluded resource for the purposes of determining Medicaid eligibility.

INTENT TO RETURN: An expression indicating that it is the applicant's plan to live in the home used as the principal place of residence after a temporary absence. The intent to return home is subjective rather than objective and, as such, must be expressed by the applicant or an authorized representative of the applicant in the form of a signed, written statement.

OWNERSHIP INTEREST: The individual holds sole or joint legal title to the residential property or is a party to a legal covenant establishing property ownership, such as a life estate.

PRINCIPAL PLACE OF RESIDENCE: The residential property where the applicant, and/or in the instances specified in this section, a spouse or a dependent child lives the majority of the time during the year. For example, one hundred and eighty-three (183) days in the previous twelve (12) months.

RESIDENT OF RHODE ISLAND: The applicant has an intent to stay in the state permanently or for an indefinite period, in accordance with the provisions set forth in Section 0106.05 through 0106.25 of the Medicaid Code of Administrative Rules.

TEMPORARY ABSENCE: A limited period of time in which the applicant is residing away from home for reasons essential to personal welfare (e.g., protective or rehabilitative services), related to medical or social needs (e.g. hospitalization or nursing home care), or over which the applicant has no direct control.

Application of the Home Exclusion

The home of an institutionalized applicant is an excluded resource, if it is located in Rhode Island, if the applicant's equity value of the home is less than five hundred and fifty-two thousand dollars ($552,000.00) and the applicant expresses an intent to return to the home. Individuals whose spouse, child under twenty-one (21), or child who is blind or disabled (as defined by section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home. If the applicant does not maintain a Rhode Island home, the home exclusion applies to the principal place of residence of the community spouse or a dependent child.

In the case of a life estate, the applicant's equity value of the life estate of an institutionalized individual is an excluded resource if the applicant's equity value of the life estate is less than five hundred and fifty-two thousand dollars ($552,000.00), the applicant expresses an intent to return to the home and the home must be located in Rhode Island.

Individuals whose spouse, child under twenty-one (21), or child who is blind or disabled (as defined by section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

The use of a Qualified LTC Insurance Partnership policy will not affect an individual's ineligibility for payment for nursing facility services, or other LTSS services, when the individual's equity interest in home property exceeds the limits set forth in section 1917(f) of the Act, as amended by the DRA.

The value of any land/building contiguous to the home is also excluded.

0382.10.05.05 Home and Associated Land Definitions

REV: 06/1994

Home and Associated Land Definition - The home exclusion applies to any land which appertains to the home and other buildings located on such land. To appertain to the home, the real property must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others.

Where real property adjoins the plot on which the home is located and has contact with that plot, it does not matter if there is more than one document of ownership (e.g., separate deeds). It also does not matter that the home was obtained at a different time from the rest of the real property, or that the holdings may be assessed and taxed separately. In considering whether real property appertains to the home plot, easements or public rights of way (e.g., streets, roads, utility lines) which run through or by the land and separate the land from the home plot or from the rest of the land are not considered. Watercourses, such as streams and rivers, do not separate land, but are included in the term "land." Land parcels which are adjoined side-to-side, corner-to-corner, or in any other fashion are considered to appertain to each other.

If some indication arises that a portion of the property is separated from the home property and does not appertain to the home, the extent of the home property as provided is determined.

Where there is no indication that the plot on which the home is located is separated from other real property, nothing further is needed.

If any of the individual's property is not contiguous with the home plot, the extent of the home property is documented. A copy of the tax assessment bill, title, deed, or other pertinent documents that the individual has in his/her possession is placed in the case record. A description of the property situation and whether all the land appertains to the home is obtained. If the individual cannot provide this evidence or the evidence is insufficient, the agency representative contacts the local tax jurisdiction regarding the property boundaries and records the information.

If the property on which the home is located is recorded as a single holding and treated as a single holding for tax assessment purposes, the agency representative treats the property as a single piece of property to which the home plot is adjoined by the rest of the land. If there has been subdividing of the original holding but the residue is treated as a single holding for tax assessment purposes, the same assumption applies.

If two or more holdings, including one or more homes, are reported to be a combined property and are treated as two or more holdings for recording and tax assessment purposes, the agency representative obtains a description of the holdings and their relationship to one another. A sufficient description is a sketch which shows the locations of the boundaries and the shelter used as a home in relation to the boundaries. The agency representative obtains the description by direct observation of the property or from the public records. If the description is by an individual, the description is recorded on the property sheet.

Where it is determined that land owned by the individual does not appertain to the home plot, such land and any buildings on it cannot be part of the home exclusion.

0382.10.05.10 Multiple Residences
REV: 03/2004

When an applicant with an ownership interest in multiple residential properties has not lived in any one for the majority of the time during the preceding twelve (12) months, the home exclusion is applied to the state residential property identified as the applicant's address on one of the following, in order of preference:

1. A valid Rhode Island driver's license;

2. The most recent voter registration form;

3. A government check or electronic deposit receipt (e.g., Social Security, SSI, State Treasury) issued within the last sixty (60) days; or

4. The most recent U.S. federal income tax return submitted by, or on behalf, of the applicant.

The home remains excluded during the applicant's temporary absence if the applicant expresses an intent to return to the home; or the applicant's spouse/dependent child resides in the home.

All other residential properties in which the applicant or the applicant's spouse maintains an ownership interest shall be treated as countable resources, in accordance with Section 0308.10.

0382.10.05.15 Out-of-State Residences
REV: 03/2004

To be eligible for Medicaid, an applicant must be a Rhode Island resident and, as such, have an intent to stay in the state permanently or for an indefinite period. Accordingly, an applicant who has expressed the intent to return to an out-of-state residential property shall not be considered a Rhode Island resident for the purposes of determining eligibility for Medicaid.

When an applicant owns residential properties both in and out-of-state, the home exclusion may only be applied to the property located in Rhode Island. The value of out-of-state residential property is a countable resource, even if it is the principal place of residence of the applicant's spouse/dependent child, as long as the applicant maintains an ownership interest in a Rhode Island residential property.

If the applicant does not own real property in Rhode Island, but lives and intends to remain in the state, the home exclusion may be applied to an out-of-state residential property if, and only if, it is the principal place of residence of the applicant's spouse or dependent child.

An out-of-state residential property may otherwise only be deemed temporarily excluded when it is determined that:

- There is a legal impediment to the sale of the property due to joint ownership (as specified in Sections 0356.10.10, 0356.10.10.05, 0382.10.10, and 0382.10.10.05); or

- The property is an unavailable resource as defined in Sections 0356.10.10.10, and 0382.10.10.10.

0382.10.05.20 Temporary Absence and Intent to Return
REV: February 2014

The home may be excluded during an applicant's temporary absence (e.g., due to hospitalization or nursing home care) when both of the following conditions are met:

- The applicant intends to return to the home; and
- The home is located in Rhode Island.

Initial Application

At the time of initial application, a signed statement (Form MA-400) must be submitted to the Medicaid agency indicating when the applicant left the home and whether the applicant intends to return to the home. If a community spouse or a dependent child continues to live in the home during the applicant's temporary absence, the value of the home is not counted as a resource regardless of whether the applicant has expressed an intent to return to the home.

The statement indicating the applicant intends to return to the home shall remain valid from the date it is received by the Medicaid agency until eligibility is redetermined unless the temporary absence ends first, or, as is specified in Sections 0382.10.05.25 and 0382.10.05.30, the applicant acts in a manner that indicates an intent to the contrary.

Redetermination of Eligibility

At the time eligibility is redetermined, whether due to recertification or a change in other eligibility factors, the Medicaid agency shall verify whether there has been a change in the intent to return to the excluded home. Providing all other eligibility requirements have been met, the home shall remain excluded if the applicant continues to express an intent to return at that time.

0382.10.05.25 Contrary Acts
REV: February 2014

If the Medicaid agency learns at any time that the applicant is acting in a manner that is inconsistent with the statement expressing an intent to return, the home may be treated as a countable resource. For example, an applicant who has taken the steps required to sell or transfer ownership interest in an excluded home is acting in a manner that is contrary to an intent to return, as it is defined in this section. If, upon review of the applicant's actions, it is determined that such acts are sufficient to invalidate an expression of the intent to return, the Medicaid agency shall provide the applicant with timely and adequate notice of the decision to treat the home as a countable resource.

0382.10.05.30 Diminished Capacity
REV: February 2014

In the event that the Medicaid agency finds that the applicant's capacity to express a clear intent to return to the home is diminished, as evidenced by a legal judgment of incompetence, or a documented mental or medical condition, an authorized representative of the applicant may submit a sworn affidavit, indicating an intent to return on the behalf of the applicant.

For the purposes of this section, an authorized representative of the applicant is any of the following:

- The person who completed and signed the application for Medicaid for the incapacitated applicant, providing the person is not an employee or representative of an institution or organization with a fiduciary interest in the care of the applicant (e.g. nursing home/assisted living employee, hospital worker, etc.);

- The applicant's spouse, child, parent, sibling, or legal guardian; or

- An individual who meets the criteria established in RIGL Section 5-37.3-3 (The Confidentiality of Health Care Information Act).

0382.10.05.35 Limitations
REV: February 2014

Although an applicant may own several residential properties either alone or in conjunction with others, only one shall be considered a home and, as such, may be treated as an excluded resource at any given point in time. Even in situations in which both spouses in the household are applicants, the value of only one home may be excluded.

When the applicant and the applicant's spouse/dependent child make conflicting claims over which residential property is subject to the home exclusion, the following decision rules shall apply:

- If the applicant and applicant's spouse live in separate residential properties in Rhode Island, in which they share equal ownership, the home exclusion applies to the residential property where the applicant(s) lived at the time the Medicaid agency received the application. If both applicants apply on the same day, the applicants must agree in writing which home is to be excluded. If no agreement can be reached, the home exclusion shall be applied to the residential property with the greatest value.

- If, at the time eligibility is redetermined, an applicant who is temporarily absent expresses an intent to return to a residential property other than the one excluded at the time the initial application was made, the residential property may only be excluded if it is located in Rhode Island and is the home - i.e. principal place of residence – of the applicant's spouse or dependent child. However, the value of the residential property excluded at the time of initial application shall be treated as a countable resource.

0382.10.10 Legal Impediments to Real Estate Sale
REV: 06/1994

Other persons, in addition to an applicant and spouse (if any), may share in ownership of property in which the individual, spouse, or child is not living. If so, the property is considered to be unavailable if the individual or couple is not legally free to dispose of the property because the other owner(s) will not consent to sell. Notwithstanding the above, the applicant/recipient must make every effort to sell their equity share of that real estate.

An unavailable resource is not countable in the eligibility determination.

0382.10.10.05 Types of Ownership of Real Estate
REV: July 2014

Whether the applicant is free to dispose of his/her share depends on the type of ownership. The agency representative should examine the deed to determine the type of ownership. The following types of ownership are the most common.

Joint Tenants

Joint Tenancy is when two or more persons own the property. (The property may be either real property or personal property). Upon the death of any Joint Tenant, title automatically vests in the surviving Joint Tenants without the necessity of a Probate proceeding. While alive, any Joint Tenant can convey his/her interest to a third person. After such a conveyance, the new parties own the property as Tenants in Common (see below).

Tenants in Common

Tenancy in Common is when two or more persons own the property with no right of survivorship between them. Upon the death of any owner, that owner's interest in the property will pass under the deceased's will or, in the absence of a will, under the applicable laws of intestacy. While alive, any Tenant-in- Common can convey his/her interest to a third person.

Tenants by the Entirety

Only a married couple can hold property as Tenants by the Entirety. It is the most common form of ownership for married couples who own property together. Like a Joint Tenant, the survivor will automatically own the property upon the death of one spouse. Unlike a Joint Tenant, however, both Tenants by the Entirety must join in any deed of an interest in the property. Property owned by a married couple under a Tenancy by the Entirety cannot be sold without the consent of both spouses. In the event a spouse refuses to dispose of the property, it is excluded as a resource of the applicant/ recipient.

The agency representative obtains documents (usually a copy of the deed) to establish the nature of the shared ownership.

It is presumed that an individual who owns an interest in property as a Joint Tenant or Tenant in Common is free to sell his/her ownership interest without the consent or signature of the other owner(s). If the property is not otherwise excludable, the applicant's proportional share of the equity value of the property is counted toward the resource limit. (Unless stated otherwise in the deed, the applicant's proportional share of ownership is the ratio of 1 to the total number of owners.)

It is presumed that a Tenant by the Entirety is NOT able to liquidate his/her interest without the consent of the other owner. The individual's share of the resource is NOT countable, pending the individual's action to make the resource available for his/her support.

Life Estate with Enhanced Powers

A deed containing a life estate with enhanced powers is also known as an “enhanced life estate deed” or a “Ladybird deed.” An enhanced life estate deed permits an individual to reserve the rights to sell, convey, mortgage, revoke, amend, and otherwise dispose of the property during his/her lifetime, but upon his/her death it passes to a remainderman, without the need for probate. The deed specifies who will become the owner of the property upon death. (See section 0382.56 herein for treatment of an enhanced life estate deed).

0382.10.10.10 Documentation of Non-Availability of Real Estate
REV: February 2014

When the individual claims that s/he is unable to liquidate a real property resource, s/he must provide documentation from a competent authority (e.g. real estate broker, attorney) that s/he cannot sell the property. The agency representative refers the case to the Office of Legal Services for a decision as to whether the property can be liquidated.

All cases in which real estate is determined to be not countable under these provisions must be referred to the Office of Legal Services for review. As a CONDITION OF ELIGIBILITY, an applicant/recipient must take all reasonable actions to liquidate the resource. The Office of Legal Services determines what actions are reasonable based on review of each particular situation.

0382.15 Intangible Personal Property
REV: 06/1994

Intangible personal property includes those resources which are in cash or payable in cash on demand, and financial instruments convertible into cash. The most common types of intangible personal property are savings accounts, checking accounts, NOW accounts, certificates of deposit, money market accounts, stocks, bonds, and mutual funds.

Other intangible resources include promissory notes, loans which may not be secured by promissory notes, and mortgages. Such personal property is always a countable resource, except as excludable under this section.

0382.15.05 Cash
REV: 06/1994

Cash is money on hand or available in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for U.S.-issued currency. Cash on hand is always counted as a resource except when it is a business resource necessary to the operation of a trade or business that is excluded as necessary for self-support.

The applicant's statement of the amount of cash on hand is acceptable without verification, unless the amount could impact the applicant's eligibility.

0382.15.10 Checking and Savings Accounts
REV: 06/1994

The terms checking/savings accounts include any and all accounts, certificates, money market or broker's funds and instruments or devices having the general characteristics commonly associated in

the community with checking and savings accounts. The countable resource from such accounts is the amount that the individual/deemor can withdraw, subject to the policy below.

A penalty for early withdrawal of the funds in a time deposit does not prevent the resource from being countable. If there is a penalty for early withdrawal of funds, the penalty amount is deducted from the balance of the account in determining the countable resource.

In determining the amount of money in, or the existence of, a bank account at least three bank statements (AP-91) are sent. One is sent to the bank where the individual has or had an account. The others are sent to the banking institutions most likely to have been used by the individual considering the location of home and/or employment. If the statement(s) shows deposit and withdrawal activity or cash flow inconsistent with the applicant's/ recipient's alleged financial situation during 30 months prior to application or while receiving assistance, the agency representative determines if funds were transferred to another individual and/or whether such funds are still available to the applicant/recipient.

0382.15.10.05 Availability of Funds
REV: 06/1994

Funds maintained in checking or savings accounts are usually payable on demand. An individual should be able to withdraw money from a checking account on the same day (s)he presents a check.

Funds can usually be withdrawn from a savings account the same day the request is made.

However, some unusual circumstances may occur which prevent the immediate withdrawal of money, and may result in the resource being unavailable. For example, if there is a joint account with only one individual having authority to withdraw money and that individual dies, a prolonged period may elapse before the surviving owner can withdraw the money.

Certain time deposits (e.g., savings certificates or certificates of deposit) may not be legally available to the applicant/deemor until a specific point in time. If so, the policy in Section 0380.30 regarding availability of resources is applied to determine if the resource is not countable until the maturity of the certificate.

0382.15.10.10 Joint Checking and Savings
REV: 06/1994

Whenever the applicant is a joint account holder who has unrestricted access to the funds in the account, ALL of the funds in the account are PRESUMED to be the resources of the applicant or deemor. The applicant or deemor will be offered the opportunity to submit evidence in rebuttal of this presumption. A successful rebuttal will result in finding that the funds (or a portion of the funds) in the joint account are not owned by the applicant or the deemor and, therefore, are not the resources of the applicant.

0382.15.10.15 Presumption of Owner, One Account
REV: 06/1994

When only one holder of a joint account is an applicant who has unrestricted access to the funds in the account, explain to the applicant that ALL of the funds in the account are presumed to be the applicant's. This presumption is made regardless of the source of the funds.

0382.15.10.20 Presumption of Owner, Two or More
REV: 06/1994

When two or more eligible individuals or applicants (with or without ineligible individuals) are holders of the same joint account and each has unrestricted access to the funds in the account, the agency representative explains the presumption that each eligible individual or applicant owns an EQUAL SHARE of the total funds in the account. This presumption is made regardless of the source of the funds.

0382.15.10.25 Presumption of Owner, Joint Account
REV: 06/1994

The presumption of ownership which apply to applicants who are joint account holders also apply to deemors who are joint account holders. When a deemor is a joint account holder with an applicant and each has unrestricted access to the funds in the account, ALL of the funds in the account are presumed to be the applicant's resources. If two or more applicants are joint account holders with a deemor, then each eligible applicant owns an equal share of the total funds in the account. If two deemors, who are not considered parents, hold a joint account, "divide" the funds EQUALLY between them for deeming purposes.

0382.15.10.30 Determining Access to Funds
REV: 06/1994

The determination of accessibility depends upon the legal structure of the account. Where an applicant is a joint holder of a bank account and is legally able to withdraw funds from that account, (s)he is considered to have unrestricted access to the funds.

It is possible to have ownership interest in a bank account but have restricted access to the funds. An example of language which restricts access is: "In trust for John Jones and Mary Smith, subject to the sole order of John Jones, balance at death of either to belong to the survivor." In this example, only John Jones has unrestricted access. When it is clearly established that all funds in an account are legally accessible to the applicant only in the event of the death of the co-owner, the applicant's access to the funds is restricted and the funds are not a countable resource. Regardless of whether the applicant has unrestricted access to the resources of an individual whose resources must be DEEMED, the funds in the account are deemable resources to the applicant.

If unrestricted access is an issue which cannot be resolved with the evidence on hand, the agency representative requests the financial institution to provide additional information. This may include the exact language used in the document which established the account, a description of any legal restrictions on the individual's access to the funds, etc.

If there is a legal impediment to the access to funds which may be owned by the recipient, see policy on availability of resources, Section 0380.30.

0382.15.10.35 Rebuttal of Presumption of Owner
REV: 06/1994

There may be a situation where an individual has unrestricted access to the funds in a joint account but does NOT consider himself/herself an owner of the funds (either fully or partially).

For example, the individual may allege that all of the funds in the account are deposited by other account holder(s). The individual may declare that (s)he has never withdrawn funds from the account or, withdrawals were made, the funds were used for or given to the other account holder(s); i.e., the applicant acts as agent for the other account holder(s).

0382.15.10.40 Rebuttal Procedures
REV: February 2014

When a joint account is alleged or discovered during the applicant process, the agency representative explains the applicable ownership presumption to the applicants or deemors.

If the applicant disagrees with the presumption of ownership, the agency representative provides an explanation of the rebuttal procedure. If the individual chooses not to rebut the presumption of ownership, the resource determination proceeds in the usual manner.

If the individual wishes to rebut the presumption, the agency representative explains to the individual that all of the necessary rebuttal evidence must be submitted within thirty days.

An additional thirty day period is granted if the applicant establishes good cause for his or her inability to provide the necessary documentation within the initial thirty day period.

IF the required information is not provided, the presumption of ownership issued to determine the value of resources.

Once the rebuttal evidence is submitted, the Medicaid agency determines who owns the funds in the joint account and documents the findings for the record.

If the applicant is ineligible due to any other factor of eligibility (such as excess income) or if a successful rebuttal would not change a determination of ineligibility due to other excess resources, it would then be unnecessary to initiate the rebuttal procedure.

0382.15.10.45 Evidence for a Successful Rebuttal
REV: February 2014

In order for an applicant/recipient to rebut successfully the presumption of full or partial ownership, ALL of the following evidence is required:

- A statement by the applicant or deemor on an AP-92 containing the penalty clause, giving his/her allegation regarding ownership of the funds, the reason for establishing the joint account, the date the account was made joint, the source of the funds, who made deposits and the source of the deposits, who made withdrawals from the account, how the withdrawals were spent, whose Social Security number was on the account; and

- Corroborating statements (on form AP-92A) from other account holder(s); and

- Submittal of the original and revised (if any) account records showing that the change above was made. Photocopies are necessary for the record; and

- The AP-92 from the applicant and the AP-92A(s) from the joint account holder(s) must provide the information needed to establish that none of the funds, or only a portion of the funds, are owned by the applicant. The applicant must submit all available documentary evidence to support the statements in the AP-92 and AP-92A(s). The evidence should, if available, include a financial institution record, or other source document. A source document is a passbook or other document which shows deposits, withdrawals, and interest for the period for which ownership is being rebutted. The documentary evidence should support the allegations of ownership, and should not contradict the statements on the AP-92 and AP-92A.

It is the applicant's or deemor's responsibility to provide the required evidence. The Medicaid agency provides assistance in obtaining the evidence only when the individual is unable to do so.

If the applicant alleges that there is no documentary evidence available, s/he must submit evidence to substantiate the allegation.

If the rebuttal is successful, a new account must be established in the name of the applicant which contains only the applicant's funds, or a change must be made in the account designation which removes the applicant's name from the account, or restricts the applicant's access to the funds in the account.

0382.15.10.50 Minor/Incompetent Co-Holder
REV: 06/1994

If either the applicant or the co-holder of the joint account is incompetent or a minor, it is necessary to obtain a corroborating statement from that individual. That person's incompetency or age may be the reason why the applicant is listed as a joint account holder. In this event, the agency representative obtains a corroborating statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account. If there is no third party, the agency representative makes a rebuttal determination without a corroborating statement.

The decision is documented with an explanation why no corroborating statement was obtained. The agency representative determines if the rebuttal is successful.

The rebuttal process may result in determinations showing the applicant owned varying dollar amounts for prior periods.

0382.15.15 Stocks, Bonds, Like Securities
REV: 06/1994

Securities may include stocks, bonds, and other securities held individually, or as shares in a mutual fund.

0382.15.15.05 Stocks
REV: 06/1994

A stock is a negotiable instrument which represents ownership in a corporation. Most stocks are assigned a certain value, known as "par value." Par value, which in many cases is only one dollar, has no significance or correlation to the actual market value of stock.

The value of stock is normally determined by the demand for it when it is bought or sold on one of the stock exchanges or on the "over- the-counter" market. The value of stock frequently varies significantly. The daily fluctuating prices of most stocks are listed on the New York Stock Exchange, the American Stock Exchange or on the "over-the-counter" market. There are also several regional exchanges located in large cities which list stocks not shown on the major exchanges. Many newspapers publish the closing prices for stocks listed on the New York and American Exchanges.

The value of the stock should be determined through one of the listings after verifying the identity of the stock and number of shares held.

0382.15.15.10 Municipal and Corporate Bonds
REV: 06/1994

A bond is not cash but a promise to pay cash to the holder (bearer) of the bond. The term "bond" signifies an obligation in writing to pay a sum of money at a future specified date, usually to the bearer. It is a negotiable instrument and is transferable. The term "bond" is commonly understood in financial circles to be the obligation of a state, its sub-divisions (counties, districts or municipalities) or private corporations. These entities issue municipal or corporate bonds to raise money for improvement projects.

To redeem a municipal or corporate bond for its stated value, it must be held until the specified date of maturity. However, if a person wants to cash in a bond before its maturity date, the current cash value is determined by the market for such bonds, which is similar to stocks. If there is a great demand for certain bonds, the market value may be more than its face value; or less, if there is little or no demand. The bond's current market value may be substantially less than the face value. The current market value of a bond can be determined in the same manner as stocks.

When an individual requests that his/her municipal or corporate bond(s) be sold, it takes about 7 to 10 work-days from the day the brokerage firm completes the transaction to the time the seller receives the proceeds from the sale.

0382.15.15.15 U.S. Savings Bonds
REV: 06/1994

U. S. Savings Bonds are backed by the Federal Government. There are several series of U.S. Savings Bonds, which normally can be quickly converted into cash at local banks. However, some bonds must be held at least 60 days from the date of issue before they can be converted into cash, and others must be held for a minimum of 6 months before they can be liquidated. During the period in which the bonds cannot be liquidated, they are not available, and are not countable

resources. U.S. Savings Bonds are usually registered in the name of the owner (the name shown on the face of the bond) and are redeemed by the owner completing a form on the back of the bond.

When it is necessary to establish the value of a U.S. Savings Bond, the date of issue on the face of the bond is controlling. The bond's value depends on the time elapsed from the date of issue.

Although many U.S. Savings Bonds have a table of values on the reverse of the bond, this table is often inaccurate since the interest rate may have changed since the bond was issued. Contact a bank for documentation of a U.S. Savings Bond's current value.

0382.15.15.20 Mutual Funds
REV: 06/1994

A mutual fund is a company that buys and sell securities and other investments as its primary business. Shares in mutual funds represent ownership in the investments held by the fund. The value of the mutual fund shares varies with market conditions. The current value of the shares of many funds is published in the financial section of newspapers. If the current value of the fund is not published, it must be obtained from a broker, or from the fund itself. Most mutual fund shares may be liquidated on demand.

0382.15.15.25 Presumption of Owner and Rebuttal
REV: 06/1994

Jointly-held financial instruments described in Sections 0382.15.15.05 through 0382.15.15.20 above are subject to the same presumptions of ownership share as for real estate, e.g., the applicant is presumed to own his/her proportional share of the resource. For example, if the applicant owns shares of stock jointly with a sibling, the applicant is presumed to own half the stocks. This presumption is subject to the rebuttal procedure set forth in Sections 0382.15.10.10.25 through 0382.15.10.10.40.

0382.15.20 Promissory Notes, Loans and Mortgages
REV: 06/1994

In some financial transactions, the applicant may be the lender who is the person to whom money is owed. This section sets forth the policy for considering transactions or agreements in which the applicant is the lender, or the person to whom money is owed.

Section 0382.15.25 provides policy when the applicant is the borrower, and receives the proceeds of a loan.

Types of instruments in which the applicant may be the lender are:
Promissory Notes

A promissory note is a written agreement signed by a person who promises to pay a specific sum of money at a specified time, or on demand, to the person or organization named on the note as holder. The note may be secured by real estate (a mortgage), or a security agreement on personal property (chattel mortgage). A promissory note held by an individual is a resource of the individual.

Loans

A loan is a transaction in which one party advances money (or other property) to another party who promises to repay the amount of the loan in full within his/her lifetime, with or without interest. The loan agreement may be oral or written. When an applicant has loaned money to another, the loan is a resource to the applicant, subject to the policy regarding its negotiability, valuation and salability set forth in the following sections.

0382.15.20.05 Negotiability of Instruments

REV: 06/1994

Promissory notes, mortgages, and loan agreements generally may be sold or discounted. For example, a bank may be willing to pay $450 for a $500 promissory note due in one year's time. Promissory notes, mortgages, and loans are negotiable if the owner (lender) has the legal right to sell the instrument, or has an interest in the instrument which can be converted into cash. Examination of the instrument establishes negotiability. Negotiable instruments are countable resources. Questions regarding negotiability are referred to the Office of Legal Services for review. Instruments determined to be non-negotiable by the Office of Legal Services are considered unavailable resources.

0382.15.20.10 Valuation

REV: February 2014

Once negotiability is established, the instrument is considered a resource in the amount of the outstanding principal balance, unless the promissory note, loan, or mortgage: (1) has a repayment term that is actuarially sound; (2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and (3) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the three requirements, the value of such document shall be the outstanding balance due as of the date of the individual's application for Medicaid long term care services.

Instruments that do not meet these criteria need to be examined under the transfer of resource policies found at Section 0384.

0382.15.20.15 Salability

REV: February 2014

If the individual is unable to sell or liquidate the resource because no market exists, the resource is considered to be unavailable, and is not countable. To establish unavailability, the individual must present:

- Evidence showing that the instrument was offered for sale for example, newspaper advertisement; and
- Statements from two different reliable sources stating that, in their opinion, the instrument cannot be sold, and the reason(s).

The case must be referred by memo to the Assistant Administrator for a determination regarding availability, who will consult with the Office of Legal Services, as necessary.

0382.15.20.20 Treatment of Count/Non-Countable Instruments
REV: 06/1994

If the instrument is determined to be a non-countable resource, the entire amount of any payments on the loan are considered to be unearned income. If the instrument is a countable resource, the principal portion of each payment is considered to be a converted resource; the interest portion is unearned income.

0382.15.25 Proceeds of a Loan
REV: 06/1994

The policy set forth in this section pertains when the applicant is the BORROWER, and receives the proceeds of a loan.

When the applicant is the borrower, the proceeds of a bona fide loan which requires repayment by the applicant are not income or resources in the month of receipt, but become a countable resource if retained beyond that month. If the loan is not bona fide, the proceeds are countable as unearned income when received.

For a loan to be considered bona fide, the terms of the loan must be legally binding on the borrower under State law.

0382.15.25.05 Commercial Loans
REV: 06/1994

Loans granted by organizations that are in the lending business (such as banks, finance companies, and credit unions) are considered to be bona fide. There will be a formal written contract between the organization and the borrower which specifies the promise to pay a sum on a certain date, or when certain circumstances are met.

0382.15.25.10 Informal Loans
REV: February 2014

Loans which are negotiated between individuals may be less formal, even unwritten. A bona fide loan may exist without a written contract. The loan need not be secured by specific items of collateral.

A loan agreement (oral or written) must include all the following to be considered bona fide:

- The borrower's acknowledgement of an obligation to repay (with or without interest); and
- A timetable and plan of repayment; and
- The borrower's express intent to repay the loan by pledging real or personal property or anticipated income. It is not necessary that the loan be secured by real or personal property.

It is necessary that the borrower express intent to repay the loan when funds become available in the future and indicate that s/he will begin repaying the loan when s/he receives future anticipated income.

If the agreement is oral, statements are obtained from all parties to the loan, and any witnesses to the transaction. The agency representative evaluates the statements to determine if the loan is bona fide.

All documents relating to informal loans are photocopied and retained in the case record. Questionable situations are referred by memo through LTSS/AS to the Office of Legal Services for review.

All available documentation is attached to the memo.

0382.15.30 Retirement Funds
REV: 06/1994

Retirement funds are annuities or work related plans for providing income when employment ends (such as a pension, disability or retirement plan administered by an employer or union), or funds held in Individual Retirement Accounts (IRAs), or plans for self- employed individuals, sometimes referred to as Keogh plans.

An applicant who owns a retirement fund must apply for the benefits of such fund or liquidate the fund. However, the applicant is not required to terminate active employment in order to make a retirement fund available. If the applicant must terminate employment in order to receive benefits from the retirement fund, the fund is not a countable resource.

If the applicant is eligible for periodic retirement benefits (monthly, quarterly payment, etc.), the retirement fund is not a resource, but the payments from the fund are unearned income when received.

If an applicant owns a retirement fund and is not eligible for periodic payments, but has the option of withdrawing the funds, the retirement fund is counted as a resource. The resource is the amount the applicant can actually withdraw from the account. If there is a penalty assessed for early withdrawal, the resource is the amount available after these penalties are deducted. If taxes are owed on the funds, any taxes due are NOT deducted in determining the value of the retirement fund.

0382.15.35 Annuities
REV: February 2014

An annuity is an investment of funds from which an individual is paid or promised regular payments over a lifetime or a fixed period of time. Generally an annuity is established with a lump sum of money which is paid to a bank, insurance company, or other entity.

A deferred annuity is one under which payments begin at some date to be specified in the future. Once an individual selects a periodic payment option (frequency, amount and duration of payments), and begins to receive income, the annuity has been annuitized.

An annuity may guarantee periodic payments for a stated period (termed period certain) or guarantee periodic payments for the remainder of the life of the individual, without regard to how long the individual lives (termed life annuity).

All applicants must disclose any interest in an annuity that the applicant or his/her spouse has at the time of application and/or recertification of eligibility. Under 42 U.S.C.1396p(e), as amended by the Deficit Reduction Act, the State becomes a remainder beneficiary of all of the couples' annuities (or other similar financial document) which were purchased or transacted by either spouse on or after February 8, 2006 by virtue of the provision of such Medicaid up to the amount of Medicaid paid on behalf of the institutionalized spouse.

Upon the determination that an applicant is eligible for benefits under LTSS-Medicaid, the Medicaid agency will notify the issuer of any annuity disclosed for purposes of section 1917(c)(1)(F) of the State's rights as a preferred remainder beneficiary.

The Medicaid agency will additionally require the issuer of the annuity to notify the Medicaid agency regarding any changes in disbursement of income or principal from the annuity.

When determining eligibility for Medicaid COUNT AS AN AVAILABLE RESOURCE:

The cash value of an annuity which can be surrendered or "cashed in." The cash value is equal to the amount of money used to establish the annuity, plus any earnings, minus any earlier withdrawals and surrender fees. No consideration in determining cash value is given for income tax withheld or tax penalties for early withdrawal.

Annuity contracts that do not allow for cash surrender but instead allow the owner to sell the annuity on the open market are assignable. Annuity contracts that are silent regarding assignability are presumed to be assignable. Assignable annuities are countable resources. The countable value of the resource is equal to the outstanding principal balance, unless the individual can furnish evidence from a reliable source which shows that the annuity is worth a lesser amount. Reliable sources include banks, other financial institutions, insurance companies, brokers, viatical settlement companies, etc.

Count as Available Income:

Payments made to the individual from an annuity are counted as unearned income. Any change in the income from the annuity must be reported within ten (10) days to the agency and may affect eligibility and/or post eligibility treatment of income.

Transfer of Asset Provisions for Institutionalized Individuals May Apply When:

A non-cashable, non-assignable annuity was purchased by the individual (or by the individual's spouse):

- Within thirty-six (36) months (if purchased prior to February 8, 2006), or OR
- Within sixty (60) months (if purchased or after February 8, 2006)

- Immediately prior to, or any time after, the date the individual was both institutionalized and applied for Medicaid. See Sec. 0384.10 for description of how the 5-year look-back on resource transfers is phased in).

In this case, a determination must be made as to whether its purchase constitutes a transfer of assets for less than fair market value.

Determine Whether Any Annuities Create a Penalty Period of Ineligibility For LTSS-Medicaid

A non-cashable, non-assignable annuity purchased by the individual (or by the individual's spouse) may be determined to be a transfer of assets for less than fair market value, and therefore create a penalty period of ineligibility.

There are two situations in which this may occur:

1. When the asset was literally converted, within certain time frames, into an annuity which does not meet the criteria for being a "VALID TRANSFER FOR FAIR MARKET VALUE" in return (See the remainder of this Section, along with Section 0356.15.35 AND 0384.35 for detailed discussions of these topics).

and/or

2. When the annuity (if purchased on or after February 8, 2006) does not name the "State as Beneficiary" of the annuity.

When such an annuity does not comply with this requirement, it is defined as being a transfer for less than fair market value.

(This requirement to name the state as beneficiary is found in Section 1917(c)(1)(F)(i) of the Social Security Act (42 U.S.C.) 1396p(c)(1)(F)(i)), as added by section 6012(b) of the Deficit Reduction Act of 2005, and as amended by the Tax Relief and Health Care Act of 2006. (See the remainder of this Section, along with Section 0356.15.35 AND 0384.35 for detailed discussions of these topics).

Time-frames for evaluating the transfer of resources DHS may "look back" at resource transfers for the 36 months, or for the 60 months, immediately prior to the date that the individual was both institutionalized, and applied for LTSS-Medicaid.

(Transfers which occurred prior to February 8, 2006 are subject to the 36 month "look back").

(Transfers which occurred on or after February 8, 2006 are subject to the 60 month "look back").

Additionally, transfers which occur any time after the application are also evaluated to determine whether they generated a penalty period of ineligibility for LTSS-Medicaid.

(See Section 0356.15.35 and 0384.10 and 0384.35 for detailed discussions of these topics).

To be considered a valid transfer for fair market value, an annuity must:

- Be irrevocable and non-assignable;

- Provide regular payments in both frequency and amount, with no deferral and no balloon payments, to or for the sole benefit of the individual; and

- Be actuarially sound. Scheduled payments must return at least the principal within the number of years of expected life remaining for the individual.

Life expectancy tables compiled from information by the Office of the Chief Actuary of the Social Security Administration for this purpose are used to determine the number of years of expected life remaining for the individual. (See MCAR Section 0382.15.35.05).

If based on life expectancy tables compiled by the Social Security Administration's Office of the Actuary and published by HCFA CMS, the individual is not expected to live longer than the guaranteed period of the annuity, the guaranteed period of the annuity, the annuity is not actuarially sound, and a transfer of assets for less than fair market value has taken place. The transfer is considered to have taken place at the time the annuity was purchased. The uncompensated value of the transfer is based on the amount projected to be paid beyond the individual's reasonable life expectancy. (See Section 0384- Resource Transfers).

If an annuity is purchased or transacted on or after February 8, 2006 whether by the applicant or by their spouse, the beneficiary clause of the annuity must provide that the beneficiary of the annuity is as follows:

- Must, except as provided in this section, name the State of Rhode Island as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the institutionalized individual.

- If, however, the institutionalized individual has a minor or disabled child, such child may be named as the beneficiary in the first position, provided the State of Rhode Island is named as beneficiary of the annuity in the second position for at least the amount of Medicaid paid on behalf of the institutionalized individual.

- In the event such child or his or her representative disposes of any such remainder for less than fair market value, the State of Rhode Island must be named in the first position.

- Any change in the beneficiary clause must be reported to the Medicaid agency within ten (10) days of any change, and may result in a transfer of assets penalty.

An institutionalized spouse, that is, an institutionalized individual who has a community spouse:

- Must, except as provided in this section, name the State of Rhode Island as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of such institutionalized spouse.

- However, the institutionalized spouse may name as the beneficiary in the first position his or her community spouse or his or her minor or disabled child, provided the State of Rhode

Island is named as beneficiary of the annuity in the second position for at least the amount of Medicaid paid on behalf of the institutionalized spouse.

- In the event the community spouse or such child or his or her representative disposes of any such remainder for less than fair market values, the State of Rhode Island must be named in the first position.

- Any change in the beneficiary clause must be reported to the Medicaid agency within ten (10) days of any change, and may result in a transfer of assets penalty.

A community spouse:

- Must name the State of Rhode Island as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of his or her institutionalized spouse.

- The community spouse may not change the beneficiary of the annuity after the death of the institutionalized spouse.

- Any change in the beneficiary clause, before or after the death of the institutionalized spouse, must be reported to the Medicaid agency within ten (10) days of any change and may result in a transfer of assets penalty.

In the event the community spouse becomes institutionalized and applies for Medicaid, the beneficiary clause must be amended to additionally name the State of Rhode Island as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of such community spouse who becomes institutionalized, at the time such spouse applies for Medicaid for himself or herself, if the annuity was purchased during the look-back period.

Cases involving annuities are referred by field staff to the LTSS Administrator (or his/her designee) for evaluation. The agency representative forwards a copy of the annuity document, including date of purchase to the LTSS Administrator.

The LTSS Administrator (or his/her designee) consults, as needed, with the Office of Legal Services, and determines:

- Whether the annuity is an available or unavailable resource;

- The countable amount of the resource (i.e., the cash surrender value and/or negotiable value of the annuity); and

- Whether the State has been made a remainder beneficiary for at least the amount Medicaid paid on behalf of the institutionalized individual; and

- Whether a transfer of assets for less than fair market value has occurred as well as the amount of the uncompensated value and date of the transfer.

0382.15.35.05 Life Expectancy Tables
REV: 12/2000

Life expectancy tables are to be used when evaluating annuities.

The Social Security Administration issues an "Annual Statistical Supplement" in April of each year (based on the annual April report of the Social Security Trustees). This supplement contains the Life Expectancy Table, including any updates for that year.

This table is titled "Period Life Table" on the Social Security Administration's website.

It may be viewed on the internet by the following steps:
1. go to http://www.ssa.gov/OACT/
2. then click on "Actuarial Publications"
3. then click on "Statistical Tables"
4. then click on "Life Tables."

This address and process are expected to remain in effect indefinitely, per the S.S.A.

0382.20 Life Insurance
REV: 06/1994

Life insurance that is owned by the applicant (or deemor) is a resource which is evaluated according to the face value threshold limits set forth in Section 0382.20.15. Policies on the applicant's life owned by others are not countable unless deeming policies apply. However, regardless of ownership, all policies on the individual's life are recorded in the case file for use in the event a subsequent request for assistance with burial expenses is made.

0382.20.05 Types of Policies
REV: 06/1994

A life insurance policy can be either a group or individual policy.

Group insurance policies generally have no cash surrender value.

Group policies are usually issued through a company or organization insuring the participating employees or members and perhaps their families. The group policy may be paid partially by the employer.

This is not counted as a resource. The individual policy is paid for entirely by the owner of the policy.

Individual policies include policies having no cash surrender value (term insurance) and those having a cash surrender value (ordinary life, limited payment life, or endowment).

0382.20.10 Life Insurance Terminology
REV: 06/1994

Face value is the amount for which a policy is written, or the benefit amount. For example, a $10,000 insurance policy has a face value of $10,000.

Cash surrender value -- As the premiums of certain life (not term insurance) policies are paid over time, a cash value accumulates in the policy. The cash surrender value is the amount of cash which may be advanced to the policy owner when the policy is surrendered according to the conditions stipulated in the policy.

A term insurance policy is a contract of temporary protection. The insured pays relatively small premiums for a limited number of years, and the company agrees to pay the face amount of the policy only if the insured should die within the time specified in the policy. If the insured outlives the period, he receives nothing.

It is a temporary protection. Usually a term insurance policy has no cash surrender value and is not counted as a resource.

An **ordinary life** (known as whole or straight) policy is a contract for which the insured pays the premium during his life time or to age one hundred (unless purchased by a single premium or by letting dividends accumulate). The company pays the face value of the policy to the beneficiary upon the death of the insured. This policy has a cash surrender value, usually after the second year.

The policy combines protection and savings with the emphasis on protection for the whole life.

A **limited payment life policy** is a contract for which the insured makes payments for a definite number of years (20 or 30) after which no more payments are required. The policy remains in force for life and affords the same protection as an ordinary life policy. The policy has a cash surrender value.

An **endowment insurance** promises payment upon death of the insured within a specified period or upon his survival to the end of a specified period. An endowment has a cash surrender value.

Insured person - The insured person shown on the policy identifies the person whose life is insured. The $1,500 ($4,000 for Medically Needy) face value exclusion applies to all policies on each insured person which are owned by the applicant (individual or couple).

The exclusion applies to policies the applicant holds on his life, the life of a family member, or the life of any other person.

Where the face value exclusion is exceeded on one insured person, this does not affect its application to policies on another insured person.

Joint policies generally cover a married couple, often with whole life for one spouse and term for the other spouse.

Family policies cover each family member on one policy. They are sometimes a combination of whole life for the father and term for the mother and children.

Owner of the policy - The owner of the policy is the only person who can receive the proceeds under the cash surrender provisions of the policy. If the applicant is the insured person, but not the owner, the value of the policy does not count as his/her resource unless deeming policy applies.

Conversely, if another individual is the insured person, but the applicant is the owner, the value of the policy counts as his/her resource (subject to the $1,500/$4,000 face value exclusion).

If the consent of another person is needed to cash in a policy, and consent cannot be obtained after a reasonable effort, the insurance policy is excluded.

0382.20.15 Policy and Procedure for Evaluation
REV: 06/1994

STEP 1: Determine the face value of each insurance policy on the individual as listed on the application. Total the face values of all policies owned by the individual or couple, or in a deeming situation, policies owned by a spouse or parent. If the total face value of all the policies is less than the appropriate face value threshold for exclusion ($1,500 for Categorically Needy determinations, $4,000 for Medically Needy), no further determination is needed. There is no countable resource from life insurance. If the total exceeds the appropriate face value threshold limit, all the policies must be reviewed further.

STEP 2: Exclude all policies that do not have a cash surrender value (e.g., group insurance, term insurance). Sum up the face values of all remaining policies to determine the total face value of all policies which do have a cash surrender value. If the total face value is now less than the appropriate limit, there is no countable resource from life insurance.

STEP 3: If the total face value still exceeds the appropriate face value threshold limit, determine the total cash surrender value of all policies. The total cash surrender value of all policies counts toward the basic resource limit.

Staff should note that the tables of values accompanying many policies may be inaccurate due to the existence of a loan on the policy, or due to changes in the rate at which the policy gains value. The cash surrender value of each policy should be obtained directly from the issuing insurance company.

STEP 4: Retain copies of all policies and relevant documents for the case record.

If countable resources exceed the appropriate basic resource limit, due in whole or in part to the countable value of life insurance, the individual/couple is ineligible and may pursue one of the following options:

- Cash in a policy to bring the resource within the limit;
- Spend down the cash amount by which the resource exceeds the eligibility limit of combined cash, stocks, bonds and personal property;
- Adjust the insurance to bring it within the eligibility limit;
- Determine eligibility for a Burial Funds Set-Aside (Section 0382.45); or
- Elect to retain the resources and the case will be rejected/ closed.

0382.20.20 Policies Owned by Spouses
REV: 06/1994

Policies owned separately by a married couple on the same person (e.g., a child) must be evaluated together (e.g., the married couple may each hold a policy on a child with a face value of $1,000). Since the COMBINED total face value exceeds the $1,500 Categorically Needy face value limit, the entire cash surrender value of both policies counts as a resource in the Categorically Needy determination. Conversely, because the combined face values are less than the $4,000 medically needy face value limit, there is no countable resource in a medically needy determination.

0382.25 Household and Personal Effects
REV: February 2014

Household goods and personal effects are excluded if their total current market value does not exceed the following threshold values:

- For Categorically Needy eligibility $2,000;
- For Medically Needy eligibility $5,000.

An applicant's household goods and personal effects are excludable unless there is strong evidence that their value is exceptional or unusual. For the purpose of determining the total joint resources of a couple, the spousal share of resources, the community spousal resource allowance, and Medicaid eligibility for an institutionalized individual with a community spouse, all household goods and personal effects are excluded, regardless of value.

Household appliances, furniture, carpeting, drapes, utensils, garden equipment, etc. are essential for the care and maintenance of the premises to support an adequate standard of health or the normal life comforts. Clothing, hobbies of reasonable value, jewelry, family heirlooms, and other effects typically restricted to the use of one individual are also essential to maintaining a reasonable living standard.

0382.25.05 Items of Exceptional Value
REV: 06/1994

When there is evidence that the applicant possesses household or personal items of unusual or exceptional value, there shall be verification that such item is a resource by establishing the fair market value (FMV) for it. Items of unusual value are those not essential to the physical health and safety, or items not normally used to maintain an adequate standard of comfort and convenience for the household.

Recreational boats, expensive jewelry (one wedding ring and one engagement ring are always excluded), art objects, or valuable collections are luxury items of unusual value and represent resources that can, along with other countable resources, exceed the resource limit for eligibility.

In such cases, a FMV is established for each such item and the amount is added to the $1,000. The $2,000 exclusion is subtracted.

(Do not include excluded items in this computation.) If there is a balance which, when added to other countable resources, would exceed the basic resource limit and render the individual/couple ineligible, it is then necessary to establish the equity value of the items and recompute in the same manner, as above. If the total equity value of household goods and personal property computed as above is in excess of the tangible personal property limit ($2,000, for Categorically Needy determinations, or $5,000 for Medically Needy determinations), the value in excess of the tangible personal property limit is a resource countable toward the appropriate basic resource limit.

0382.30 Automobile(s)
REV: 06/1994

An automobile is any vehicle which is used to provide necessary transportation, such as passenger automobiles, trucks, boats and special vehicles (e.g., snowmobiles, animals or animal-drawn vehicles).

0382.30.05 Exclusion Based on Use
REV: February 2014

One automobile (motor vehicle) will be totally excluded regardless of value if (for the individual or member of the individual's household):

- It is necessary for employment; or
- It is necessary to get to medical treatment for a specific or regular medical problem (used at least four times a year to receive treatment or to pick up prescribed medication for a specific medical problem); or
- It is modified for operation by or for transportation of a disabled person.

0382.30.10 Threshold Exclusion
REV: 06/1994

If no automobile (motor vehicle) is excluded based on use, one automobile is excluded from counting as a resource to the extent its NADA book value does not exceed a threshold of $4,500. If the automobile exceeds the $4,500 threshold, the amount in EXCESS of $4,500 is counted toward the basic resource limit. Equity value is not used in applying this provision. However, the lowest nada value assigned to the type of automobile is used, minus the amount allowed for any equipment the automobile does not have.

0382.30.15 Additional Vehicles
REV: 06/1994

The equity value of any additional automobiles or motor vehicles is counted toward the basic resource limit.

0382.35 Burial Spaces
REV: 06/1994

Burial space owned by the individual intended for use by the individual, his/her spouse or another member of the individual's immediate family is excluded from resources.

Burial space owned by an individual from whom resources are deemed to an applicant is excluded if the burial space is intended for use by the individual, the individual's spouse or another member of the individual's immediate family.

0382.35.05 Definitions
REV: 06/1994

The following definitions apply to determinations regarding burial spaces:

Burial Space
Burial spaces are conventional gravesites, crypts, mausoleums, urns or other repositories which are customarily and traditionally used for the remains of deceased individuals.

Immediate Family
Immediate family includes an individual's minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those individuals.

Dependency and living-in-the-same household are not factors. Immediate family does not include the members of an ineligible spouse's family unless they meet this definition.

0382.35.10 Examples of Burial Space Eval
REV: February 2014 Repealed

0382.40 Irrevocable Burial Contracts, Trusts
REV: 06/1994

Funds in an irrevocable agreement which are available only for burial are excluded from countable resources. These are:

- Funds which are held in an irrevocable burial contract, or irrevocable burial trust; or
- An amount in an irrevocable trust specifically identified for burial expenses.

When, prior to application, an individual has an irrevocable contract or trust, the funds are not considered as a countable resource. To determine revocability or irrevocability, the contract or trust must be evaluated. A photocopy must be filed in the record.

0382.40.05 Identification of a Revocable Contract/Trust
REV: February 2014

A burial arrangement that may be liquidated by the mutual consent of the buyer (the individual) and the seller (the funeral director) is considered revocable unless the seller refuses to consent to liquidation. A statement of the seller's willingness or unwillingness to liquidate the arrangement is obtained and a copy placed in the record. If the seller is willing to liquidate, the arrangement is

considered revocable; if the seller is unwilling to liquidate, the arrangement is considered irrevocable.

Any questions regarding revocability will be sent in writing through the Assistant Administrator in Long Term Care, with appropriate documentation, who will consult with the Office of Legal Services, as necessary.

If the contract or trust is revocable, it may be considered as "funds set aside for burial" or cash, depending on the amount of other resources. If the contract or trust is irrevocable, then the amount allowed as "funds set aside for burial" must be reduced by the amount held in the irrevocable burial arrangement.

0382.40.10 Post-Eligibility Burial Agreement
REV: 06/1994

After eligibility has been established, an individual who wishes to do so may place some or all of his/her resources that are within the resource limit, in an irrevocable burial arrangement without affecting eligibility.

0382.45 Funds Set Aside For Burial
REV: 06/1994

In addition to cash which may be retained under the appropriate basic resource limit, the applicant is permitted to set aside up to $1,500 in a separately identifiable fund for burial purposes. Funds can include a revocable burial contract, burial trust or any separately identifiable resource. If the conditions set forth below are met, the set-aside amount is excluded from resources.

The maximum amount which may be excluded from resources as a burial set aside is $1,500 for both Categorically Needy and Medically Needy determinations. The maximum excludable set aside amount is reduced by amounts held in irrevocable burial contracts and certain insurance policies, as specified below. At each application it is necessary to learn whether any funds are set aside for burial of the eligible individual or the eligible individual's spouse. If there are no such funds, no special procedures are required.

0382.45.05 Computation of Burial Set-Aside Funds
REV: 06/1994

If the applicant has funds set aside for burial, the amount which is excluded from resources is determined in the following manner:

- Start with the maximum of $1,500 for an individual and $1,500 for the spouse. Funds can include a revocable burial contract, burial trust or any separately identifiable resource.

- Reduce the maximums by the face value of any non-term life insurance policies on the individual's life, owned by the individual or the spouse, if the cash surrender values of the policies were excluded in determining countable resources according to policy in section 0382.20, Life Insurance. For Categorically Needy individuals, this means the total face values of such non-term life insurance policies which have cash surrender values and the

total face values are $1,500 or less. For Medically Needy individuals, this means the total face values of such non-term life insurance policies which have cash surrender values and the total face values are $4,000 or less. (The face amounts of term life insurance or other life insurance on the individual's life, owned by his/her spouse, which have no cash surrender values, have no affect on the amount that can be set aside for burial).

- Reduce the balance further by the amount held by each individual in an irrevocable burial arrangement as defined in 0382.40.

- When both of these resources have been deducted from the $1,500 limit, any remaining balance may be set aside in a burial fund which meets the following requirements.

The funds must be:

- Separately identifiable and not combined with other funds or resources which are not set aside for burial. If they are combined, they must be restructured into separate accounts with separate account numbers within the month of application, if eligibility is to exist for that month.

- Clearly designated as set aside for burial. If the funds are not so designated, the funds may be excluded if the individual states that he/she intends to use the funds for burial and submits, within 30 days of application, a statement (AP-5.2) and documentary evidence that the funds have been designated as set aside for burial. Where the funds are set aside in a bank account, it is necessary to obtain a copy of the account to verify the existence and amount of the "set-aside account. The designation that the funds are for burial need not be indicated on the account since banks will not normally allow the designation.

Obtain a statement (AP-5.2) from each individual and/or deemor regarding the revocable burial agreement, trust and/or fund set aside for burial. The statement must be dated and must include the amount, account number (if applicable) and other pertinent information in each such arrangement. If a contract or trust, the statement should be fastened to the record copy of the contract or trust.

Once excluded from resources, any increase in the value of excluded burial funds due to interest on such funds which was left to accumulate, or appreciation of such funds which occurred after the date of first eligibility, is excluded.

Once a burial set-aside is excluded in whole or in part from resources, the excluded funds may not be used for any purpose other than burial expenses. An individual with set-aside must be advised that if the excluded set aside funds are used for any purpose other than burial, the amount used must be counted as income.

Eligibility will need to be redetermined (including this additional income) for the period during which the income was used. Any question of fraud should be referred in accordance with Section 107.

0382.45.10 Burial Set-Aside Examples
REV: February 2014 Repealed

0382.50 Trusts
REV: February 2014

A trust is an arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or certain designated beneficiaries.

When an applicant or recipient is a party to a trust, the trust must be reviewed to determine if it has an impact on the individual's eligibility for Medicaid. Trusts and portions of trusts may be treated as available income, available resources or as a transfer of assets for less than fair market value. Trusts are referred to the LTSS Administrator for evaluation.

Trusts established prior to 8/11/93, called Medicaid Qualifying Trusts, are treated under provisions contained in 0382.50.05 and 0382.50.05.05.

Trusts established on or after 8/11/93 are evaluated in accordance with provisions contained in 0382.50.10.

Exceptions to trust provisions are contained in 0382.50.25.

The following definitions apply in general to trusts created other than by will:

A trust is any arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or other designated beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by will. If the trust includes assets of the individual and other person(s), this policy applies only to the portion of the trust attributable to the individual. A trust must be valid under Rhode Island law.

A revocable trust is one which:

- Under RI law can be revoked by the grantor;
- Provides for modification or termination by a court; or
- Terminates if some action is taken by the grantor.

An irrevocable trust is one which cannot, in any way, be revoked by the grantor.

The grantor/settlor is the person who creates a trust. For purposes of this policy the term grantor/settlor includes:

- The individual;

- The individual's spouse;

- A person, including a court or administrative body, with legal authority to act on behalf of the individual or the individual's spouse; and

- A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

The beneficiary/grantee is the person(s) for whose benefit the trust exists. In some cases, the person creating the trust (the trustor) is named as one of the beneficiaries.

The trustee is the person or entity (such as a bank or insurance company) that holds and manages a trust, and has fiduciary responsibilities. In most cases, trustees do not have the legal right to use the trust fund for their own benefit.

The trustee's discretion is the power the terms of the trust grant expressly to the trustee to use judgment as to when and/or how to handle trust income and/or principal. Not all trusts grant discretion to a trustee.

The trust principal is the property or funds placed in trust by the trustor who set up the trust.

Trust income is the amount earned by trust property. Trust income may take various forms, such as interest, dividends, or rent. Trust income may also be called trust earnings.

A trust document is the legal document setting forth the terms of the trust.

0382.50.05 Trusts Established Prior to 8/11/93
REV: February 2014

A trust, or similar legal device, is called a Medicaid qualifying trust when it:

- Was established prior to 8/11/93 by the individual, the individual's spouse or legal guardian, or the individual's legal representative acting on his/her behalf;

- Was established through a method other than a will;

- Names the individual as a beneficiary;

- Gives a trustee any discretion to disburse funds from the trust to or for the benefit of the individual; and

- Was created for a purpose other than to qualify for Medicaid.

Medicaid Qualifying Trusts may be irrevocable or revocable. There are no "use" limits on the funds in a Medicaid Qualifying Trust; trusts established by the individual to pay for special needs (e.g., medical, rehabilitative, or educational) may be considered Medicaid Qualifying Trusts insofar as they meet the criteria above.

However, if a beneficiary of a trust is an intellectually disabled individual who resides in an Intermediate Care Facility for the Mentally Retarded (ICF-MR), that individual's trust is NOT considered a Medicaid Qualifying Trust, provided the trust or initial trust decree was established prior to April 7, 1986, and is solely for the benefit of that intellectually disabled individual.

Legal instruments such as trusts are almost always drafted by an attorney. It is the grantor (beneficiary) himself who actually establishes or creates the trust when he signs or executes it.

0382.50.05.05 Evaluating a Medicaid Qualifying Trust
REV: February 2014

In the determination of financial eligibility and in the post- eligibility treatment of income, count as available to the applicant the maximum amount which the trustee(s) may distribute from a Medicaid Qualifying Trust. The maximum amount is the amount that the trustee could disburse if (s)he exercised his/her full discretion under the terms of the trust.

Distributions are considered available to the individual establishing the trust whether or not the distributions are actually made or the trustee(s) exercise their authority under the trust.

The amount from the trust that is deemed to be available as a resource to the beneficiary is the maximum amount that could have been distributed to the beneficiary from the principal of the trust under the terms of the trust, provided the trustee exercised his full discretion under the terms of the trust to distribute the maximum amount to the beneficiary.

The amount from the trust that is deemed to be available as income to the beneficiary is the maximum amount that could have been distributed to the beneficiary from the income of the trust under terms of the trust, provided the trustee exercised his full discretion under the terms of the trust to distribute the maximum amount to the beneficiary.

The maximum distributable amounts deemed available include only those amounts which can be but are not distributed from either the income (interest) or principal of the trust. Amounts which are actually distributed to the beneficiary for any purpose, including amounts to pay for the beneficiary's health, personal and other maintenance needs, are treated as income and/or resources, depending on whether the distribution was made from the income or principal of the trust.

0382.50.10 Trusts Established on or After 8/11/93
REV: February 2014

The following provisions apply to trusts established by the individual (as defined below) other than by will on or after 8/11/93. These rules apply without regard to:

- The purpose for which the trust was established;
- Whether the trustees have or exercise any discretion under the trust;
- Any restriction on when or whether distribution can be made from the trust; or
- Any restriction on the use of distributions from the trust.

The term individual includes: the individual; the individual's spouse; any person, including a court or administrative body, with legal authority to act on behalf of the individual or the individual's spouse; and any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse. A trust must be valid under RI law.

I. **Revocable Trusts**

A revocable trust is a trust which under RI law can be revoked by the grantor. A trust which provides for modification or termination by a court is considered to be revocable since the grantor can petition the court to terminate the trust. A trust which is called irrevocable but which terminates if some action is taken by the grantor is also a revocable trust. For example, a trust may require the trustee to terminate a trust and disburse funds to the individual if the individual leaves a nursing facility. This would be considered to be a revocable trust.

Revocable trusts are treated as follows:

- The entire corpus of the trust is treated as a countable resource;

- Payments made from the trust to or for the benefit of the individual are counted as available income;

- Any other payments made from the trust are considered to be a transfer of assets for less than fair market value and are subject to a transfer penalty as provided Section 0384 when payment was made within sixty (60) months immediately prior to or any time after the individual was both institutionalized and applied for Medicaid.

- The home or former home of the individual held in a revocable trust established on or after December 1, 2000 is a countable resource. Where the home is an asset of the trust, it is not subject to the exclusion provision contained in 0382.10.05.

II. **Irrevocable Trusts**

An irrevocable trust is one which cannot, in any way, be revoked by the grantor. Irrevocable trusts are treated as follows:

- Payments from trust income or principal which are made to or for the benefit of the individual are treated as income to the individual;

- Portions of the principal which could be paid to or for the benefit of individual are treated as an available resource;

- Payments from income or principal which under the trust could have been made to or for the benefit of the individual, but are instead made to someone else and not for the benefit of the individual are treated as a transfer of assets for less than fair market value and are subject to a penalty if made with thirty-six (36) months immediately prior to or any time after the month the individual was both institutionalized and applied for MA.

- Portions of the trust which cannot under any circumstances be paid to or for the benefit of the individual are treated as a transfer of assets for less than fair market value and are subject to a penalty if made within sixty (60) months immediately prior to or any time after the month individual was both institutionalized and applied for MA.

- The home or former home of the individual held in an irrevocable trust established on or after December 1, 2000 is not subject to the intent to return exclusion provision contained in 0382.10.05.

For portions of trusts which are treated as a transfer, the date of the transfer is considered to be the date the trust was established or, if later, the date which payment to the individual was foreclosed. The uncompensated value of the transfer can be no less that its value on the date of transfer.

When additional funds are added to a trust, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds were added to that portion of the trust.

0382.50.15 Trust Evaluation Process
REV: February 2014

When field staff encounters a trust, the individual must provide a copy of the trust document or other device, and relevant documents to verify the value of any investments and distributions that have been made by the trustee. A memorandum, along with copies of the trust document and all documentation, is forwarded to the LTSS Administrator for a determination of: a) the amount of countable income and/or resources; and b) the date and amount of any prohibited transfer of assets. Copies are retained in the case record. The Office of Legal Services is available for consultation with the Administrator to aid in establishment of the countable resource amount. The countable income/resource amount is added to other countable income/resources to determine eligibility. The imposition of a penalty related to a prohibited transfer is calculated based on the date of the transfer and the uncompensated value of the transfer.

0382.50.20 Exceptions to Trust Provisions
REV: July 2014

The following trusts receive special treatment in the determination of eligibility for Medicaid. Under certain circumstances, no transfer of assets is considered to have taken place as a result of establishing the trust. The income and resources considered available to the individual are only those made available by the trust.

1. **Special Needs Trust**, defined as a trust which:

- Contains the assets of an individual under age 65 who is disabled (as defined by the SSI program);

- Was established as a trust for the sole benefit of the individual by a parent, grandparent, legal guardian or court; and

- Provides that upon the death of the individual, the State will receive all amounts remaining in the trust, up to an amount equal to the total Medicaid payments made on behalf of the individual.

The trust may contain assets of individuals other than the disabled individual.

This exemption remains once the individual turns age 65 as long as there are no changes in the terms of the trust once the individual attains age 65. Any assets added to the trust as of age 65 are not subject to this exemption.

AND

2. **Pooled Trust**: A pooled trust is a trust that can be established for a disabled individual under the authority of 1917(d)(4)(C) of the Social Security Act (the Act). The statute provides an exception to imposing a transfer penalty for funds that are placed in a trust established for a disabled individual. The pooled trust (or more accurately, a sub-account within the pooled trust) is established for each individual beneficiary.

All the beneficiary sub-accounts are pooled for investment and management purposes. Upon the death of the disabled individual, the balance remaining in the account is paid back to the State Medicaid agency in an amount equal to the Medicaid paid on behalf of the beneficiary. The statute also allows the trust to retain some portion of the balance remaining after the death of the beneficiary, which is not to exceed $15,000.

A pooled trust is a trust that contains the assets of a disabled individual and meets the following conditions:

- The trust is established and managed by a non-profit association;
- A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools the funds in these accounts;
- Accounts in the trust are established solely for the benefit of the disabled individual by the individual, parent, grandparent, legal guardian or by a court; and
- To the extent that any amounts remaining in the beneficiary's account upon his/her death are not retained by the trust, the trust pays to the State the amount remaining in the account, up to the total amount of Medicaid paid on behalf of the individual.

0382.50.25 Claims of Undue Hardship
REV: February 2014

Trust provisions shall be waived if application of those provisions would cause the individual undue hardship. Undue hardship exits when:

1) Application of trust or transfer of asset provisions would deprive the individual of medical care to the extent that his/her life or health would be endangered or would deprive the individual of food, shelter, clothing or other necessities of life; AND

2) All appropriate attempts to retrieve the prohibited transfer have been exhausted; AND

3) The nursing facility has notified the individual of its intent to initiate discharge or the agency providing essential services under a home and community based waiver has notified the individual of its intent to discontinue such services for reasons of non-payment; AND

4) No less costly non-institutional alternative is available to meet the individual's needs.

Undue hardship does not exist when application of the trust provisions merely causes inconvenience or restricts lifestyle but would not put him/her at risk of serious deprivation.

When eligibility for Medicaid has been denied due to imposition of trust provisions, the individual may claim undue hardship. The individual must submit a written request and any supporting documentation. The individual's request for consideration of undue hardship does not limit his or her right to appeal denial of eligibility for reasons other than hardship.

Claims of undue hardship are forwarded to the Long Term Care Administrator for evaluation. The LTSS Administrator may instruct the agency representative to obtain documentation from the individual which can include but is not limited to the following:

- A statement from the attorney, if one was involved;
- Verification of medical insurance coverage and statements from medical providers relative to usage not covered by said insurance;
- A statement from the trustee and/or transferee.

The LTSS Administrator, in consultation with the Office of Legal Services, determines whether undue hardship exists. The individual is provided written notification of the Medicaid agency's decision, along with appeal rights, within sixty (60) days of the Medicaid agency's receipt of the request.

0382.55 Life Estate
REV: 07/2006

A life estate is a legal procedure giving a person certain rights in a property for his/her lifetime. Usually a life estate conveys the property to one party (the life estate holder) for life and to a second party (remainderman) when the life estate expires. The holder of the life estate agreement is entitled to all of the income produced by the property unless the life estate specifies otherwise. The agreement which creates a life estate is a will, a deed or some other legal instrument.

The physical property has one value and the life estate has another, separate value. The value of the life estate is based on the equity value of the property and the age of the life estate holder.

The life estate holder may use the property as his home for the rest of his life, or he may rent the property or sell his interest.

A primary obligation of the life estate holder is to preserve the property in the same condition as when s/he received it so that, at his/her death, it will pass to the remainderman in much the same condition.

The remainderman has an ownership interest in the physical property but s/he cannot possess or use the property until termination of the life estate. Unless restricted by the life estate agreement, the remainderman can sell his/her interest in the property before the life estate expires.

0382.55.05 Life Estate Exclusions
REV: April 2015

A life estate in real property located in Rhode Island that is the home of the applicant/recipient is excluded, if the equity value of the life estate is less than five hundred and fifty-two thousand dollars ($552,000.00) (and the applicant intends to return to the home) or is the primary residence of the LTSS resident's spouse, minor child or disabled child of any age.

Please note that under the Deficit Reduction Act of 2005, if an individual has purchased a life estate in another individual's home on or after July 1, 2006, the individual must have resided in the home for a period of at least one (1) year after the date of purchase. A life estate may be excluded if the life estate cannot be sold.

If the life estate cannot be sold, then the value is not available to the applicant and it is excluded on that basis.

The salability of the life estate must be reviewed at each redetermination.

0382.55.10 Evaluation of Life Estate/Remainder Interest
REV: February 2014

The value of a life estate or remainder interest is based on the equity value of the real property and the mortality table.

To determine the value of a life estate, the Office of LTSS will:

- Determine the EQUITY VALUE of the real property by subtracting any encumbrances from the Fair Market Value;

- Round the age of the estate holder to the nearest year;

- Consult the Life Estate and Remainder Interest Tables which provide the value of a life estate and the value of a remainder estate at any given age. Multiply the equity value of the real property by the appropriate figure from the Life Estate and Remainder Interest Tables.

0382.55.15 Resource Transfer
REV: 07/2006

When an individual owns real estate and establishes a life estate for himself or herself in the property, the individual has transferred an asset, the remainder interest. These transfers are handled the same way as any other transfer of real property. Please refer to the above sections regarding the requirements of life estates and apply the transfer rules as found at section 0384. The value of the transfer is the remainder interest in the life estate.

The remainder interest is the equity value of the property minus the value of the life estate.

0382.56 Life Estate with Enhanced Powers
EFF: July 2014

01. Every applicant or recipient of Medicaid who owns a life estate in property (as defined in section 0382.10.10.05 herein) that is his or her primary residence, with a retained right to revoke, amend or redesignate the remainderman, will not be eligible for Medicaid, unless the applicant or recipient exercises the retained power thereby conveying all outstanding remainder interest to him or herself.

02. Said real estate shall be transferred to the Medicaid applicant or recipient by a warranty deed or quitclaim deed created, executed and recorded. Thereby, said applicant or recipient shall hold said real estate in fee simple.

03. An applicant or recipient who has reserved a life estate with retained rights to revoke, amend or redesignate the remainderman by a deed created, executed, and recorded prior to July 1, 2014 shall not be ineligible for Medicaid on the basis of such deed, regardless of whether the remainderman designated in such deed is a person or persons, a trust or entity.

Evaluation of Real Estate / Transfers

04. ***Evaluation of a Life Estate with Enhanced Powers*:** The property of a Medicaid applicant or recipient who: 1) owns a life estate in property that is his or her primary residence; and 2) exercises a retained right to revoke, amend or redesignate the remainderman in compliance with the provisions of this section; and 3) who is otherwise determined to be eligible for Medicaid; shall be evaluated in accordance with the provisions of section 0382.10 herein and all of the subsections thereunder.

05. ***Transfers***: Transfers for life estates with enhanced powers shall be treated in accordance with section 0382.10 herein and all of the subsections thereunder and in a manner similar to other resource transfers as provided herein.

0382.60 RSDI and SSI Retroactive Payments
REV: February 2014

An RSDI or SSI retroactive payment due for one (1) or more prior months is excluded from resources for six (6) months following the month of receipt.

This exclusion applies to retroactive payments received by the individual, the individual's spouse and/or any other individual whose income is deemed to the individual (or spouse).

RSDI benefits are regularly paid for the prior month. Therefore, a retroactive RSDI payment is one made for a month that is two (2) or more months prior to the month of payment.

This exclusion applies to retroactive payments only if they remain in the form of cash or identifiable funds; this exclusion does not apply once the retroactive payment has been converted to any other form.

If a resource is excluded under this policy, the case record must clearly indicate the resource, its amount and the period of the exclusion. If the excluded resource in conjunction with other resources would render the individual ineligible for Medicaid the redetermination must be scheduled for the month prior to the month in which the period of exclusion ends.

Although excluded from resources, retroactive RSDI benefits are countable unearned income in the month received. As such, they are included in the calculation of income, and the calculation of the excess income under the flexible test policy. Such benefits are also included in the calculation of monthly income to be applied to the cost of care of a recipient in an LTSS facility, or the cost of services received under a Waiver.

0382.65 Resources for Self-Employment
REV: February 2014

Resources essential to the recipient's (or deemor's) means of self-support are excluded from countable resources if the property is currently used to produce income, or will be used to produce income within one year, such as the boat of a shell fisherman during the winter. Such resources are the tools and equipment necessary for and normally used in the operation of a trade or business, or for an employee to perform his/her job.

0382.70 Plan for Achieving Self-Support
REV: 06/1994

When a blind or disabled individual has a specific plan approved by the Social Security Administration (SSA) for achieving self-support (PASS), resources (and income) necessary for accomplishing the objective of the plan are excluded from countable resources.

To document the exclusion, the applicant must provide a copy of the approved plan, or, with the applicant's permission, a copy must be obtained from SSA.

0382.75 Resources Excluded by Statute
REV: 06/1994

The statutory exclusion of resources retained from such benefits obtains so long as the resource is maintained in a separate and identifiable account, and not commingled with other, countable resources. Except as noted below or in the policy on specific types of resources (e.g. burial set-asides), interest or dividends paid on the excluded resource are not excluded from counting as income, or if retained, as resources.

0382.75.05 Disaster Assistance
REV: 06/1994

Disaster assistance provided under a federal statute pursuant to a Presidential declaration of a disaster, which is excluded from income, is also excluded from resources for a period of nine (9) months from the date of receipt. In addition, interest earned on such funds is also excluded from income and resources for a period of nine months. The exclusions may be continued for one

additional nine month period if circumstances beyond the control of the recipient make it impossible for him/her to use the funds for the purpose intended within the first period.

0382.75.10 German Reparation Payments
REV: February 2014

As a result of the court case Grunfeder v. Heckler (9th Cir. 1984) and section 4715 of OBRA '90, German Reparation Payments are not counted for any Medicaid Program purpose. German Reparation Payments are disregarded in Medicaid eligibility determinations and in the post-eligibility process, and payments retained beyond the month of receipt are excluded from resources.

0382.75.15 Agent Orange Settlement Payment
REV: 06/1994

OBRA '89 (Federal Omnibus Budget Reconciliation Act) provides that Agent Orange Settlement Payments paid from a trust fund set up, pursuant to the Agent Orange product liability settlement, by manufacturers of a chemical defoliant used by the U.S. military in Vietnam are excluded from income and resources for veterans or their survivors.

0382.75.20 Burial Spaces, Accrual Income
REV: 06/1994

OBRA '89 provides that interest earned on the value of agreements representing the purchase of burial spaces (provided that the burial spaces are excluded from resources and provided that the interest is left to accrue) is excluded from income and resources in eligibility determinations.

The intent of the statute is that interest left to accumulate together with the excluded value of the burial space should not be counted as income or resources because it is not intended to be used for the purchase of food, clothing, or shelter (the criteria used to define countable income).

0382.75.25 Restitution Pay to Japanese, Aleutian Islanders
REV: February 2014

Public Law 100-83 provides for the U. S. Government to make individual restitution payments to certain Japanese-Americans and Aleuts who were relocated or interned during World War II. In certain instances, payments on behalf of deceased individuals will be made to survivors. The payments will be $20,000 to Japanese-Americans, and $12,000 to Aleuts. Payments made under this law are not to be considered resources (or income) for Medicaid purposes.

The recipient should have documentation of the amount of the payment. If documentation is not available, or a potential recipient wishes to inquire about eligibility for benefits, s/he may write to:

Office of Redress Administration
U. S. Dept. of Justice
P. O. Box 66260
Washington, D. C. 20035-6260

0382.75.30 Qualified Long Term Care Insurance Partnership (QLTCIP) Payments
REV: July 2014

The Deficit Reduction Act of 2005 provides:

1. That an amount equal to the benefits paid under a Qualified LTC Insurance Partnership policy, as of the month of application, is to be disregarded from an individual's resources in determining eligibility for Medicaid, and

2. That same amount is to be disregarded in the determination of the amount to be recovered from a beneficiary's estate. The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination. (See Sec.0382.80 regarding the Qualified Long Term Care Insurance Partnership program).

0382.80 Qualified Long Term Care (LTC) Insurance Partnership
REV: February 2014

RI has established a Qualified Long Term Care Insurance Partnership (QLTCIP) program.

This Qualified LTC Insurance Partnership provides:

1. For the disregard of a Medicaid applicant's resources in an amount equal to the benefits paid by their QLTCIP policy as of the time of their application for Medicaid, and

2. For the total amount paid by the individual's QLTCIP policy at the time of death to be disregarded in the determination of the amount to be recovered from a beneficiary's estate.

The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination.

(There may be continuing QLTCIP policy payments after Medicaid eligibility is established, so if the person later gains assets, he/she may have more protected than he/she had at the time of eligibility. Thus, the total amount paid by the individual's QLTCIP at the time of death is to be disregarded in the determination of the amount to be recovered from a beneficiary's estate).

0382.80.05 Basis of the QLTCIP Resource Disregard
REV: February 2014

The insurance benefits upon which the resource disregard may be based include:

1. Benefits paid as direct reimbursement of LTSS expenses;

2. As well as benefits paid on a per diem, or other periodic basis, for the periods during which the individual received LTSS services.

The LTC insurance benefits may have been paid to, or on behalf of, an individual who has received Medicaid.

It is not required that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied.

0382.80.10 Home and Associated Land Exclusion
REV: July 2014

The use of a qualified partnership policy will not affect an individual's ineligibility for payment for nursing facility services, or other LTSS services, when the individual's equity interest in home property exceeds the limits set forth in Sec. 0382.10.05.

0382.80.15 Technical Requirements for QLTCIP Policies
REV: 07/2008

The policy must be a qualified partnership policy as certified by the Rhode Island Department of Business Regulation.

0382.80.20 Changes in QLTCIP Policies
REV: 07/2008

Changes in a QLTCIP policy after it is issued will not affect the applicability of the disregard of resources as long as the policy continues to meet all of the requirements referenced above.

0382.80.25 Converting an Existing LTSS Policy to QLTCIP
REV: 07/2008

If an individual has an existing LTC insurance policy that does not qualify as an LTC Partnership policy due to the issue date of the policy, and that policy is exchanged for another, the State Insurance Commissioner or other State authority must determine the issue date for the policy that is received in exchange.

To be a qualified Partnership policy, the issue date must not be earlier than the effective date of the state's Qualified LTC Partnership. Only QLTCIP policies qualify for the resource disregard.

0382.80.30 Interstate Reciprocity of QLTCIP Policies
REV: 07/2008

The U.S. Secretary of Health & Human Services will develop standards for reciprocal recognition of Partnership policies among Partnership States.

This will enable individuals who purchase a Partnership policy in one state, and later move to another Partnership State, to enjoy the same protections in the new state.

0382.80.35 Rationale for Establishing a QLTCIP Program
REV: 07/2008

States that implemented LTC Partnerships more than 10 years ago continue to operate these successful programs. These States have found that while thousands of their residents have purchased LTC insurance policies, only a small fraction of these insured individuals ever find the

need to apply for Medicaid. The continued success of these Partnerships for more than a decade encouraged all states to consider the benefits of implementing a Partnership.

0382.85 Severability
EFF: July 2014

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

Wednesday, April 08, 2015
0382finalapril2015

0384 Resource Transfers

0384.05 Legal Basis

REV: April 2014

The Omnibus Budget Reconciliation Act (OBRA) of 1993 provides a penalty for institutionalized individuals who on or after 8/11/93, transfer or have transferred assets for less than fair market value.

Asset transfers, prior to February 8, 2006, are examined for potential penalty when the transfer took place within thirty six (36) months prior to or anytime after the date the individual was both institutionalized and applied for Medicaid. All asset transfers made on or after February 8, 2006 shall be subject to a look back period of sixty (60) months.

Under OBRA provisions, trusts and/or portions of trusts established on or after 8/11/93 are in some cases treated as a transfer of assets and subject to a penalty. Asset transfers involving a trust are examined for potential penalty when the transfer took place within sixty (60) months prior to or anytime after the date the individual was both institutionalized and applied for Medicaid. In the event that application of the transfer rules and the trust rules result in an individual being subject to a transfer penalty twice for actions involving the same resource, the trust rules supersede the transfer rules in determining eligibility. (See Medicaid Code of Administrative Rules (MCAR) Section 0382 for detailed information about Trusts.)

The Deficit Reduction Act of 2005 (DRA) provides a penalty for institutionalized individuals who on or after February 8, 2006, transfer or have transferred assets for less then fair market value.

All asset transfers made on or after February 8, 2006 are examined for potential penalty when the transfer took place within sixty (60) months prior to or anytime after the date the individual was both institutionalized and applied for Medical Assistance.

The penalty is a period of restricted Medicaid eligibility during which payment for Long Term Care Services is denied. Long Term Care Services include nursing facility services, Intermediate Care Facility Services for the Mentally Retarded (ICF-MR), administratively necessary days in a hospital, and home and community based waiver services.

The computation of the penalty period for transfers of assets made prior to February 8, 2006 and how the penalty is imposed for such transfers are determined as provided in Section 0384.20.

The computation of the penalty period for transfers of assets made on or after February 8, 2006 and how the penalty is imposed for such transfers are determined as provided in Section 0384.25.

The uncompensated transfer of resources which have been disregarded under the Qualified Long Term Care Insurance Partnership Program are treated as the uncompensated transfer of any other resource.

0384.10 Individuals Ineligible for Nursing Facility Payment

REV: April 2014

Unless exempt, transfers of assets (income and resources) made for less than fair market value by an institutionalized individual (or the community spouse - if made prior to the establishment of the applicant's Medicaid /LTC eligibility) are subject to a penalty if the transfer was made:

A. For transfers of assets made prior to February 8, 2006 within thirty six (36) months immediately prior to or any time after the date the individual was both institutionalized AND applied for Medicaid; or

B. For transfers of assets made on or after February 8, 2006, within sixty (60) months immediately prior to or anytime after the date the individual was both institutionalized AND applied for Medicaid; or

C. If the transfer involves a trust, within a sixty (60) month look back period immediately prior to or anytime after the date the individual was both institutionalized AND applied for Medicaid.

D. Since transfers involving a trust have for many years already been subject to a look back period of 60 months, their treatment is unaffected by Paragraph B. above. The look-back period in Paragraph B, above, is effective for all other transfers made on or after February 8, 2006. As a result of this phase in, the look back periods, and those transfers which must be reported by applicants, are as follows:

For applications which are filed from February 8, 2011 and thereafter, the look back period is sixty (60) months immediately prior to or anytime after the date the individual was both institutionalized AND applied for Medicaid.

If the individual has multiple periods of institutionalization and/or applications, the look back period starts with the first date on which the individual was both institutionalized and applied for Medicaid.

The penalty is a period of ineligibility for payment of long term care services for an otherwise eligible individual.

For transfers of assets prior to February 8, 2006 see Section 0384.20 for the rules as to how the penalty period is calculated and how it is imposed.

For transfers of assets on or after February 8, 2006 see Section 0384.25 for the rules as to how the penalty period is calculated and how it is imposed.

0384.15 Resource Transfer Definitions

REV: April 2014

For purposes of evaluating transfers of assets, the following definitions apply:

1. **Assets** means:
   - All income and resources of the individual or the individual's spouse that would be countable in the determination of Medicaid eligibility for an SSI-related individual; and

   - The home (and associated land) of an institutionalized individual.

This includes any income and resources to which the individual or his/her spouse is entitled but does not receive because of action taken by:

- The individual or his/her spouse;
- A person, including a court or administrative body, with legal authority to act in place of the individual or his/her spouse; or
- Any person, including any court or administrative body, acting at the direction or upon the request of the individual or his/her spouse.

2. **Compensation/Consideration** means:

All real and/or personal property (money, food, shelter, services, stocks, bonds, etc.) that is received by an applicant/recipient pursuant to a binding contract in exchange for an asset either prior to, at the time of, or after the transfer.

3. **Fair Market Value (FMV)** means:

The amount for which the property (real and personal) can be expected to sell on the open market in the geographic area involved and under existing economic conditions at the time of transfer.

4. **Institutionalized Individual** means:

An inpatient of a nursing facility, an inpatient of a medical institution for whom payment is based on a level of care provided in a nursing facility, an inpatient of an intermediate care facility for the mentally retarded (ICF-MR), and/or a home and community based waiver recipient.

5. **Sole Benefit** means:

A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a blind or disabled individual, when the transfer is established using a written agreement that legally binds the parties and clearly expresses that the transfer is for the spouse, blind or disabled child, or blind or disabled individual only, and that no one else can benefit from the assets transferred. Without this agreement, a transfer cannot be determined to be for the sole benefit of the individual.

6. **Long Term Care Services** means:

Services provided to individuals in nursing facilities, ICF-MRs, as an inpatient in a medical institution for whom payment is based on a level of care provided in a nursing facility, and under home and community based waivers and administratively necessary days.

7. **Look Back Date** means:

The look back date is a date that is the appropriate number of months, as provided for in Section 0380.05, before an institutionalized individual has applied for Medicaid.

8. **Look Back Period** means:

The look back period is that period of time beginning with the look back date through the date an institutionalized individual has applied for Medicaid.

9. **Penalty Period** means:

The period of time during which payment for long term care services is denied. The number of months in a penalty period (P) is equal to the total uncompensated value (UV) of prohibited transfers made by the institutionalized individual (or spouse, if made prior to establishment of individual's Medicaid /LTC eligibility) during the thirty-six (36) or sixty (60) month period immediately prior to the date of institutionalization (or if later the date of Medicaid application) divided by the average monthly cost of a private patient in a nursing facility at the time of application. For transfers made on or after February 8, 2006, the penalty period begins from the date of transfer or the date that the individual would have otherwise been eligible, whichever is later.

$$P = UV/C$$

10. **Prohibited Transfer** means:

Transfer of an asset for less than fair market value by an individual (or spouse, if made prior to establishment of individual's Medicaid /LTC eligibility) which was made within thirty-six (36) months or sixty (60) months prior to or anytime after the date the individual was both institutionalized and applied for Medicaid.

11. **Transfer** means:

The conveyance of right, title, or interest in either real or personal property from one person to another by sale, gift, or other process; or the gift or assignment of income from one person to another. Disposal of a lump sum payment before it can be counted as a resource can be an example of a transfer of income.

Transfers made by an individual include transfers made by:

- The individual;
- His/her spouse;
- Any person, including a court or administrative body, with legal authority to act on behalf of the individual or his/her spouse; or
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or his/her spouse.

12. **Uncompensated Value** (UV) means:

The equity value (fair market value less any outstanding loans, mortgages or other encumbrances) minus the value of any compensation /consideration received by the applicant/recipient in exchange for the asset.

0384.20 Penalty Period for Payment of Long Term Care Services
REV: April 2014

The rules in this section, MCAR 0384.20, apply to transfers of assets which occurred prior to February 8, 2006.

The penalty for an otherwise eligible institutionalized individual who transfers assets for less than fair market value is a period of ineligibility for payment of long term care services.

A. The following provisions apply in determining the penalty period for a prohibited transfer:

1. **Start date of the penalty period.**

The penalty period begins on the first day of the month in which the transfer was made and runs continuously from the penalty date regardless of whether the individual remains in or leaves the institution (or waiver program). Thus, if an individual leaves the nursing facility, the penalty period nevertheless continues until the end of the calculated period.

2. **Calculation of the length of the penalty period**

To calculate the penalty period (P) for a prohibited transfer, divide the amount of the uncompensated value (UV) of the transfer by the average monthly cost (C) for private payment in a nursing facility.

$$P = UV/C$$

Currently, the average monthly cost for private payment in a nursing facility is $9,113 per month.

When more than one prohibited transfer occurs during the same month, the uncompensated values of all prohibited transfers made during the month are totaled, then divided by the average monthly private payment for an individual in a nursing facility.

Penalty periods are imposed for full months only; penalty periods of less than one month are not imposed.

There is no maximum length to the penalty period. However, no penalty is imposed for resources transferred prior to the look back period.

Multiple Transfers with Overlapping Penalty Periods

When assets have been transferred in amounts and/or frequency that make the calculated penalty periods overlap, a single penalty period is imposed. This penalty period begins on the first of the month in which the first prohibited transfer was made and is calculated as follows:

First, add the total of the uncompensated value of all assets transferred; then, divide the sum by the average private pay cost of nursing facility care. This produces a single penalty period that begins on the first day of the month in which the first transfer was made.

Multiple Transfers with No Overlapping Penalty Periods

When multiple prohibited transfers are made in such a way that penalty periods do not overlap, each transfer is treated as a separate event with its own penalty period. Each separate penalty period is calculated by dividing the total amount of the uncompensated value of the transfer by the average monthly nursing facility cost for a private patient.

Each separate penalty period begins on the first of the month in which transfer occurred.

B. **Transfers by the Spouse**

When a transfer by the spouse results in a penalty period for the institutionalized individual, and the spouse later becomes institutionalized and applies for Medicaid payment of long term care services, the penalty period remaining is apportioned equally between the spouses. If both spouses are institutionalized in the same month the period of ineligibility is divided equally between them. When one spouse is no longer subject to a penalty, any remaining penalty is then imposed on the remaining institutionalized individual.

C. **Transfers of Income**

When lump sum income is transferred (e.g., a stock dividend check is given to another person in the month in which it is received by the individual), a penalty period is calculated based on the value of the lump sum payment and the date transfer was made.

When a stream of income has been transferred, a penalty period is calculated for each income payment that is periodically transferred.

When the right to a stream of income is transferred, a penalty period is calculated based on the total amount of income expected to be transferred during the individual's lifetime, based on life-expectancy tables established by the Social Security Administration's Office of the Actuary.

0384.25 Partial Month Penalty

REV: April 2014

The rules in this MCAR Section, 0384.25, apply to transfers of assets which occur on or after February 8, 2006.

The penalty for an otherwise eligible institutionalized individual who transfers assets for less than fair market value is a period of ineligibility for payment of long term care services. The following provisions apply in determining the penalty period for a prohibited transfer:

A. The following provisions apply in determining the penalty period for a prohibited transfer:
Start Date of the penalty period:

The penalty period begins the later of:

a. The date on which an individual is eligible for Medicaid and would otherwise be receiving institutional level of care, described in MCAR Section 0384.10, based on an approved application for such care but for the application of the penalty period; or

b. The first day of the month during or after which the assets have been transferred for less than fair market value, and which does not occur during any other period of ineligibility based on a transfer of assets.

The provisions of (a) require that an application for Medicaid be filed.

0384.25.05 Calculation of Partial Month Penalty

REV: 03/2007

This Section, 0384.25.05, is applicable to calculations of penalty periods as of July 1, 2006.

When more than one prohibited transfer occurs during the look back period, the uncompensated values of all prohibited transfers made during the look back period are totaled.

To calculate the penalty period (P) for a prohibited transfer(s), divide the amount of the uncompensated value(s) (UV) of the transfer(s) by the average monthly cost (C) for private payment in a nursing facility. P+UV/C

In making these calculations, there is no "rounding down."

In making these calculations, partial month penalties are applied, if appropriate.

When calculating penalty periods, for transfers covered by this section, both the average monthly and daily rate of private nursing facility care will be utilized. The rate is set forth in section 0384.20.

There is no maximum length to the penalty period. However, no penalty is imposed for assets transferred prior to the look back date.

In order to assess a transfer penalty period, the uncompensated transfer amount is divided by the monthly rate, and the remainder is divided by the daily rate. Individuals are responsible for paying the cost of care until their penalty period expires. Medicaid begins paying for long term care expenses on the day the penalty period expires.

0384.35 Exceptions to Period of Ineligibility

REV: April 2014

A penalty period is not imposed when:

- The asset was transferred for fair market value;
- The transferred resource was the individual's home and title to the home was transferred to:
  - the individual's spouse;
  - a child of the individual who is under the age of 21, or is blind, or permanently and totally disabled (as evidenced by receipt of SSI or RSDI benefits, or as defined in MCAR Section 0352.15);

- a sibling of the individual who has an equity interest in the home and who resided in the home for at least one year immediately prior to the institutionalization of the individual;

- a son or daughter of the individual who:

  - was residing in the home for at least two years prior to the parent's institutionalization; and

  - can demonstrate that s/he provided care to the parent which prevented the parent from entering an institution for the two year period.

- The asset (other than a home, see above) was transferred to:

  - the spouse, or to another for the sole benefit of the spouse, or from the spouse to another for the sole benefit of the spouse;

  - the individual's child who is blind or permanently and totally disabled, or to another for the sole benefit of such child; or to a trust established for the sole benefit of such child;

  - a trust established for the sole benefit of an individual who is under the age of 65 and permanently and totally disabled (as defined in MCAR Section 0352.15);

- The individual can prove his/her intention was to receive fair market value or other valuable compensation/ consideration;

- The individual can prove the transfer was exclusively for some purpose other than to qualify for Medicaid;

- Denial of payment for long term care services would work an undue hardship;

- The asset is returned to the individual.

NOTE: Annuities that:

1. were obtained on or between February 8, 2006 and December 31, 2008 and

2. during that time, complied with EOHHS policy as it was promulgated in July 2006, by naming the state as a beneficiary of the remainder of the annuitant's annuity, and

3. were not subsequently changed to preclude the naming of the state as a beneficiary for the Medicaid expenses of the institutionalized and/or community spouse and

4. are documented by the issuer to be unable to be changed to comply with the requirement to name the state as a beneficiary for recovery of Medicaid up to the amount of Medicaid paid on behalf of the institutionalized spouse, based on the terms and conditions of the annuity contract, are deemed to meet the criteria listed above, that "The individual can prove his/her intention was to receive fair market value or other valuable compensation / consideration."

0384.40 Responsibilities
REV: April 2014

Field staff responsibilities pertaining to transfer of assets are the following:

FIRST

The agency representative is responsible to explain the policy on transferred assets and how it may affect eligibility for nursing facility payment, and assist the applicant in determining what documentation is relevant and how such documentation is generally obtained.

SECOND

Exceptions to the penalty period which involve transfer of an individual's home to his/her spouse, child under 21, or blind or disabled child are referred with relevant documentation to the casework supervisor for review.

All other exceptions should be referred to the Long Term Care Administrator or his designee, who will consult with the Legal Counsel as necessary.

Any and all documents relative to the transferred resource and its fair market value, such as bills of sale, deeds, purchasing agreements, and compensation received must be provided by the applicant as a part of the application process.

THIRD

Transfers of assets for less than FMV are presumed to be for the purpose of establishing eligibility for nursing facility payment. The applicant can rebut the presumption by making a satisfactory showing that the transfer was for some other purpose.

If the applicant/recipient wishes to rebut the presumption, the Medicaid agency representative shall explain that it is the applicant/recipient's responsibility to make a satisfactory showing that the assets were transferred exclusively (i.e., only) for some other reason. The information furnished by the applicant/ recipient should cover, but need not be limited to, the following factors:

- The purpose for transferring the asset;
- The attempts to dispose of the asset for FMV;
- The reasons for accepting less than FMV;
- The applicant/recipient's relationship, if any, to the person(s) to whom the asset was transferred.

The applicant/recipient should be assisted in obtaining information to rebut the presumption when necessary; however, the burden of proof rests with the applicant/recipient.

FOURTH

Once the LTC Administrator determines that an asset was transferred for less than fair market value and the resultant uncompensated value, the Medicaid agency representative will determine the period of ineligibility for nursing facility payment.

FIFTH

The Medicaid agency representative is responsible to inform the applicant of the outcome of the review conducted by LTC Administrator, and the period of ineligibility, if any. The individual must be notified of the decisions, and his/her right to appeal.

SIXTH

If the individual is either eligible for Medicaid or pending spenddown, but is determined to have a period of ineligibility for payment of LTC services due to the transfer, the penalty period information is recorded. Eligibility or pending spenddown status for Medicaid is approved, and the case is transferred to the appropriate Medicaid unit.

The responsibilities of the LTC Administrator are:

FIRST

Determine the fair market value (FMV) of the transferred asset based on the documentation forwarded by field staff.

SECOND

Determine the uncompensated value, if any, by subtracting the value of any compensation/ consideration received from the equity value.

THIRD

Evaluate the individual's rebuttal of the agency's presumption that resources were transferred in order to become eligible for nursing facility payments, and consult with the Office of Legal Services, as necessary.

FOURTH

Evaluate claims of undue hardship.

0384.45 Rebuttal of Presumption of Prohibited Transfers

REV: April 2014

An individual may rebut the Medicaid agency's presumption that assets were transferred in order to become eligible for nursing facility payments.

The presence of one or more factors may indicate that the asset was transferred exclusively for some purpose other than establishing eligibility for nursing facility payments.

These factors are:

- A traumatic onset (e.g., traffic accident) of disability or blindness after transfer of the resource

  If the applicant/recipient states that after the transfer s(he) experienced a traumatic onset of disability which could not have been foreseen at the time of transfer, and which resulted in the inability to provide for his/her own support, consider the applicant's/recipient's age, medical history, and medical condition at the time of transfer as well as his/her financial situation. Was the applicant/recipient in good health at the time of the transfer and spending a minimal amount on medically related costs such as insurance, routine doctor visits, etc.? Did the applicant/recipient have sufficient income and/or resources to meet his/her medical needs, as well as basic living expenses, as they existed at the time of the transfer and as they could be foreseen over the next 36 months?

  The applicant/recipient may submit whatever medical documentation s(he) wishes to substantiate his/her claim.

- Inability to dispose of the asset for fair market value

  The applicant/recipient must provide evidence of attempts to dispose of the asset for fair market value, as well as evidence to support the value at which the asset was disposed.

- Diagnosis of previously undetected disabling condition

- Unexpected loss of other resources (including deemed resources) which would have precluded Medicaid eligibility

- Unexpected loss of income (including deemed income) which would have precluded Medicaid eligibility

- Total countable resources that would have been below the resource limit at all times from the month of transfer through the present month even if the transferred resource had been retained

- Court-ordered transfer.

0384.45.05 Claims of Undue Hardship

REV: April 2014

A. **Standards for Granting an Undue Hardship Waiver**

A transfer penalty shall be waived if imposition of the penalty would cause the individual undue hardship. The entire penalty period or a portion of the penalty period shall be waived when:

1) Imposition of the penalty period would deprive the individual of medical care to the extent that his/her life or health would be endangered or would deprive the individual of food, shelter, clothing or other necessities of life; and

2) All appropriate attempts to retrieve the transferred asset have been exhausted; and

3) The nursing facility has notified the individual of its intent to initiate discharge or the agency providing essential services under a home and community based waiver has notified the individual of its intent to discontinue such services for reasons of non-payment; and

4) No less costly non-institutional alternative is available to meet the individual's needs.

Undue hardship does not exist when application of the transfer provisions merely causes inconvenience or restricts lifestyle but would not put him/her at risk of serious deprivation.

B. **Availability of Undue Hardship Waivers**

When eligibility for payment of long term care services has been denied due to imposition of a transfer of assets penalty, the Medicaid agency shall notify the applicant in writing that an undue hardship exception exists. The individual may claim undue hardship. The facility in which the institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual if done with the consent of the individual or the personal representative of the individual.

C. **Process for Undue Hardship Waiver**

The individual and/or facility must submit a written request and any supporting documentation within 30 days of a denial from the Medicaid agency. A request for consideration of undue hardship does not limit the individual's right to appeal a denial of eligibility for reasons other than hardship.

Claims of undue hardship are forwarded to the Long Term Care Administrator or his/her designee for evaluation. The LTC Administrator or his/her designee may instruct the agency representative to obtain documentation from the individual which can include, but is not ~~be~~ limited to, the following:

- A statement from the attorney, if one was involved;
- Verification of medical insurance coverage and statements from medical providers relative to usage not covered by said insurance;
- A statement from the transferee relative to his/her financial position;
- Resource documents such as a deed, bank book, etc. to verify the existence and structure of the resource;
- If jointly held, a statement from the other owner(s) of the jointly held resource relative to the reason for and circumstances of the transfer.

The LTC Administrator or his/her designee, in consultation with the Office of Legal Services determines whether undue hardship applies.

Written notification of the Medicaid agency's decision regarding undue hardship, along with appeal rights, is provided to the individual within sixty (60) days of the Medicaid agency's receipt of the request.

0384.45.05.05 DRA Claims of Undue Hardship

REV: April 2014

The Medicaid agency may waive the penalty period if the transfer penalty being imposed is the direct result of an action taken on or after February 8, 2006 and before May 8, 2006, which would not have caused ineligibility prior to that date, but resulted in ineligibility because of the changes in policy due to the Federal Deficit Reduction Act, 42 U.S.C.1396p(e). The requestor must show that he/she (and his/her legal counsel, if applicable) was unaware of the provisions of the Deficit Reduction Act. The process shall follow 0384.45.05.

0384.50 SSI Recipients

REV: April 2014

Resource transfers do not impact Medicaid or SSI eligibility determinations. Individuals may be eligible for Medicaid-only or SSI and Medicaid while at home or while in an institution, without regard to resource transfers.

However, once institutionalized, all Medicaid recipients are subject to the policies contained in this section regarding resource transfers.

The Social Security Administration (SSA) questions SSI recipients regarding transferred resources at the time of application and redetermination for SSI benefits. SSA maintains a record of those SSI recipients who have transferred resources which is transmitted to the Medicaid agency on a regular basis.

Prior to authorizing a vendor payment to a nursing facility, the Medicaid agency screens the list of alleged transferors to ascertain that the individual in question has not disclosed a resource transfer to SSA. In the event that this screening indicates that the applicant has transferred a resource, the case is referred for review and evaluation of the impact of the transfer on eligibility for nursing facility payment.

0386 INCOME GENERALLY

0386.05 INCOME STANDARDS – INDIVIDUAL/COUPLE

REV:07/2011

Refer to Section 0362.05, Income Generally, for the standards used in the determination of an individual's or couple's income eligibility.

0386.10 TREATMENT OF INCOME

REV:06/1994

Section 0366 sets forth the treatment of income rules for spouse to spouse deeming of income when both members of a couple live together in the community, and when an ineligible parent lives in the same household with an eligible child under 18. DEEMING STATUS IS CHANGED WHEN AN ELIGIBLE INDIVIDUAL BECOMES INSTITUTIONALIZED.

If an eligible individual moves into a medical facility, deeming stops for the purpose of determining MA eligibility effective with the month following the month of separation.

Eligibility determinations for persons applying for or receiving services under a Waiver are conducted AS IF THE PERSON WERE ACTUALLY INSTITUTIONALIZED. This means that deeming of spousal/parental income does NOT apply after the month of separation due to institutionalization.

0386.15 RECIPIENT INCOME APPLIED TO COST OF CARE

REV:01/1996

If the institutionalized individual is eligible for MA, either as Categorically Needy or Medically Needy, and Medical Assistance payment is requested for the individual's institutional care expenses, a determination is made regarding the amount of income the institutionalized individual must allocate to his/her cost of share.

0388 TREATMENT OF INCOME

0388.05 EARNED/UNEARNED INCOME EXCLUS

REV:06/1994

Certain exclusions apply only to EARNED income, some apply only to UNEARNED income and a few apply to BOTH earned and unearned income.

The following exclusions apply to both earned and unearned income:

- Infrequent and irregular income exclusions;
- $20 per month General Income Exclusion;
- PASS Exclusion.

0388.05.05 Infrequent/Irregular Income Exclusion

REV:06/1994

Income which is received infrequently and irregularly is excluded provided the total income of such exclusion does not exceed:

- $10/month of earned income; and/or,
- $20/month of unearned income.

An individual receives income on an INFREQUENT basis if s/he receives it no more than once in a calendar quarter from a single source. An individual receives income on an IRREGULAR basis if s/he could not reasonably expect to receive it.

This exclusion can apply to both earned and unearned income in the same month provided the total of each does not exceed the allowed limits. Thus it is possible to exclude as much as $30 in a month under this provision.

0388.05.10 $20/Month General Income Disregard

REV:04/1995

The first $20 per month of unearned income is deducted from income. The $20 is applied to earned income only if the $20 cannot be applied to unearned income. The dollar amount of this exclusion is not increased when an eligible individual and eligible spouse both have income. An eligible couple receives one $20 exclusion per month.

0388.05.15 PASS Exclusions

REV:06/1994

Income, whether earned or unearned, of a blind or disabled recipient may be excluded if such income is needed to fulfill a Plan for Achieving Self-Support (PASS).

This exclusion does not apply to a blind or disabled individual age 65 or older, unless s/he was receiving SSI or State disability or blind payments for the month before s/he reached age 65.

0388.10 EARNED INCOME EXCLUSIONS

REV:06/1994

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income. Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

0388.10.05 $65 and 1/2 Earned Income Exclusion

REV:06/1994

If the applicant or spouse is employed, earned income of $65/month plus one-half (1/2) of the balance is excluded. When both eligible spouses are employed, this exclusion is applied to only one earned income.

0388.10.10 Impairment Related Work Expenses

REV:06/1994

Impairment related work expenses are deducted provided:

- The individual is under age 65 and disabled (but not blind), or received SSI as a disabled individual (or received disability payments under a former State plan) for the month before attaining age 65; and,

- The severity of the impairment requires the individual to purchase or rent items and services in order to work; and,

- The expense is reasonable; and,

- The cost is paid in cash (including checks, money orders, credit cards and/or charge cards) by the individual and is not reimbursable from another source (e.g. Medicare, private insurance); and,

- The payment is made in a month the individual receives earned income for a month in which s/he both worked and received the services or used the item, or the individual is working but makes a payment before the earned income is received.

The determination of the amount of the allowable work expense is an off-line evaluation. The allowable work expense is deducted from gross income.

0388.10.15 Blind Work Expenses

REV:06/1994

The following expenses related to a blind individual's employment are excluded:

- TRANSPORTATION EXPENSES: Bus, cab fare, instructions for use of cane; cost/upkeep of guide dog; private automobile.

- JOB PERFORMANCE: Braille instruction; child care costs; equipment needed on job (e.g. for homebound work); instructions in grammar (if work related); licenses; lunch; prosthesis needed for work even though not related to blindness; optical aids; reader; safety shoes; income (federal, state, local) taxes; FICA taxes; self-employment taxes; translation of material into braille; uniforms and care of them; union dues; wheelchair if necessary due to other disability.

- JOB IMPROVEMENT: Computer program training, key punch training, stenotype instructions for blind typist. Further expenses are disregarded if the individual has an approved plan for self support. The amounts must be reasonable and not exceed the earned income of the blind individual or a blind spouse.

The determination of the amount of the allowable work expense is an off-line evaluation. The allowable work expense is deducted from gross income.

0388.10.20 Earned Income Tax Credit Exclusion

REV:06/1994

The earned income tax credit (EITC) is a special tax credit which reduces the Federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from the employer or as a refund from the IRS.

Income from any EITC received January 1, 1991 or later is excluded, regardless of the tax year involved.

0388.10.25 Child Student Earned Income Exclusion

REV:06/1994

For a blind or disabled child who is a student regularly attending school, up to $400/month of earned income (but not more than $1620 in a calendar year) is excluded.

The exclusion is applied only to the child's income. The child must be under age 22 and regularly attending school. Regularly attending school means the child was a student in at least one month of the current calendar quarter, or expects to attend school for at least one month in the next calendar quarter.

0388.15 TREATMENT OF UNEARNED INCOME

REV:06/1994

Exclusions never reduce unearned income below zero. Except for the $20 general unearned income exclusion, no other unused unearned income exclusion may be applied to earned income.

0388.15.05 Distinguishing IBON and ABON

REV:06/1994

Income Based On Need (IBON) is assistance provided under a program which uses income as a factor of eligibility and is funded wholly or partially by the Federal government or a non-government agency (e.g. Catholic Charities or the Salvation Army) for the purpose of meeting basic needs.

Income Based on Need is COUNTED as income dollar for dollar UNLESS it is totally excluded by statute (e.g. Food Stamps) or excluded under PASS.

Assistance Based On Need (ABON) is assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a State. (If a program uses income to determine payment amount but not eligibility, it is not ABON.) Assistance Based on Need is EXCLUDED from income. (Note that State supplementary payments made to refugees are considered to be ABON even if the Federal government reimburses the State).

In short, ABON is excluded from income and IBON is counted as income dollar for dollar unless excluded under PASS or by statute.

0388.15.10 AFDC Under a PASS

REV:06/1994

AFDC payments under a PASS are excluded. However, AFDC payments are based on need; and, unless excluded under a PASS, are counted dollar for dollar as income. The $20 general income exclusion does not apply to this income.

AFDC makes a payment to family unit rather than to an individual.

The payment is frequently referred to as a grant. An individual who meets the eligibility requirements for AFDC and SSI may choose the

program under which s/he prefers to receive benefits. However, if the individual receives SSI, s/he may no longer be included in the AFDC grant.

0388.15.15 Foster Care Payments

REV:06/1994

An individual is considered to be in foster care when:

- A public or private (nonprofit) agency places an individual under a specific placement program; and,
- The placement is in a home or a facility which is licensed or otherwise approved by the State to provide care; and,
- The placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

Foster care payments made to the provider of foster care is not income to the provider.

0388.15.15.05 Effects of Foster Care Payments

REV:06/1994

Foster Care payments made under Title IV-E are federally funded income based on need (IBON) to the child in care. This income is not subject to the $20 general exclusion. The total payment is counted dollar for dollar.

Foster Care payments involving funds provided under Title IV-B or Title XX of the Social Security Act are social services and are excluded from the foster child's income.

0388.15.20 Adoption Assistance

REV:06/1994

Adoption Assistance Programs provide payments and/or services for children for whom unassisted adoption is unlikely because of age, ethnic background, physical, mental, or emotional disability etc.

The income of either the adopting parent, the adopted child or both may have been considered in determining the amount of the adoption assistance.

Adoption assistance provided by States under Title IV-E of the Social Security Act involves Federal funds and is needs-based.

Under IV-E there is no income test for the adopting parents. The law requires that the child, to be eligible for federally funded foster care must be AFDC or SSI eligible (but not necessarily receiving AFDC or SSI) at the time adoption proceedings are initiated, and meet the additional criterion of special needs.

Adoption assistance cash payments made to adoptive parents under Title IV-E are federally funded income based on need (IBON) to the adopted child. This income is not subject to the $20 general exclusion and is counted dollar for dollar.

0388.15.25 Support Payments

REV:06/1994

Alimony and support payments are cash or in-kind contributions to meet some or all of a person's need for food, clothing or shelter.

Support payments may be made voluntarily or because of a court order. Alimony is an allowance made by the court from the funds of one spouse to the other spouse in connection with a suit for legal separation or divorce.

Alimony, spousal and other adult support payments are unearned income to the parent.

Child support payments are unearned income to the child. However, one-third of a child support payment made to or for an eligible child by an absent parent is excluded.

A parent is considered absent if the parent and the child do not reside in the same household. If there are brief periods of living together, the parent is considered absent if the child remains independent or under the care and control of another person, agency or institution, or is living in the home of another unless the parent retains parental control and responsibility.

A parent is not considered absent if he is away due to employment (except for military service), intends to resume living with the child, and retains parental responsibility and control.

0388.15.30 Grants, Scholarships, Fellowship

REV:06/1994

Grants, scholarships, and fellowships are amounts paid by private, nonprofit agencies, the U.S. Government, instrumentalities or agencies of the U.S., State and local governments and private concerns to enable qualified individuals to further their education and training or research work.

Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses is excluded from income. This exclusion does not apply to any portion set aside or actually used for food, clothing or shelter.

Allowable expenses include carfare, stationery supplies, and impairment related expenses necessary to attend school or perform schoolwork. Allowable fees include laboratory fees, student activity fees, etc.

0388.15.35 Student Loans

REV:06/1994

Federal funds or insurance are provided for educational programs at middle school, secondary school, undergraduate and graduate levels under Title IV of the Higher Education Act and student assistant programs of the Bureau of Indian Affairs.

Any grant, scholarship or loan to an undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education is excluded from income and resources.

Any portion of student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965 or under BIA Student Assistance Programs is excluded from income and resources.

Attendance costs are:

- Tuition and fees normally assessed a student carrying the same academic workload (as determined by the institution) required of all students in the same course of study;

- Allowances for books, supplies, transportation and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

0388.15.40 Interest Earned on Burial Fund

REV:06/1994

Interest earned on the value of excluded burial funds is excluded from income (and resources) if left to accumulate in the burial fund.

Interest earned on agreements representing the purchase of an excluded burial space is excluded from income (and resources) if left to accumulate.

THIS INCOME EXCLUSION APPLIES ONLY IF THE BURIAL FUND OR SPACE PURCHASE AGREEMENT IS EXCLUDED AT THE TIME THE INTEREST IS PAID.

Appreciation in value and the interest must be left to accumulate to be excluded from income. If not left to accumulate (e.g. paid directly to the individual, spouse or parent), the receipt of the interest may result in countable income.

0388.15.45 Gifts of Domestic Travel Tkts

REV:06/1994

The value of a ticket for domestic travel received by an individual (or spouse) is excluded from income and, if retained, is not a resource if:

- The ticket is received as a gift; and,
- The ticket is not converted to cash.

0388.15.50 Death Benefits

REV:06/1994

A death benefit is something received as the result of another's death.

Examples of death benefits are:

- Proceeds of a life insurance policy received due to the death of the insured;
- Lump sum death benefit from SSA;
- Railroad Retirement burial benefits;
- VA burial benefits;
- Inheritances in cash or in-kind;
- Cash or in-kind gifts given by relatives, friends or a community group to "help out" with expenses related to the death.

NOTE: Recurring survivor benefits such as those received under Title II, private pension programs etc. are not death benefits.

Death benefits are excluded to the extent the beneficiary paid the expenses of the deceased's last illness and burial expenses.

Last illness and burial expenses include:

- Related hospital and medical expenses;
- Funeral, burial plot and internment expenses;
- Other related expenses.

0388.15.55 Home Energy Assistance Payment

REV:06/1994

Home energy or support and maintenance assistance is excluded if it is certified in writing by the appropriate State agency to be both based on need and:

- Provided in-kind by a private nonprofit agency; or,

- Provided in cash or in kind by a supplier of home heating oil or gas, a utility company providing home energy, or a municipal utility providing home energy.

State certification may be in the form of an individual certification of a particular case, or a "blanket" certification of a program or organization.

The exclusion applies to assistance provided for:

- An SSI applicant/recipient;
- A member of the SSI applicant/recipient's household; or,
- An SSI applicant/recipient's spouse, parent(s), sponsor (sponsor's spouse) or essential person.

0388.15.60 Disaster Assistance

REV:06/1994

At the request of a State governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and local governments, and federal assistance is needed.

Assistance provided to the victims of a presidentially-declared disaster area includes assistance from:

- Federal programs and agencies;
- Joint Federal and State programs;
- State or local government programs;
- Private organizations (e.g. the Red Cross).

The value of support and maintenance in cash or in-kind is excluded from countable income if:

- The individual lived in a household maintained as the home at the time the disaster occurred in the area; and,
- The President declared the area a Federal disaster area; and,
- The individual stopped living in the home because of the disaster and began to receive support and maintenance within 30 days after the catastrophe; and,
- The individual receives support and maintenance while living in a residential facility maintained by another person. A residential facility is to be interpreted broadly, to mean a private household, a shelter, or any other temporary housing arrangement as a result of the disaster.

0388.15.65 Federal Housing Assistance

REV:06/1994

The Federal Government provides many forms of housing assistance through the Office of Housing and Urban Development (HUD) and the Farmers' Home Administration. The forms of housing assistance include:

- Subsidized housing (e.g. public housing, reduced rent, cash towards utilities etc.);
- Loans for renovations;
- Loans for construction, improvement, or replacement of farm homes and other buildings;
- Mortgage or investment insurance;
- Guaranteed loans and mortgages.

This assistance may be provided directly by the Federal Government or through other entities such as local housing authorities, nonprofit organizations etc.

The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

- The United States Housing Act of 1937;
- The National Housing Act;
- Section 101 of the Housing and Urban Development Act of 1965;
- Title V of the Housing Act of 1949; or,
- Section 202(h) of the Housing Act of 1959.

0388.15.70 Food Programs with Fed Involve

REV:06/1994

Food and assistance provided by the following Federal programs are excluded from income (and resources):

- Food Stamp Program;
- School Lunch program;
- Child Nutrition programs;
- Nutrition Programs for Older Americans.

The following may be assumed to have Federal involvement and to be excludable under Federal statutes:

- Meals and milk provided at reduced rates or free to children in schools and service facilities such as day care centers, recreational facilities or recreation centers;
- Meals provided for free or at reduced rates to senior citizens by a center or project under the auspices of a State or local government or nonprofit program for the aging;
- U.S.D.A. food commodities distributed by any program;
- Food stamps and cash which has been verified as the value of the food stamps provided in lieu of the stamps;
- WIC distributions to pregnant women and children.

0388.15.75 Refugee Cash Assistance

REV:06/1994

Refugee Cash Assistance, Cuban and Haitian Cash Assistance, and federally reimbursed general assistance payments to refugees may be excluded under a PASS.

If not excluded under a PASS, it is federally funded income based on need (IBON) and counted dollar for dollar as income. The $20 general income exclusion does not apply to this income.

0388.15.80 Relocation Assistance

REV:06/1994

Relocation assistance is provided to persons displaced by projects which acquire real property. Relocation assistance provided to persons displaced by any Federal, federally-assisted, State, State- assisted or locally assisted project is excluded.

The following types of relocation assistance may be provided:

- Moving expenses;
- Reimbursement for losses of tangible property;
- Expenses of looking for a business or farm;
- Displacement allowance;
- Amounts required to replace a dwelling over the acquisition cost for the prior dwelling to the project or agency;
- Compensation for increased interest cost and other debt service costs of a replacement dwelling (if encumbered by

a mortgage);

- Expenses for closing costs (but not prepaid expenses) on replacement dwelling;

- Rental expenses for displaced tenants;

- Amounts for downpayments on replacement housing for tenants who decide to buy;

- Mortgage insurance through Federal Programs with Waiver or requirements of age, physical condition, or personal characteristics etc., which borrowers must usually meet; and,

- Direct provision of replacement housing (as a last resort).

0388.15.85 Certain Reparation Payments

REV:06/1994

Reparation payments which are excluded from income are:

- Reparation payments received from the Federal Republic of Germany;

- Austrian social insurance payments based in whole or in part on wage credits granted under the Austrian General Social Insurance Act;

- Restitution payments made by the U.S. Government to individual Japanese Americans (or if deceased, their survivors) and Aleuts who were interned or relocated during World War II;

- Agent Orange settlement payments.

0388.15.90 Miscellaneous Exclusions

REV:06/1994

The following sources of unearned income are excluded from countable income when determining MA eligibility for individuals and couples:

- Victim Compensation Payment which is any payment received from a fund established by a State to aid victims of crime;

- Home Produce which is consumed by the individual or the individual's household; and,

- Refund of Taxes Paid on Real Property or Food.

0388.15.95 Non-SSA Statutory Exclusions

REV:06/1994

Many Federal statutes in addition to the Social Security Act provide assistance or benefits for individuals and specify that the assistance or benefit will not be considered in deciding eligibility for SSI. These statutes are listed and placed in categories according to the kind of income or assistance they provide. The list gives the name of the Federal statute (where possible), the public law number, and the citation. Each item briefly describes what the statute provides that will not reduce or eliminate an SSI payment.

FOOD

- Value of food coupons under the Food Stamp Act of 1977, section 1301 of Pub. L. 95-113 (91 Stat. 968, 7 U.S.C. 2017(b)).

- Value of federally donated foods distributed under section 32 of Pub. L. 74-320 (49 Stat. 774) or section 416 of the Agriculture Act of 1949 (63 Stat. 1058, 7 CFR 250.6(e)(9)).

- Value of free or reduced price food for women and children under the

  - (1) Child Nutrition Act of 1966, section 11(b) of Pub. L. 89-642 (80 Stat. 889, 42 U.S.C. 1780(b)) and section 17 of that Act as added by Pub. L. 92-433 (86 Stat. 729, 42 U.S. C. 1786); and,

  - (2) National School Lunch Act, section 13(h)(3), as amended by section 3 of Pub. L. 90-302 (82 Stat. 119, 42 U.S.C. 1761(h)(3)).

HOUSING AND UTILITIES

- Assistance to prevent fuel cut-offs and to promote energy efficiency under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program as authorized by section 222(a)(5) of the Economic Opportunity Act of 1964, as amended by section 5(d)(1) of Pub. L. No. 93-644 and section 5(a)(2) of Pub. L. 95-568 (88 Stat. 2294 as amended, 42 U.S.C. 2809(a)(5)).

- Fuel assistance payments and allowances under the Home Energy Assistance Act of 1980, section 313(c)(1) of Pub. L. 96-223 (94 Stat. 299, 42 U.S.C. 8612(c)(1)).

- Value of any assistance paid with respect to a dwelling unit under

  - (1) The United States Housing Act of 1937;

  - (2) The National Housing Act;

- (3) Section 101 of the Housing and Urban Development Act of 1965; or,

- (4) Title V of the Housing Act of 1949.

Note: This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the housing assistance.

o Payments for relocating, made to persons displaced by Federal or federally assisted programs which acquire real property, under section 216 of Pub. L. 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

EDUCATION AND EMPLOYMENT

o Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under section 507 of the Higher Education Amendments of 1968, Pub. L. 90-575 (82 Stat. 1063).

o Any wages, allowances, or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible handicapped individual employed in a project under title VI of the Rehabilitation Act of 1973 as added by title II of Pub. L. 95-602 (92 Stat. 2992, 29 U.S.C. 795(b)(c)).

NATIVE AMERICANS

o Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act, Pub. L. No. 92-203 (85 Stat. 713, 43 U.S.C. 1620(a).

Note: This exclusion does not apply in deeming income from sponsors to aliens.

o Indian tribes - Distribution of per capita judgment funds to members of

- (1) The Blackfeet and Gros Ventre Tribes under section 4 of Pub. L. No. 92-254 (86 Stat. 265, 25 U.S.C. 1264) and under section 6 of Pub. L. No. 97-408(96 Stat. 2036);

- (2) The Papago Tribe of Arizona Indians under section 8(d) of Pub. L. No. 97-408 (96 Stat. 2038);

- (3) The Grand River Bank of Ottawa Indians in Indian Claims Commission docket numbered 40-K under section 6 of Pub. L. No. 94-540 (90 Stat. 2504);

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (4) Tribes or groups under section 7 of Pub. L. No. 93-134 (87 Stat. 468, 25 U.S.C. 1407);

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (5) The Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation as authorized by section 2 of Pub. L. No. 95-433 (92 State. 1047, 25 U.S.C. 609c-1);

- (6) The Wyandot Tribe of Indians under section 6 of Pub. L. No. 97-371 (96 Stat. 1814, 42 U.S. C. 1305);

- (7) The Shawnee Tribe of Indians under section 7 of Pub. L. No. 97-372 (96 Stat. 1816, 42 U.S.C. 1305);

- (8) The Indians of the Miami Tribe of Oklahoma and Indiana under section 7 of Pub. L. 97-376 (96 Stat. 1829, 42 U.S. C. 1305);

- (9) The Clallam Tribe of Indians under section 6 of Pub. L. 97-402 (96 Stat. 2021);

- (10) The Pembina Chippewa Indians under section 9 of Pub. L. No. 97-403 (96 Stat. 2025);

- (11) The Confederated Tribes of the Warm Springs Reservation under section 4 of Pub. L. No. 97-436 (96 Stat. 2284);

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (12) The Red Lake Band of Chippewa Indians under section 3 of Pub. L. No. 98-123 (97 Stat. 816); and

- (13) The Assiniboine Tribe of Fort Peck Montana under section 5 of Pub. L. No. 98-124 (97 Stat. 818, 42 U.S.C. 1305) and the Assiniboine Tribe of Fort Belknap under section 5 of Pub. L. No. 98-124 (97 Stat. 818, 42 U.S.C. (1305) and section 6 of Pub. L. No. 97-408 (96 Stat. 2036).

o Receipts from land held in trust by the Federal government and distributed to members of certain Indian tribes under section 6 of Pub. L. No. 94-114 (89 Stat. 579).

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (1) The Pueblo of Santa Ana Indians of New Mexico under section 6 of Pub. L. No. 95-498 (92 Stat. 1677, 42 U.S.C. 1305);

- (2) The Pueblo of Zia Indians of New Mexico under section 6 of Pub. L. No. 95-499 (92 Stat. 1680, 42 U.S.C. 1305); and

- (3) The Shoshone and Arapahoe Tribes of the Wind River Reservation of Wyoming under section 2 of Pub. L. No. 98-64 (97 Stat. 365, 25 U.S.C. 117).

o Revenues from the Maine Indian Claims Settlement Fund and the Maine Indian Land Acquisition Fund paid under section 5 of the Maine Indian Claims Settlement Act of 1980, Pub. L. No. 96-420 (94 Stat. 1796, 25 U.S.C. 1728(c)).

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

OTHER

o Compensation provided volunteers in the foster grandparents program and other similar programs, unless determined by the Director of the Action Agency to constitute the minimum wage, under sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973 (87 Stat. 409, 413), as amended by Pub. L. No. 96-143; (93 Stat. 1077); 42 U.S.C. 5044(g) and 5058).

Note: This exclusion does not apply to the income of sponsors of aliens.

o Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102(h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 U.S.C. 3020a).

0388.20 RENTAL PROPERTY INCOME

REV:06/1994

If the applicant reports income from property, the AP-759 is completed and signed by the applicant. For individuals and couples (SSI-related), net income from rental property or roomer/boarders is normally unearned income. (In rare instances in which an individual makes his/her living in the real estate or boarding home business, the rental income may be earned income. Any questions regarding classification of rental income are referred by memorandum to the Regional Manager).

0388.20.05 Rental Inc, Ind Lives in Prop

REV:06/1994

If the applicant/recipient owns and lives in a multiple family dwelling, the agency representative must pro-rate the allowable expenses based on the number of rental units.

Allowable expenses are:

- Interest payment on the mortgage(s);
- Insurance;
- Taxes;
- Water and sewer charges and assessments;
- Utilities provided to the tenant as part of the rent and billed to the applicant for the building as a whole.

To determine the countable UNEARNED income from rental property which is also the home of the applicant:

- The monthly rental income from all units is totaled;
- The expenses that the client incurs for the building as a whole are determined;
- All expenses are converted to monthly amounts and totaled. The allowable expenses on the basis of the number of rental units to the number of dwelling units in the building are pro-rated. For example, an applicant renting one unit in a two-family house may deduct one-half of the allowable expenses; an applicant occupying a three-family house may deduct two-thirds of the allowable expenses;
- The cost of the tenant's utilities, if billed to and paid by the applicant separately from the applicant's own utilities are determined and may be deducted in full;
- The allowable deductions from the rental income are totaled to determine the countable unearned income.

0388.20.10 Rental Inc, Prop is Not Home

REV:06/1994

The property must first be evaluated as a resource. The value of the property combined with the value of other resources must not exceed the resource limit. If the resources are within the limit, all the allowable expenses are deducted from the gross rental income to determine the countable rental income of the applicant/recipient.

Allowable expenses are:

- Interest payments on the mortgage(s);
- Insurance;
- Taxes;
- Water and sewer charges and assessments.

0388.20.15 Roomer or Roomer/Boarder Inc

REV:06/1994

ROOMER INCOME

An individual may rent one or more rooms of his/her single family home or apartment. If the applicant/recipient has roomer income, allowable expenses are pro-rated based on the number of rented rooms to the total number of rooms in the house. Bathrooms, unfinished attics and basements do not count in determining total rooms. For example, if a house with six rooms has one room rented, one-sixth of the allowable expenses are deducted from the gross roomer income. The balance after deduction of the pro-rated expenses is countable unearned income.

ROOMER/BOARDER

The applicant/recipient may provide meals in addition to lodging.

If so, the allowable expenses which are deducted from the roomer/boarder income may include the cost of providing food. To reflect the added cost of providing food, the Food Stamp Program "Maximum SNAP Allotment" amount is deducted for the number of roomer/boarders. (See SNAP Manual, Sec. 1038).

0388.25 VA PAYMENTS

REV:06/1994

The Department of Veterans Affairs (VA) has numerous programs which make payments to Supplemental Security Income (SSI) recipients and their families. For SSI purposes, treatment of those VA payments depends on the nature of the payments.

The most common types of payments and their treatment is the following:

- VA PENSION PAYMENTS are income based on need and the $20 general income exclusion does not apply;
- VA COMPENSATION PAYMENTS, which are made on the basis of a service-connected disability or death, are unearned income subject to the $20 general income exclusion if made to the veteran, spouse, child or widow(er). VA compensation payments made to a surviving parent of a

veteran are federally funded income based on need and the $20 general income exclusion does not apply;

- VA AID AND ATTENDANCE ALLOWANCES, which are paid to veterans, spouses of disabled veterans and surviving spouses in regular need of the aid and attendance of another person, or who are housebound, is excluded. This allowance is combined with the individual's pension or compensation payment;

- VA EDUCATIONAL BENEFITS are provided under a number of different programs, including vocational rehabilitation. Payments made as part of a VA program of vocational rehabilitation is excluded. Any VA educational benefit or portion of such a payment which is funded by the government, and is not part of a program of vocational education, is unearned income.

  Some VA educational assistance programs are "contributory". The money is contributed to an educational fund and the government matches the money when it is withdrawn while the veteran is pursuing an education. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contributions is a conversion of a resource and is not income.

- VA CLOTHING ALLOWANCES related to the use of a prosthetic or orthopedic appliance, payable in August of each year to a veteran with a service connected disability, is excluded.

0388.30 Sponsor Deeming

REV:01/2007

Sponsorship deeming will be implemented effective July 1, 2007.

Under deeming provisions, the income and resources of the sponsor(s) are counted as available and received, even if not in fact received, by the applicant. Income and resources of the sponsor(s) and of the sponsor's spouse (when living together) are counted when determining the income and resources of the non-citizen applicant.

Deeming applies ONLY to Lawful permanent residents (LPR) who:

- 0 Entered the U.S. or were granted LPR status on or after 12/19/97; and

- 0 Were sponsored by an individual or individuals (family-based immigrants and some employment based immigrants whose employer is a family owned business); and

- 0 Whose sponsors signed new, legally binding affidavits of support (USCIS Form I-864).

Deeming continues until the individual:

a) Attains U.S. citizenship; or

b) Can be credited with forty (40) quarters of work as defined under Title II of the Social Security Act, provided that no credit is given for any quarter after 12/31/96 in which any federal means tested benefit was received.

Deeming provisions may be waived in some circumstances. See Section 0304.05.90.

If the applicant is unable to supply a copy of the USCIS Sponsorship Affidavit, or if further verification or information is needed from USCIS, the agency representative shall offer to assist the applicant in obtaining this information directly from USCIS. USCIS Form G-639 may be sent directly to USCIS with the applicant's written permission. It is the responsibility of the applicant to provide information and documentation of the sponsor's income and resources.

Resources belonging to the sponsor(s) and/or the sponsor's spouse, if living together, which would be countable under MA program provisions are deemed available to the immigrant and are a countable resource in determining MA eligibility.

The amount of income deemed to the applicant is calculated as follows:

1. Add the total of the sponsor's unearned and earned income, after applying applicable MA income exclusions. If there are two sponsors and they are married and living together, combine their incomes and perform a single computation. If they are not married, perform separate deeming computations.

2. From this total, subtract:

   a) An allocation for the sponsor equal to the monthly FBR for an individual (See Section 0362.05 for FBR amount); plus

   b) An allocation for the sponsor's spouse, if living together, equal to one-half the FBR for an individual; OR an allocation for the sponsor's spouse who is also a co-sponsor of the applicant, equal to the FBR for an individual; plus

   c) An allocation equal to one-half the FBR for an individual for each dependent of the sponsor. If the spouses are both sponsors of the applicant, only one allocation is given for each dependent, even if the person is a dependent of both spouses.

      A dependent's income is not subtracted from the sponsor's dependent's allocation.

3. The difference between the total income (1) and the total allocations (2) is deemed as unearned income to the applicant. This deemed income is added to the applicant's own income to determine MA eligibility.

0390 FLEXIBLE TEST OF INCOME

0390.05 USE OF EXCESS INCOME

REV:06/1994

An institutionalized individual who meets the other eligibility requirements, but has income in excess of the Medically Needy income limits may be eligible for Medical Assistance in accordance with the Flexible Test of Income.

During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

0390.10 DETERMINE SPENDDOWN LIABILITY

REV:01/2000

CATEGORICALLY NEEDY

To be eligible as Categorically Needy, the gross income of an institutionalized individual (who is not an SSI recipient or receiving 1619(b) benefits) may not exceed the FEDERAL CAP set forth in Section 0386.05.

MEDICALLY NEEDY

An applicant who has countable income less than or equal to the Medically Needy Income Limit (MNIL) is eligible as Medically Needy, without regard to the cost of medical services.

If countable income is greater than the Medically Needy Income Limit, a flexible-test calculation must be completed. The flex-test BUDGET PERIOD IS ONE MONTH for institutionalized individuals. (Although the budget period is one month, the APPLICATION PERIOD is the same as for other institutionalized individuals. A NEW APPLICATION IS NOT NEEDED FOR EACH MONTH.) The flex-test calculation is as follows:

From the applicant's monthly gross income, first deduct the $20 general disregard (from unearned income first), then any other applicable disregards ($65 and 1/2 the balance of wages, etc.) Compare the countable income to the MNIL for an individual set forth in Section 0386.05. If income

exceeds the MNIL, deduct the MNIL from the countable income. The balance is the monthly excess income.

From the monthly excess income, deduct the PROJECTED cost of institutional care over the month, if any. The projected cost of institutional services is the number of days of institutional care (not covered by Medicare) multiplied by the PRIVATE per diem rate. If the excess income is absorbed, the applicant is eligible for Medical Assistance for the month. If the excess income is not absorbed, then deduct the documented monthly cost of medicare and other medical insurance premiums, then the documented cost of incurred medical expenses (including coinsurance liabilities) for the month in question. If, after the previous deductions, a balance of excess income remains, the individual is ineligible because of excess income. The balance of excess income becomes the flex-test spend down liability for the month. The individual does not become eligible until and unless s/he incurs costs for OTHER non-covered medical services which equal or exceed the remaining balance of income.

If, after the deduction of projected institutional expenses and incurred medical expenses, the individual still has excess income, s/he is ineligible. S/he must be notified that eligibility does not exist and notified in writing of the amount of excess income which must be absorbed each month in order to establish eligibility.

If eligibility is established for a month, the individual must be so notified. At the same time, if the case is being certified for the current month only, written notification is sent to notify the client of the closing.

If Medical Assistance payment is requested for an individual's institutional care expenses, the post-eligibility treatment of income described in Section 0392 must be followed to apply the individual's income to the cost of the institutional care. Those medical expenses actually INCURRED (not projected) for services in the current month that are used to establish flex-test eligibility are deducted from income before applying income to the cost of care

If the institutionalized individual is eligible for MA, either as Categorically Needy or Medically Needy, go to the discussion of Resource Transfers in Section 384. If not

eligible for MA, the applicant must be notified in writing that eligibility does not exist.

0390.10.05 When Eligibility Begins

REV:06/1994

The date of eligibility is the actual day of the month on which the applicant incurs a medical expense which reduces income to the income standard. THEREFORE, THE DATE OF ELIGIBILITY IS THE DAY THAT THE MEDICAL SERVICE IS PROVIDED AND NOT THE DATE OF THE BILLING, which may be a later date. The expense is incurred on the day of the service.

When an incurred medical expense is a hospital bill, the date of eligibility is the first day of hospitalization. An AP-758 is required to establish the amount of the hospital bill for which the individual is liable. The individual's liability is his/her excess income on the first day of hospitalization, providing there is no expense subsequently incurred which reduces such excess income to a lesser amount.

0390.15 RECOGNIZED MED/REMEDIAL CARE

REV:06/1994

Care which is not being provided within the MA scope of services and which may be used to offset excess income includes:

- Adult Day Care;
- Respite Care; and,
- Home Health Aide/Homemaker Services.

0390.15.05 Adult Day Care

REV:06/1994

The cost of adult day care services may be used to offset a flexible-test spenddown liability. In order to be considered a cost of "medical or remedial care", these conditions must be met:

o The service must have been rendered by a provider agency approved by the Department of Elderly Affairs (DEA); and,

o The service was required to assist an individual, who because of severe disability related to age or chronic illness, encountered special problems resulting in physical and/or social isolation detrimental to his/her well-being, or required close monitoring and supervision for health reasons.

0390.15.10 Respite Care

REV:06/1994

The cost of respite care may be used to offset a flexible-test spenddown liability if the applicant receives overnight respite care at a licensed nursing facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).

0390.15.15 Home Health Aide/Homemaker Ser

REV:06/1994

The cost of Home Health Aide services or Homemaker services may be used to offset a flexible-test spenddown liability under certain circumstances. In order to be considered a cost of "medical or remedial care", the following three conditions must be met:

o The service must have been rendered by an agency licensed by the Rhode Island Department of Health, and recognized as a service provider by DHS under the Homemaker Program (see Section 0530.35 for list); and,

o At least a portion of the service provided each month MUST be for personal care services (assistance with bathing, dressing, grooming, etc.). If the applicant does not (or did not) receive assistance with personal care during a month, no part of that month's cost of service may be used to offset the flexible-test spenddown liability; and,

If the foregoing three criteria are met, eligibility staff may recognize, without further review, the cost of up to 65 hours per month in Home Health Aide/Homemaker services to offset a flexible- test spenddown liability. Deductions in

excess of this amount must be approved in writing by the Nurse/Consultant for Homemaker Services located at 111 Fountain Street, Providence. The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the agency representative, a copy of the individual's Plan of Service obtained from the provider agency, and a copy of the physician's certification of need for services. The Nurse/Consultant reviews the material to determine the extent to which the costs of service in excess of 65 hours per month may be recognized as a deduction from excess income. Only the cost of substantive services may be allowed as a deduction from excess income.

0390.20 DEDUCT LOANS TO PAY MED BILLS

REV:06/1994

A loan can be an incurred health care expense and, in some circumstances, may be applied against the CURRENT spenddown liability when the applicant has a CURRENT obligation under the loan. The objective of the policy is to allow the recipient to use his or her liability to the lender in place of his or her liability to the provider. However, since the applicant may apply only the amount that would have been deducted had the provider's bill been used, the deduction of interest paid or payable on the loan is precluded.

A loan that is taken out in the current eligibility period to pay a health care provider for services rendered in the same period (or, in the case of a new application, for services rendered in the month of application or within the three preceding months) may be applied against the spenddown liability for the current period IN PLACE OF the provider's bill. (The loan expense and the provider's bill may not BOTH be applied against the spenddown liability).

A loan taken out in the current period or a preceding period to pay a provider's bill incurred in a preceding period may be applied against current spenddown liability to the extent of any unpaid balance in certain cases. Current principal payments and any remaining unpaid principal balance on the loan may be applied against the spenddown liability to the extent that:

o The proceeds from the loan WERE actually used to pay the provider's bill (i.e., the loan payments are not

deductible until after the proceeds have been paid to the provider); and,

o Neither the provider's charges nor the loan payments and the unpaid balance were previously applied against spenddown liability or deducted from income.

Loan proceeds that will not be used until after the current eligibility period may not be applied against the spenddown liability in the current period because only loan proceeds THAT HAVE BEEN USED to pay for health care expenses may be applied.

However, such proceeds could be used against any spenddown liability for the subsequent period in which they actually are used.

This policy gives the recipient the relief intended by the spenddown (i.e., application of the remaining liability for old medical expenses against the person's spenddown liability). The policy does not change the treatment of old bills that remain unpaid -- i.e., they are still deductible in the spenddown to the extent that a current liability continues to exist and the bills have not been previously deducted.

STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Statement of Need for Emergency Filing

MEDICAID CODE OF ADMINISTRATIVE RULES

SECTION 0392: POST-ELIGIBILITY TREATMENT OF INCOME

The Executive Office of Health & Human Services (EOHHS) is filing this "emergency" amendment to rule #0392 "Post-Eligibility Treatment of Income" in order to incorporate recent changes to the federal 2016 Medicaid "Spousal Impoverishment Standards", the updated minimum monthly maintenance needs allowance (MMMNA), and the monthly housing allowances for community spouses that become effective July 1, 2016.

Because the revised standards were published by the federal Centers for Medicare and Medicaid Services (CMS) on May 31, 2016 and must take effect on July 1, 2016, EOHHS is filing on an "emergency" basis to accommodate this compressed time line. Additionally, the State is adopting these amended rules to set forth these provisions in a timely manner in order to prevent wrongful denial, discontinuance, or interruption of benefits for Medicaid applicants and beneficiaries.

_____

Elizabeth H. Roberts, Secretary
Signed this th day of June 2016

0392 Post-Eligibility Treatment of Income

0392.05 Overview

REV: 06/1994

Institutionalized Medicaid recipients are required to apply their income toward the cost of institutional care. Once Categorically Needy or Medically Needy eligibility has been established, and the applicant has been determined eligible for payment of institutional care services, a determination is made of the amount of income that the institutionalized individual must allocate to the cost of care.

The individual may protect certain prescribed amounts of income for specific needs. ONLY the prescribed amounts for the specific purposes may be protected. ALL of the institutionalized individual's remaining income must be used to reduce the Medicaid payment for institutional care. The applicant's income, protected amounts, and allocation to the cost of care are computed on a monthly basis.

The policy in this section applies to individuals who reside in nursing facilities and public medical facilities. See Section 0396 for the specific post-eligibility policies which apply to individuals who receive home and community based services under a waiver. For eligibility determination purposes, children receiving Medicaid under the "Katie Beckett" provisions are considered to be institutionalized. However, "Katie Beckett" eligible children are not subject to the post-eligibility process since only regular covered medical services are provided.

0392.10 Income for Post-Eligibility Purposes

REV: 03/1995

There are differences between the definition of income for determining Medicaid financial eligibility and the definition of income for post-eligibility purposes. In the post-eligibility process, income means all income that is defined to be part of the client's gross income when determining financial eligibility.

The income disregards which were excluded in the eligibility determination process are added back as countable income in the post-eligibility process.

Generally, certain types of income that are paid to a client for medical or social services and are excluded in determining financial eligibility are counted as income in the post-eligibility process. However, Aid and Attendance (A&A) benefits or benefits for unusual medical expenses (UME) paid by the Veterans Administration are excluded in determining financial eligibility and are also excluded as income in the post-eligibility process.

Likewise, SSI benefits are not considered to be income in the Medicaid eligibility process and are "invisible" (not countable) in the post-eligibility treatment of income as well.

0392.10.05 Income Ownership

REV: 06/1994

During any month in which an institutionalized spouse is in the institution, except with respect to trust property as provided below, no income of the community spouse shall be deemed available to the institutionalized spouse.

In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined to be eligible for Medicaid, the following rules apply, regardless of any state laws relating to community property or the division of marital property:

NON-TRUST PROPERTY

Non-trust property is all property not subject to a trust. The caseworker reviews the instruments, if any, which provides the income and applies its specific provisions regarding payment and availability of income. If the instrument providing the income lacks specific provisions relating to payment and availability of income, the following provisions apply:

- If payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

- If payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them;

- If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to that spouse's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.

In the case of income not from a trust in which there is no instrument establishing ownership, subject to Section 0392.10.05.05, one-half of the joint interest shall be considered available to the institutionalized spouse and one-half to the community spouse.

TRUST PROPERTY

In the case of a trust, income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust:

- If payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

- If payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them;

- If payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.

0392.10.05.05 Rebutting Income Ownership
REV: 06/1994
The rules set forth in Section 0392.10.05 regarding non-trust property may be superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence that the ownership interests in income are other than as provided under that section.

0392.15 Income Applied to Cost of Care
REV: 06/1994

For each month in which Medicaid is requested to pay for the individual's institutional care, the individual must contribute his/her income to pay for institutional services, deducting only certain allowable amounts. The individual's income remaining after allowable deductions is paid to the institution as his/her contribution to the cost of the institutional care. Such income is known as APPLIED INCOME. The Medicaid payment to the institution is reduced by the applied income amount.

The calculation of applied income starts with the individual's gross income, which includes the deduction and disregard amounts which were subtracted from gross income in the determination of eligibility. To determine applied income, certain allowable deductions are subtracted from the recipient's gross income. The deductions, and the order in which they are subtracted from the recipient's gross income, are:

- Personal Needs Deduction (Regular) or $90 Reduced Pension Deduction;
- Personal Needs Deduction (Expanded);
- Personal Needs Deduction (Guardian and Legal);
- Community Spouse Allowance;
- Community Dependent Allowance;
- Medical Insurance Premiums;
- Medical/Remedial Items;
- Home Maintenance Deduction;
- First/Last Month Institutionalization Expenses.

0392.15.05 Personal Needs Deduction / $90 Pension
REV: 07/1999

This deduction is a personal needs deduction which is normally $50 per month, but may be larger for certain individuals with greater needs.

Beginning with benefits payable June 1, 1991 and continuing until September 30, 1997, Veterans Administration (VA) improved pensions payable to certain institutionalized veterans (those with neither spouse nor children, and who are eligible for Medicaid) are limited to $90 per month. This reduced pension amount is protected and can be used to meet the veteran's needs while in the institution. The Veterans' Benefits Act of 1992 extended the application of the law that limits VA pensions to $90 per month and bars Medicaid from counting the amount in the post-eligibility process to include surviving spouses with no children on the same basis that it applies to veterans. Therefore, for personal needs, a veteran or a surviving spouse of a veteran, with no

children, receiving a reduced pension is entitled to the greater of the $50 Personal Needs Allowance or, the $90 pension protected amount. In the post-eligibility added to the individual's other income. From the total income, subtract $90 for the veteran's personal needs.

0392.15.10 Personal Needs Deduction, Expanded
REV: 07/1999

Certain institutionalized individuals have higher than normal personal needs which result from their employment, and which allow them a personal needs deduction greater than the normal $50.

This higher personal needs deduction can be retained from the GROSS earned income of certain institutionalized individuals who are employed in public or private employment, or in sheltered workshops.

The employment and the retention of earned income must be therapeutic.

To be considered therapeutic, the employment must be part of a written plan to encourage the individual to attain his/her highest level of independence. For these individuals, an ADDITIONAL $85 plus one-half (1/2) the remainder of earned income per month may be protected for personal needs. The maximum expended personal needs allowance will vary with the amount of earnings, but can never exceed $400: ($50 + $85 + ($265 maximum) = $400).

0392.15.15 Increased Personal Needs Deduction
REV: 04/2001

An increased personal needs deduction is allowed for institutionalized individuals who incur certain fees.

Expenses which may result in an additional personal needs deduction under this provision are:

- Guardianship/Conservatorship Costs as provided in Section 0392.15.15.05;
- Legal Fees as provided in 0392.15.15.10;
- Tax Assessments as provided in Section 0392.15.15.15.

If specified criteria are met, the individual may retain income, in the form of an increased personal needs deduction, to meet the allowed expense(s).

0392.15.15.05 Guardian/Conservator Costs
REV: 04/2001

Individuals who have court-appointed guardians or conservators are allowed to retain income in the form of an additional Personal Needs Deduction to pay for certain court-approved guardian/ conservator's fees or court-ordered fees relating to the guardianship/conservatorship. Such fees include but are not limited to:

- Court filing fees;

- The cost of a Probate Bond;
- Court-approved guardianship/conservatorship fees; and
- Court-approved legal fees.

To be considered, the expense must be required for the individual to make income or resources available, or in the case of an incompetent individual who needs a court-appointed guardian, required to access or consent to necessary medical treatment (including applying for Medicaid). The individual must submit a copy of the Probate Court Order and any supporting documentation, including an itemized bill for allowable guardianship/conservatorship expenses, to the Medicaid agency.

Such cases are referred to the Office of Legal Services by the Administrator of Long Term Services and Supports (or his designee). The referral must contain a brief description of the case, a copy of the Probate Court Order, an itemized bill from the guardian, and any other supporting documentation submitted by the individual.

The Office of Legal Services may consider as deductions reasonable court-approved expenses (not covered by other sources) listed above, subject to the Rhode Island Supreme Court approved fee schedule (currently $30 per hour for guardians under "Executive Order" Number 95-01). When such guardianship fees have been approved by the Probate Courts, related guardian ad litem fees not exceeding $250 may also be recognized.

The total amount allowed must be reasonable shall be based the hours approved by the particular Probate Court for items as provided above at the rate of compensation paid for guardians ad litem in Family Court as specified in the then-current Rhode Island Supreme Court Executive Order on fee schedules.

Monthly deductions of up to one hundred twenty five dollars ($125) may be allowed for guardianship expenses. Monthly deductions up to one hundred twenty five dollars ($125) may also be allowed for related legal fees. An additional deduction from income of up to two hundred fifty dollars ($250) is recognized for allowable expenses related to a guardian-ad-litem during the month in which the individual pays the expense.

0392.15.15.10 Legal Fees
REV: 06/1994

Individuals who incur legal fees resulting from legal action to obtain income or resources for their support may retain income in the form of an additional Personal Needs Deduction to pay such fees. The maximum which may be deducted from income is the LESSER of the actual fee, or one third of the settlement amount.

0392.15.15.15 Tax Assessments
REV: 06/1994

Individuals ordered by the Internal Revenue Service, the Rhode Island Division of Taxation, or other State or municipal taxing authority to pay income taxes may retain income to pay the taxes.

0392.15.20 Community Spouse Allocation
REV: April 2015

Rhode Island is an income first state in which the income is first examined as part of the allocation. If the institutionalized individual has a community spouse, the individual may wish to allot an amount to the community spouse for his/her support. In reviewing for eligibility, DHS must consider all the income of the institutionalized spouse that could be made available to a community spouse has been made available before DHS allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse. This is applicable to individuals who became institutionalized individuals on or after February 8, 2006. Reference is made to applying this Section to fair hearings, as found in Section 0380.40.35. The amount of the community spouse allocation is based on the income already available to the community spouse. Thus, the calculation of this allocation is preceded by a determination of the community spouse's income.

If the institutionalized individual has a community spouse and other community dependents, s/he may choose in addition to the community spouse and can allocate only to his/her dependents.

The maximum amount that may be taken from an institutionalized individual's income for the support of a spouse and dependents in the community is $ 2,980.50 per month, except:

- In the case of a court order for spousal support; or
- In the case of a court order or a finding by an administrative hearing.

The allocation to community spouse is based upon the gross income otherwise available to the community spouse. The income of the community spouse is determined in the same manner as gross income for purposes of eligibility determination. No disregards or deductions are applied to the community spouse's gross income in determining the allocation from the institutionalized spouse.

0392.15.20.05 Calculation of Community Spouse Allocation
REV: ~~August 2015~~ July 2016

The calculation of the community spouse allowance considers the following:

- The community spouse's gross income; and
- The spouse allowance which consists of two parts, the basic allowance and the excess shelter allowance.

The BASIC ALLOWANCE to a community spouse with no other income is ~~$1991.25~~ $2002.50 per month.

An EXCESS SHELTER ALLOWANCE is added to the basic spouse allowance if the community spouse's shelter expenses exceed ~~$597.38~~ $600.75 per month.

0392.15.20.10 Excess Shelter Allowance
REV: ~~August 2015~~ July 2016

The excess shelter allowance is the amount by which the community spouse's shelter expenses exceed ~~$597.38~~ $600.75 monthly.

Only shelter expenses relating to the community spouse's principal place of residence may be used to calculate the excess shelter allowance.

Shelter expenses are defined as and limited to:

- Rent;
- Mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge;
- The STANDARD UTILITY ALLOWANCE, as updated annually in Sec.1038.20.05 of the SNAP Manual (Standard Utility Allowance), regardless of the actual utility costs, IF utility costs are incurred by the community spouse.

If the total allowable monthly shelter expenses are less than ~~$597.38~~ $600.75 there is no excess shelter allowance. The amount of shelter costs that EXCEEDS ~~$597.38~~ $600.75 is the excess shelter allowance.

0392.15.25 Dependent's Allocation with Community Spouse

REV: ~~August 2015~~ July 2016

Other family members of the institutionalized individual who live with the community spouse are also entitled to an allowance from the institutionalized individual. The dependent's allowance, when the dependent is living with the community spouse, is IN ADDITION to any spouse allowance, and MUST BE ALLOWED AS A DEDUCTION WHETHER OR NOT IT IS MADE AVAILABLE TO THE DEPENDENT(S) BY THE INSTITUTIONALIZED INDIVIDUAL.

To qualify for this dependent's allowance, the relative must live with the community spouse and must be:

- A minor (less than 18 years old) dependent child of either the institutionalized or the community spouse;
- A dependent parent of either spouse;
- A dependent sibling of either spouse (including an adoptive sibling or sibling of half blood).

Family members living with a community spouse for whom a dependent's allowance is sought must be determined to be financially dependent on the institutionalized individual. A family member is dependent if s/he is (or could be) claimed as a tax dependent of either the institutionalized spouse or the community spouse.

If the above criteria are met, the allowance for each dependent is calculated as follows:

- The allowance for a dependent with no income is ~~$663.75~~ $667.50 per month.

- If the dependent has income, his/her gross monthly income is deducted from the basic allowance of ~~$1991.25~~ $2002.50.

The difference between ~~$1991.25~~ $2002.50 and the dependent's monthly income is DIVIDED BY 3. The divisor 3 is a constant value in this computation. The QUOTIENT is the MONTHLY DEPENDENT'S ALLOWANCE FOR THAT PARTICULAR DEPENDENT.

0392.15.25.05 Dependent's Allocation / No Community Spouse
REV: 07/1999

Dependent family members of the institutionalized individual, WHEN THERE IS NO COMMUNITY SPOUSE, are entitled to an allowance from the institutionalized individual based on the Medically Needy Income Unit. To qualify for this dependent's allowance, the relative must be:

- A minor (less than 18 years old) dependent child;
- A dependent parent;
- A dependent sibling (including an adoptive sibling or sibling of half-blood).

Family member(s) for whom a dependent's allowance is sought must be determined to be financially dependent on the institutionalized individual. A family member is dependent if s/he is (or could be) claimed as a tax dependent.

The basic allowance for a dependent without a community spouse is equal to medically needy income limit for an individual, less any income of the dependent. If there is more than one dependent, the Medically Needy Income Limit for the family size is used.

0392.15.30 Fair Hearing
REV: 07/2006

If either the institutionalized spouse or the community spouse is dissatisfied with a determination of the community spouse monthly income allowance or the amount of income otherwise available to the community spouse, such spouse is entitled to a hearing. In addition, if either spouse establishes that due to extreme rare circumstances resulting in significant financial duress, the community spouse requires additional income, the hearing officer may order an allocation to provide such additional income as is necessary.

0392.15.35 Medical Insurance Premiums
REV: 07/2006

The deduction is the total of premiums paid for medical insurance coverage identified on the InRHODES system STAT/INSU or STAT/MEDI panels. If the institutionalized individual's Medicare premium is being paid by the State, it is not allowed as a deduction.

0392.15.40 Medical/ Remedial Care Costs
REV: 06/1994

The deduction consists of the cost of medical or remedial care recognized under state law but not covered under the Medicaid scope of services. This includes the cost of such items as chiropractic services, hearing aids for the Medically Needy, and certain ambulance services. Medical/remedial items which may be included in this deduction from the institutionalized individual's gross income are identified on the STAT/MEDX panel.

0392.15.45 Allocation for Home Maintenance

REV: 07/1999

If the institutionalized individual has no spouse living at home, and a physician has certified that s/he is likely to return home within six months, an amount can be allocated for the maintenance of the home. This deduction cannot exceed the Medically Needy Income Limit for one, nor can the amount be allocated for more than six months in any continuous period of institutionalization.

An institutionalized individual may not allocate income for both HOME maintenance and for the support of dependents at home.

The dollar amount per month that the individual is allowed to pay for expenses of the home are identified on the InRHODES system STATEMENT OF NEED/ HOME, RENT, and UTIL panels.

Expenses that can be deducted from the income are:

- Rent or mortgage;
- Taxes;
- Insurance;
- Special assessments and water bill.

THE MONTHLY TOTAL ALLOCATED CAN NOT EXCEED THE MONTHLY MEDICALLY NEEDY INCOME LIMIT FOR AN INDIVIDUAL. (See Section 0386.05)

0392.15.50 First/ Last Months of Institutional Expenses

REV: 07/2006

In determining the amount of income to be protected for the needs of an institutionalized individual WITHOUT a community dependent, the fact that a patient who is institutionalized for less than a full month will have out-of-institution expenses is recognized. In fact, the likelihood is great that an individual entering an institution during the middle of the month will have already expended his/her personal income for ONGOING EXPENSES.

This deduction is the amount of extra expenses allowed during partial months of institutionalization for an individual with no community spouse or dependents. It is manually entered and maintained in the InRHODES system by the Long Term Services and Supports worker.

Evidence of an on-going expense can be either a receipt for payment or a bill that is due. An UNPAID BILL need not be for the month of admission or the month of discharge from the facility; an overdue bill is still an ongoing expense for which the individual is liable.

However, a RECEIPT must be for an expense incurred for the month of admission and/or the month of discharge from the facility. (These concepts comport with the policy on spenddown.)

Copies of receipts and/or bills are inserted in the case record.

However, this section does not apply to an allocation if prohibited transfer(s) has/have occurred and caused a penalty period.

0392.20 Medicaid Payment for Institutional Care
REV: 07/2009

An allocation for the support of the community spouse and/or dependents, and the deduction allowed for medical insurance may only be subtracted from the recipient's income as described in Sections 0392.15.20 and 0392.15.35.

After the appropriate deductions have been subtracted from the institutionalized individual's income, the remaining balance of the income is applied to the cost of institutional care. The monthly Medicaid payment to the medical institution is reduced by the applied income amount.

0392.25 Institutionalized SSI Recipients
REV: 07/1999

Recipients of SSI are automatically Categorically Needy Medicaid recipients. If the applicant is eligible for payment of institutional care services (s/he has not incurred a period of ineligibility by a resource transfer), LTSS/AS staff determine the applicant's income to be applied to the cost of care in the institution. The SSI payment itself (and the State Supplement, if any) is excluded from consideration in the post-eligibility allocation of income to the cost of institutional care.

ALL OTHER INCOME of the SSI recipient is considered in the monthly income allocation from the first month of confinement in a Long-Term Care facility.

There are two groups of SSI recipients for whom post-eligibility applies:

- Community SSI recipients whose SSI benefits continue during inpatient confinement; and
- Employed individuals receiving SSI under Section 1619 who are institutionalized.

0392.25.05 Three (3) Month Continuation of SSI Benefits
REV: 06/1994

The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for the continuation of full SSI benefits for up to three (3) months to individuals who enter medical facilities, including acute care hospitals and nursing facilities, but who intend to return to their community residences within ninety (90) days. Retention of full SSI benefits is intended to allow these individuals to maintain their community residences while temporarily confined to a hospital or long-term care facility. To be eligible for continued SSI benefits, three conditions must be met:

- A physician must certify in writing that the individual's medical confinement is not expected to exceed ninety (90) days; and

- The individual must certify in writing that s/he needs the SSI benefit to maintain the home; and

- Documents attesting to the above conditions must be received by SSA not later than ten (10) days after the end of the month in which the individual entered the institution.

0392.25.05.05 Processing Continuation of SSI Benefits

REV: 06/1994

SSI recipients eligible for continuing SSI benefits may enter a LTSS facility from a hospital or may request placement directly from home.

SSI Recipient Entering an LTSS Facility from a Hospital

The Long-Term Care/Adult Services (LTSS/AS) worker obtains an application and supporting documentation in the normal manner in order to determine the income to be applied to the cost of care, to determine eligibility for Medicaid if SSI is terminated prior to discharge, and to determine if a prohibited resource transfer has been made. The worker communicates with the Social Security Administration to advise SSA of the recipient's entry into a LTSS facility.

SSI Recipient Requesting Placement Directly from Home

The LTSS/AS worker obtains an application and supporting documentation in order to determine income to be applied to the cost of care, to determine eligibility for Medicaid if SSI terminates prior to discharge, and to determine if a prohibited resource transfer has been made. The worker effecting the placement informs the individual of the availability of extended SSI benefits. If the individual intends to return home and medical evidence indicates that the individual will be able to do so within ninety (90) days, the LTSS/AS worker obtains a statement from the individual's doctor that indicates when the individual's return home is anticipated. The worker also obtains a signed statement from the individual which states that the SSI benefit is needed to maintain the home for his/her return. A copy of the doctor's statement and the individual's statement are sent to SSA. These documents must be received by SSI before the tenth day of the month following the month of institutionalization for SSA to continue full SSI benefits.

Termination or Reduction of SSI

If an SSI recipient remains institutionalized beyond the time limit, the SSI payment is terminated or reduced to the $30 level. LTSS/AS assumes responsibility for eligibility determinations for those individuals who no longer receive an SSI payment.

Allocation of Income to the Cost of Care

The SSI payment is excluded from the individual's gross income when calculating income to be applied to the cost of care.

0392.25.10 Employed/Institutionalized SSA 1619(B) Recipients

REV: 06/1994

Section 1619 of the Social Security Act provides for special SSI payments for disabled persons who are working. Persons who received SSI payments under Section 1619 of the Social Security Act in the month prior to institutionalization may receive two months of continued SSI benefits when admitted to:

- Eleanor Slater Hospital;
- Zambarano Hospital.

The LTSS/AS worker, as part of the normal intake process, secures an application and supporting documents from the individual. The worker determines if an individual admitted to one of the institutions listed above is a member of this group by communicating with the Social Security Administration. If so, the allocation of income to the cost of care EXCLUDES the SSI payment from the individual's gross income.

0392.30 Special Situations

REV: 07/2006

Some situations produce unusual results in the three-step sequence of financial determinations, especially in months in which the recipient is Medicaid-eligible for only a partial month, or in those circumstances in which the individual is Medicaid-eligible based on a flexible-test income calculation which includes projected institutional care expenses.

June 16, 2016
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0394 SSI-RELATED COVERAGE GROUPS

0394.05 INSTIT IND, SSI ELIG IN COMM

REV:01/2002

This coverage group consists of individuals in a medical or nursing facility who would be eligible for SSI if living in the community. This includes individuals with sufficient income to meet personal needs while in the facility, but not enough income to meet their needs outside the community according to SSI and State Supplement Standards.

0394.10 INSTIT IND, NOT SSI ELIG IN COM

REV:01/2002

This coverage group consists of individuals in a medical or nursing facility who would not be eligible for SSI if s/he were living in the community. While in the facility these individuals are MA eligible under a special income level for institutionalized individuals (the Federal Cap). The resources of institutionalized persons in this coverage group must be within SSI limits.

0394.15 12/73 RES OF TITLE XIX FACILIT

REV:06/1994

This coverage group (InRHODES Category Code 18) consists of individuals who were eligible for AABD as residents or inpatients of Title XIX facilities or were, on the basis of need for institutional care, considered to be eligible for AABD in the month of December, 1973. The Title XIX facilities are the Eleanor Slater Hospital and Zambarano Hospital.

Eligibility for Medical Assistance continues for these individuals as long as they:

- Remain residents of the Title XIX facilities; and,
- Meet the eligibility conditions of AABD as of December, 1973; and,
- Are in need of institutionalized care.

Due to the small number of individuals in this coverage group, this category will be entered to InRHODES by the Eligibility Technician using the InRHODES manual determination command (MANL).

0394.20 CONTIN SSI ELIG, SHORT CONFINE

REV:01/2002

This coverage group consists of SSI recipients who enter medical facilities, including acute care hospitals and Nursing facilities, and who intend to return to their community residences within ninety (90) days. The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for the continuation of full SSI benefits for up to three months. The intent of the OBRA provision is to allow individuals to retain their community residences while temporarily confined to a hospital or Long Term Care facility.

The eligibility requirements for continued SSI benefits are:

- A physician must certify in writing that the individual's medical confinement is not expected to exceed ninety (90) days; and,

- The individual must certify in writing that s/he needs the benefit to maintain the home; and,

- Documents attesting to the above conditions must be received by the SSA not later than ten (10) days after the end of the month in which the individual entered the hospital.

0394.25 EMPLOYED IND, SSI BY 1619 (B)

REV:01/2002

This coverage group consists of disabled persons who are working and who receive special SSI payments under Section 1619b of the Social Security Act. Individuals who received SSI payments in the month prior to institutionalization receive two (2) months of continued benefits when admitted to:

- Eleanor Slater Hospital;
- Zambarano Hospital.

0394.30 INSTIT IND, AABD ELIG IN 12/73

REV:01/2002

This coverage group consists of individuals who, whether or not they actually received cash assistance in December, 1973 satisfy the following criteria:

- Eligibility for cash assistance in December, 1973 because they were blind or disabled under the State's approved AABD plan; and,

- For each consecutive month after December, 1973, continued eligibility based on the December, 1973 conditions of blindness or disability, and the other conditions of the plan in effect in December, 1973; and,

- Income and resources within current SSI standards.

0394.35 DISABLED CHILD-KATIE BECKETT

REV:08/2006

This coverage group consists of certain disabled children under the age of nineteen (19) who are living at home and who would qualify for Medical Assistance if in a medical institution.

"Katie Beckett" coverage requires that the child meet special eligibility conditions in addition to financial eligibility.

A child under 19 years of age who is living at home but who is in need of the level of care provided in a hospital, Nursing Facility, or Intermediate Care Facility for Mental Retardation, has his/her Medical Assistance financial eligibility determined as if s/he were actually institutionalized. ONLY THE CHILD'S OWN INCOME AND RESOURCES ARE USED IN THE DETERMINATION OF FINANCIAL ELIGIBILITY. THE INCOME AND RESOURCES OF THE CHILD'S PARENTS ARE NOT DEEMED TO BE AVAILABLE TO THE CHILD. A "Katie Beckett" child is deemed Categorically Needy for the full scope of medical services. The purpose of "Katie Beckett" coverage is to make Medical Assistance for home care available to children who might otherwise be disqualified due to the parents' income.

0394.35.05 Special Elig Conditions

REV:08/2006

To be eligible for Katie Beckett coverage, it must be determined that:

- The child requires the level of care provided in a hospital, a Nursing Facility, or an ICF-MR. The DHS worker must assure that a completed assessment of the child's needs is sent to the Center for Child and Family Health (CCFH). This unit has the responsibility of determining the level of care and disability status for the child and the specific time frame for re-evaluation.

- The level of care provided at home is appropriate for the child;

- The estimated cost to Medical Assistance for providing the appropriate level of care at home does not exceed the cost to Medical Assistance for providing care in an institutional setting.

If the child meets these special eligibility conditions and is otherwise eligible, the DHS worker authorizes medical coverage. Children eligible for Medical Assistance under this coverage group may be enrolled in a Rite Care Health Plan in accordance with provisions contained in Section 0348, if they are not otherwise covered by a third party health insurance plan.

0394.35.10 Instit, Home Cost Comparison

REV:08/2006

The estimated cost to MA of providing care for the child at home cannot exceed the estimated cost to MA of providing care in an institution.

To make this determination, the DHS worker compares the gross monthly cost for the required level of care (hospital, NF, or ICF-MR, as appropriate) to the total gross monthly cost for allowed home care services), using the Waivered Services Panel in the InRHODES eligibility function.

0394.35.10.05 Allowed Home Care Services

REV:09/2003

Allowed home care services are:

- Certified home health agency services, including skilled nursing; physical, speech and occupational therapy and home health aid services; and,
- Purchase or rental of durable medical equipment;
- Home based therapeutic services; and,
- Minor assistive devices, minor home modifications, and other special equipment.

Certain services may be provided by school systems for school age children, by family members and/or by volunteers and are not to be considered in estimating the cost of care at home. It should be noted, however, that for school age children these services are the legal responsibility of the school system.

0394.35.10.10 Determ Costs of Instit Care

REV:08/2006

The DHS worker determines if the costs of services required to provide an appropriate level of care in the home are within the costs of care in the appropriate institution.

If eligible, there is no income applied to the cost of services.

The child is allowed to retain all income for community living expenses.

If the total estimated cost of care in the home is less than the total estimated cost of care in the appropriate institution, the child meets this special condition and, if otherwise eligible, is eligible for the full scope of MA benefits.

If the total estimated cost of services required to allow the child to be cared for at home exceeds the cost of institutional care, the child is ineligible, even if the child meets all other eligibility requirements.

0394.35.15 Financial Eligibility Requirements

REV:08/2006

To establish financial eligibility for "Katie Beckett" coverage, the DHS worker determines if the child would be eligible for Medical Assistance, as either Categorically Needy or Medically Needy, if the child were institutionalized. Under the law, if the child meets the "Katie Beckett" requirements, s/he, for MA purposes only, is deemed to be receiving an SSI cash payment, and is therefore CATEGORICALLY NEEDY.

Only the income and resources of the child are considered. Any payment provided under Title XX or other federal, state or local government programs for in-home supportive services is excluded from income.

The DHS worker determines if the child would be financially eligible for Medical Assistance if institutionalized. An institutionalized child is financially eligible for Medical Assistance if s/he is in one of the following groups:

- If s/he would be eligible for SSI if institutionalized, i.e., has resources within the SSI limit of $2,000, and income LESS THAN $70.00 MONTHLY. These individuals receive cash SSI payments even when they are institutionalized and are therefore Categorically Needy;

- If s/he had resources within the $2,000 limit and income of at least $70.00 but NOT MORE THAN THE Federal Cap set forth in Section 0386.05. These individuals lose their SSI cash payment when they are institutionalized because their gross personal income is $70 or more per month. However, because their income is less than the Federal Cap they remain eligible for Medical Assistance as Categorically Needy;

- If s/he has with resources less than the Medically Needy resource level of $4,000 and income less than the cost of care in the institution. These individuals are eligible as Medically Needy.

The income and resources of the parents are not considered in the determination of eligibility, and are not used to reduce the cost of Medical Assistance services.

0396 Waiver Programs, Provisions

0396.05 Overview of Waiver Programs

REV: April 2014

Many individuals who require the level of care provided in an institutional setting may be able to receive such services at home.

Programs that provide home and community-based services to persons who would otherwise require institutional care require special waivers of the normal Medicaid rules. These Waiver Programs must be approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

Home and community-based services are a humane, cost-effective, and generally preferable way of providing institutional levels of care to eligible individuals. The Medicaid agency provides Home and Community Based Services to eligible aged and disabled individuals under a Waiver Program operated by the Long Term Care/Adult Services unit (see Section 0398.05).

The Medicaid agency also operates Waiver Programs in conjunction with other agencies to serve the needs of certain target populations. These jointly operated programs are the following:

- The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) program for developmentally disabled individuals ("MR Waiver" - see Section 0398.10);

- The Division of Elderly Affairs (DEA) program for individuals in the community or seeking to return home from nursing facilities ("DEA Waiver" - see Section 0398.20);

- The Division of Elderly Affairs (DEA) program for aged and disabled individuals in specified Residential Care/Assisted Living Residences ("Assisted Living Waiver" - see Section 0398.30).

State agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of financial eligibility for Medicaid for all waiver recipients. Since categorically needy individuals receive a greater scope of services, waiver recipients must be determined to be eligible as categorically needy whenever possible.

Case managers at BHDDH, DEA, and for the PersonalChoice Program assist in the determination of eligibility for the Waiver Programs by forwarding information to the state agency LTC/AS unit, and by communicating directly with their applicants and recipients regarding eligibility and income allocation matters.

The Waiver Programs differ in:

- Target populations;

- Special home and community-based services provided to eligible recipients;

- Eligibility level required for participation (Categorically Needy or Medically Needy); and

- Procedures.

This section contains the policies that generally pertain to all Waiver Programs, including determinations of eligibility, post-eligibility treatment of income, and determinations of cost-effectiveness. Exceptions are listed, where applicable, in the following sections specific to each Waiver Program.

0396.10 Determination of Eligibility

REV: April 2014

Eligibility determinations conducted for individuals applying for or receiving services under a Waiver Program are conducted as if the individual were actually institutionalized. Policies contained in Sections 0376 through 0392 are generally applicable to individuals applying for Medicaid eligibility and services under a Waiver Program. This means that:

- Deeming of spousal resources and/or income does not apply after the month of separation due to institutionalization;

- Deeming of parental income and/or resources does not apply to a child under 18 after the month in which the child is determined to be separated due to institutionalization;

- All transfers of assets made within sixty (60) months prior to, or any time after, the individual applies for services under the Waiver Program must be evaluated under transfer provisions contained in Section 0384. Trusts established within sixty (60) months immediately prior to, or any time after, the individual applies for services under the Waiver Program must be evaluated under trust and transfer provisions contained in Section 0382. Resource transfers may render an individual ineligible for payment of Waiver-specific services.

0396.10.05 Persons Eligible

REV: April 2014

Individuals potentially eligible for Waiver Programs include Supplemental Security Income (SSI) recipients and non-SSI recipients.

SSI RECIPIENTS

SSI recipients (and former SSI recipients who are determined eligible for Medicaid by SSA under section 1619(b)) are automatically eligible for Categorically Needy Medical Assistance and thus potentially eligible for Waiver services unless the individual has transferred an asset with a resulting uncompensated value. See Section 0384 for specific information about the penalties related to transfer of assets, and Section 0382 for information about trusts and portions of trusts which are treated as a transfer of assets.

SSA transmits a list of individuals who have transferred resources to the LTC Unit at CO. These transfers must be evaluated when a request for Waiver services is made.

NON-SSI RECIPIENTS

Eligibility for non-SSI recipients is determined as if the applicant were entering or in an institutional setting. The applicant must meet the technical, characteristic, and financial requirements of the Medicaid program.

0396.10.10 Technical Eligibility Requirements

REV: 06/1994

Technical requirements which must be met are:

- Level of care;
- Residency;
- Enumeration;
- Citizenship/Alienage;
- Assessing potential income and resources;
- Cooperation in making resources/income available;
- Transfer of assets.

0396.10.10.05 Institutional Level of Care

REV: April 2014

In order for an individual to be eligible for home-based services under a Waiver, s/he must require the level of care provided in an institutional setting. Case managers recommend the appropriate level of institutional care for each Waiver applicant, subject to the review and approval of the State's Office of Medical Review (OMR).

Policy and criteria for establishing levels of care are found in Section 0378, prior authorization.

Each Waiver Program's targeted population is a specific subset of the overall population requiring institutional services. The appropriate level of care for eligibility varies with each Waiver Program.

0396.10.15 Characteristic Requirements

REV: 06/1994

The characteristic requirements are those of the SSI program: Age (65 years or older); Blindness; or Disability. Only aged individuals can be served under the Waiver Program for Deinstitutionalizing the Elderly (DEA Waiver).

0396.10.20 Financial Requirements

REV: 12/2000

For categorically needy eligibility to exist, the applicant's resources must be within the categorically needy limits set forth in Section 0380, and the applicant's gross income must not exceed the federal cap set forth in Section 0386.05.

The Waiver Programs requiring Categorically Needy eligibility are:

- Waiver for Aged and Disabled Individuals (Section 0398.05); and

- Waiver Program for Aged and Disabled Individuals in Assisted Living (Assisted Living Waiver) (Section 0398.30).

For medically needy eligibility to exist, the individual's resources may not exceed the Medically Needy resource limits set forth in Section 0380. The applicant's countable income must be less than the Medically Needy income limit for an individual set forth in Section 0386.05; OR the individual must incur each month allowable medical expenses (including the anticipated cost of Waiver services) which exceed the amount of the individual's monthly income which is over the Medically Needy income limit.

The Waiver Programs in which an individual may be either Categorically Needy or Medically Needy are:

- Waiver Program for the Severely Handicapped (PARI Waiver) (Section 0396);
- Waiver Program for Aged Individuals (DEA Waiver) (Section 0398.20);
- Waiver Program for Developmentally Disabled Individuals (Section 0398.10).

0396.10.25.05 Cost Neutrality Requirement

REV: April 2014

The Medicaid agency is responsible for reviewing and approving the aggregate cost neutrality of each Waiver Program on an annual basis. To meet cost neutrality, the average per capita expenditures under a waiver cannot exceed one hundred percent (100%) of the average per capita expenditures for the appropriate level(s) of care that would have been made in that year had the waiver not been granted.

0396.10.25.10 Cost Neutrality - Level of Care Costs

REV: July 2015

The average monthly costs to Medicaid by level of care are:

Level of Care	Cost
Nursing Facilities	$6,510.00
Intermediate Care Facilities for the Developmentally Disabled (ICF-MR)	$21,932.94
Hospitals	$24,195.00

0396.15 Average Cost of Care
REV: April 2014

The post-eligibility treatment of income applies to those individuals who are:

- Categorically Needy by virtue of having resources within the Categorically Needy limits, and income within the federal cap; and

- Medically Needy.

SSI RECIPIENTS: SSI recipients and individuals receiving Categorically Needy Medical Assistance by virtue of 1619(b) status are NOT subject to the post-eligibility process. The SSI payment itself is invisible in the allocation process, and for Waiver Program recipients who are also SSI recipients, NONE of the other income of an SSI recipient is subject to the post-eligibility process.

The state agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of the post-eligibility allocation of patient income to the cost of Waiver services for all Waiver services recipients who are subject to the post-eligibility process. The calculation starts with the individual's full, gross income, including amounts which were disregarded in the determination of eligibility. For purposes of the post-eligibility process, income means all amounts that are available to the individual that would be defined to be part of the applicant's gross income in the determination of Medicaid financial eligibility.

0396.15.05 Post-Eligibility Treatment of Income
REV: July 2015

The following is a list of allowable deductions in the order they are to be deducted:

- **Maintenance Needs Allowance**

The Maintenance Needs Allowance is one thousand dollars and eighty-three cents ($1,000.83) per month. This amount is in lieu of the Personal Needs Deduction and the Home Maintenance Deduction available to other institutionalized (non-Waiver) individuals.

For employed individuals eligible under the Waiver for the Developmentally Disabled (Section 0398.10), the Maintenance Needs Allowance is equal to one thousand dollars and eighty-three cents ($1,000.83) plus all gross earned income per month, an amount not to exceed the federal cap. To qualify for this expanded Maintenance Needs Allowance, the individual's employment must be in accordance with the plan of care.

- **Spouse/Dependent Allowance**

This deduction is an allowance for the support of a spouse and any dependents. The basic allowance for a spouse is equal to the monthly medically needy income limit for an individual, less any income of the spouse.

If there are also dependent children to be supported, the Medically Needy Income Limit for the number of children is used.

- **Medical Insurance Premiums**

This deduction is insurance premiums paid by the individual, such as Medicare and Medigap policies such as Blue Cross and Plan 65.

- **Allowable Costs Incurred for Medical or Remedial Care**

This deduction is reasonable costs for medical services recognized under state law but not covered in the scope of the Medicaid Program.

Any balance of income remaining after these expenses are deducted is allocated toward cost of home-based services according to the plan worked out with the Case Manager.

0396.15.10 Allowable Income Deductions

REV: April 2014

Beginning with the second (2nd) month in which the individual receives services, income is allocated toward the cost of home-based services in the manner indicated below. The LTC/AS staff will calculate costs for individuals receiving services under the Aged and Disabled Waiver.

0396.15.10.05 Calculation of Income Allocation

REV: 01/2012

From the full gross income of a single individual the following amounts are deducted in order:

- Maintenance Needs Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care.

Any balance of income remaining after these expenses are deducted is allocated toward the cost of home-based services according to the plan developed with the Case Manager.

*NOTE: To qualify as Medically Needy, an individual must have income within the Medically Needy income limit or incur allowable medical expenses (including the anticipated cost of Waiver services) which exceed the amount of the individual's monthly income which is over the Medically Needy Income Limit.

0396.15.10.10 Individual With Community Spouse/Dependent

REV: 01/2012

When an eligible individual lives with a spouse (or a parent in the case of a child with an ineligible parent), the individual is considered to be a single individual.

The spouse's (or parent's) income is not considered in determining the amount the individual must pay for the cost of services.

Deduct from the applicant's full, gross income the following amounts, in the order presented:

- Maintenance Needs Allowance
- Spousal and Dependent Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care.

0396.15.10.15 Medicaid Payment for Waiver Service

REV: April 2014

The Waiver services recipient is responsible to pay the income allocation toward cost of home-based services according to the plan worked out with the Case Manager.

The Medicaid payment for Waiver services is reduced by the amount of the income allocation each month.

0396.20 Repealed April 2014

0396.20.05 Repealed April 2014

0396.20.10 Repealed April 2014

0396.20.15 Repealed April 2014

0396.20.20 Repealed April 2014

July 10, 2015
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0398 Specific Waiver Programs

Home-Based For Elder/Disabled

REV: 06/1994

Since July 1982, under a Waiver approved by the Health Care Financing Administration (HCFA), DHS has operated a program to divert elderly and disabled individuals from entering a Nursing Facility (NF). This Waiver program provides to eligible participants an array of home-based services which are equal to or less than the cost of institutional care. To be eligible for Waiver services, individuals must be Categorically Needy and meet the requirements of the Long Term Care Alternatives Program.

The program is designed to supplement the existing scope of services already provided by Medical Assistance, Federal Medicare, other State and local programs, and "informal" caretakers such as relatives, friends and neighbors.

Waiver Services

REV: 06/1994

The additional MA services provided under the Waiver are:

- Case MANAGEMENT SERVICES - a broad coordinating function which authorizes, arranges, and monitors home-based services. Case management services are provided by LTC Social Service staff.

- HOMEMAKER/PERSONAL CARE SERVICES - defined in Section 0530 of the DHS Policy Manual.

- ADULT DAY CARE - defined in Section 0514 of the DHS Policy Manual.

- MINOR MODIFICATIONS TO THE HOME - such as portable wheel chair ramps, grab bars, modifications to tubs and toilets.

- MINOR ASSISTIVE SERVICES - such as cooking and eating aids, grooming aids, and other devices which assist in the Minor Assistive Services may include payment for the installation fee and monthly monitoring fee of a Personal Emergency Response System (PERS). The PERS is an in-home, twenty-four hour electronic alarm system which allows a functionally impaired housebound individual to signal a central switchboard in the event of an emergency.

This service is limited to high risk, physically vulnerable individuals who must live alone or spend prolonged periods of time alone, and who have the mental capacity to understand the purpose of PERS and to use it properly.

Minor Assistive services requires prior authorization via an MA-505 by the individual's physician, evaluation of the individual by the LTC Case Manager and service provider (usually the hospital discharging the patient), and is subject to the approval of the Chief of Pharmacy Services in the Division of Medical Services.

The additional services provided under the Waiver are meant to fill remaining gaps in service, not to substitute for existing services for which the individual is eligible. For example, many of the individuals served under the Waiver may be entitled to Medicare-home-health aide or rehabilitation specialists such as a physical therapist. Thus, the home-based service plan written by the Case Manager would not include services already available through other programs such as Medicare.

Target Population

REV: 06/1994

Under the Waiver, two groups of beneficiaries receive services. They are Categorically Needy SSI Recipients (Group I) and Newly Diverted Individuals (Group II).

- **Group I - Categorically Needy SSI Recipients**

Group I is active SSI recipients who, as of January 1, 1982, had been previously diverted from entering a NF through the use of Homemaker Services, and meet the financial and non-financial eligibility criteria for Categorically Needy MA. No new beneficiaries may be added to this group.

- **Group II - Newly Diverted**

Group II is individuals who qualify for NF care and meet the financial and non-financial eligibility criteria for Categorically Needy MA.

Eligibility Determination

REV: 06/1994

Initial eligibility for Group II individuals is determined by the appropriate Long Term Care (LTC) staff as if the individual were entering a nursing facility. If the individual meets the MA technical and characteristic requirements, has income and resources within Categorically Needy limits, and meets the criteria for the Long Term Care Alternatives Program, s/he may choose home care services in lieu of institutional care. If so, the Case Manager in the LTC Unit will be responsible for the case.

TRANSFER OF GROUP I CASES TO THE LTC UNIT

There are two situations in which Group I cases are transferred to the LTC Unit. A previously diverted Group I individual loses SSI eligibility, or a Group I case requires minor modifications to the Home, or Minor Assistive Devices.

- **Group I Individual Loses SSI Eligibility**

When a previously diverted Group I individual loses SSI eligibility, the Adult Services worker refers the case to the appropriate LTC unit and eligibility is determined as for an individual in Group II. The individual must have an aged, blind or disabled characteristic, have income within the Federal Cap and resources within the Categorically Needy limits. In addition to meeting MA eligibility requirements, the individual must meet the criteria for the Long Term Care Alternatives Program and choose home care services in lieu of institutional care.

When the determination of eligibility is completed, the social worker is notified. If the individual is ineligible, the social worker discontinues Homemaker Services and/or Adult Day Care Services. IF the individual is eligible under the Waiver, the Case Manager assumes responsibility for the case.

- Active Group I cases requires Modifications to Home or Minor Assistive Devices.

If a currently active Group I case requires Minor Modifications to the Home, or Minor Assistive Devices, the case responsibility is transferred to the appropriate LTC/AS Unit.

0398.05.20 Redetermination

REV: 06/1994

GROUP II - NEWLY DIVERTED

Redetermination of financial eligibility is conducted at least annually for Group II Waiver service recipients, or when there is a change in circumstances which would affect eligibility. The redetermination is completed by the LTC Unit of the Case Manager servicing the case. Waiver-eligible individuals with a spouse are considered to be living separately, as if in a nursing facility or medical institution. Resources of the spouse are considered as if the individual were applying for care in a medical institution.

GROUP I - PREVIOUSLY DIVERTED

Redetermination of financial eligibility is conducted by the SSA, concurrently with the SSI determination. When a previously diverted case requires redetermination of need for services, the case will continue to be handled by the Adult Services worker with current responsibility for the case. Current procedures apply, except that the CP-1 and CP-1.1 are sent to the Homemaker Review Office in lieu of an HS-1 and HS-2. One copy of the CP-1 is forwarded from the Homemaker Review Office to the LTC Unit at CO.

Case Management Function

REV: 06/1994

In addition to determining eligibility, and the level of care required, DHS Case Mangers coordinate the array of home-based services. Case Mangers will:

- Plan alternative services;
- Arrange and authorize services;
- Monitor and adjust the service mix; and
- Reassess to determine eligibility and need for services under the Waiver, including need for a Nursing Facility level of Care.

Planning Alternative Services

REV: 06/1994

The hospital Social Service staff identifies likely candidates for home-based services under the Waiver. Potential candidates are Categorically Needy MA patients who qualify for SNF/ICF Care and express an interest in receiving those services in the community rather than a facility. The hospital social worker completes the CP-1 and CP-1.1 and notifies the DHS Case Manager.

Hospital Social Services Staff apprise each candidate of the availability of services either in an institutional setting or in a home-based setting under the Waiver program. Each recipient's choice is documented by a signed form, CP-12. The CP-12 is retained in the LTC/AS case record.

The DHS Case Manager carries out the following sequence of functions:

- The Case Manager meets (within one workday of notice when possible) with the hospital discharge team to design a care plan which compensates for all deficits identified on the CP-1 and CP-1.1. The Case Manager completes the CP-4 in order to ascertain the maximum amount available for home -based services under the Waiver. (CP-4, line 10).

- The service plan agreed to by the DHS Case Manager and the hospital discharge team is recorded by the Case Manager on the CP-3.

- The Case Manager discusses the Preliminary Care Plan with the patient and family and negotiates modifications.

- The Case Manager completes line 11-19 of the CP-4 to ensure that the planned services to not exceed the amount on line 10.

- When the plan is agreed to by the patient and family, the Case Manager completes the Individual Plan of Care (CP-5). The Case Manager discusses the allocation of the individual's income toward the cost of home-based services, and helps the individual select providers, when there is a choice.

- The Case Manager notifies the individual of his/her eligibility and the amount (if any) of contribution toward the cost of care by sending a CP-7.

- Before authorizing and arranging services, the Case Manager completes Forms CP-1, CP-1.1 or 70.1 or 72.1 as appropriate, and obtains a Level of Care from the LTC Unit at DHS Central Office, CP-3, CP-4, CP-5, and CP-99. The Case Manager will verify that the client has completed a CP-12.

Planning Alt Services - Comm

REV: 06/1994

The LTC/AS staff identifies likely candidates for home-based services under the Waiver. Potential candidates are Categorically Needy MA individuals who qualify for NF care and express an interest in receiving these services in the home rather than in a facility.

LTC/AS staff apprises each candidate of the availability of services in either an institutional setting or in a home-based setting under the Waiver program. Each recipient's choice is documented by a signed form, CP-12. The CP-12 is retained in the LTC/AS case record.

The LTC/AS worker (Case Manager) carries out the following sequence of functions:

- The LTC/AS worker (Case Manager) forwards a completed 72.1 and 70.1 to the Medical Review office at CO. The level of care will be issued on a MA 510 and sent to LTC/AS.

- The LTC/AS worker (Case Manager), in concert with the candidate, designs a care plan which compensates for the deficits identified. The Case Manager completes the CP-4 in order to ascertain the maximum amount available for home-based services under the Waiver (CP-4, line 10).

- The service plan agreed to by the Case Manager and the candidate is recorded by the Case Manager on the CP-3.

- The Case Manager discusses the Preliminary Care Plan with the candidate and family and negotiates modifications.

- The Case Manager completes lines 11-19 of the CP-4 to ensure that the planned services do not exceed the amount on line 10.

- When the plan is agreed to by the candidate and family, the Case Manager completes the Individual Plan of Care (CP-5). The Case Manager discusses the allocation of the individual's income toward the cost of home-based services and helps the individual select providers, when there is a choice.

- The Case Manager notifies the individual of his/her eligibility and the amount (if any) of contribution to the cost of care by sending a CP-7.

- Before authorizing and arranging services, the Case Manager completes forms CP-3, CP-4, CP-5, and CP-99.

Arranging/Authorizing Serv

REV:06/1994

As part of the Case Management function, the Case Manager arranges and authorizes a variety of services, including

- Homemaker/Personal Care Services;
- Adult Care Services;
- Devices to Adapt the Home Environment and Minor Assistive Devices; and
- Other Services.

0398.05.30.15 Homemaker/Personal Care Serv

REV: 06/1994

To arrange Homemaker/Personal Care services, the Case Manager telephones the provider selected to discuss the Service Plan and the beginning date of services. The provider is informed of the total amount of service to be purchased, and what share, if any, the recipient is responsible to pay directly.

The service recipient's share of the payment must be allocated to the first hours of service delivered in a provider/payroll period (four weeks). For example, thirty hours of service per payroll period are authorized and the recipient is responsible to pay for ten hours (form CP-4, line 19) and Medical Assistance is responsible to pay for twenty hours of services. In the event the provider delivers only twenty five hours of service, the recipient is still responsible for ten hours, and Medical Assistance is responsible for fifteen hours.

Homemaker Services are authorized on form HS-3. Four copies are completed. The original is sent to the Family and Adult Services Fiscal Unit at Central Office, one copy is sent to the provider, one copy to the recipient, and one copy is kept in the case record.

When the plan for service(s) is finalized, the individual is notified of his/her eligibility and the amount of his/her contribution toward cost of care by a CP-7. Copies of the CP-5, Individual Plan for Care and the appropriate authorization form, HS-3, is also sent.

The provider receives a copy of the Individual Plan of Care (CP-5) and a copy of the Authorization for Homemaker Services (HS-3).

Adult Day Care Services

REV: 06/1994

The Case Manager monitors the provision of home-based service at least once weekly for the first four weeks. If possible, the Case Manager should avoid modifying the service plan during the first thirty days to allow sufficient time for proper adjustment by the individual, family and providers.

All contacts with the recipient, family or providers are entered in the Activity Log (CP-2).

- The Case Manager is responsible to maintain appropriate contact with providers of home-based service.

The Case Manager learns the amount and duration of Home Health Services to be delivered under federal Medicare by contacting the visiting nurse who is responsible for completing the home assessment.

The Case Manager and the visiting nurse should discuss the total service plan to assure the adequacy and compatibility of the various services.

- The Case Manager will visit the recipient at home within thirty days following the start of Waiver services to reassess the service needs and to make appropriate adjustments in the service mix.

Dev for Home/Minor Assist Dev

REV: 06/1994

Certain durable medical equipment can be provided when it is necessary as part of a total care plan to prevent institutionalization. These are:

- Devices to adapt the home environment, such as portable ramps, grab bars and devices for adapting tubs and toilets. Installation is included in the purchase price and modifications requiring more than incidental construction are excluded; and,

- Minor assistive devices, such as grooming, eating and cooking aids and Personal Emergency Response Systems (PERS).

Provision of these items requires prior authorization from the Chief of Pharmacy Services in the Division of Medical Services.

The Chief of Pharmacy Services may be consulted if the Case Manager is not certain which vendors provide the required items.

If time is important, the Chief of Pharmacy Services can grant verbal authorization.

The process will be facilitated if a physical/occupational therapist participates on the hospital discharge team for patients who may require these items.

The Case Manager contacts the vendor who completes an MA-505. For, PERS, in addition to the MA-505 completed by the physician and the service provider, the LTC/AS Case Manager must evaluate the individual's suitability for the service. Factors to be considered are the individual's diagnosis, living arrangements, and physical and mental ability to use the PERS equipment properly. A memo detailing the evaluation accompanies the MA-505 to the Chief of Pharmacy Services. Once prior authorization has been received, the Case Manager calls the vendor to arrange delivery and/or installation.

Arranging Other Services

REV: 06/1994

The Case Manager should be familiar with the entire range of other services which may be brought to bear on existing deficits.

This includes the services provided under Medicare and Medical Assistance as well as those funded by other Federal, State, local or private sources. The Case Manger assists the individual in arranging these services.

Examples of services which may be used to complete the Individual Plan of Care are:

- Social services - from Family and Adult Services or other providers;

- Meals-on-Wheels;

- Transportation - from Senior Citizens Transportation (SCT) or informal providers;
- Recreational activities - senior citizens, church groups, service clubs;
- Universal services - beauticians or barbers who can serve the handicapped, legal services, financial advisors, consumer advisors, etc.

Monitoring Home-Based Service

REV: 06/1994

The Case Manager monitors the provision of home-based service at least once weekly for the first four weeks. If possible, the Case Manager should avoid modifying the service plan during the first thirty days to allow sufficient time for proper adjustment by the individual, family and providers.

All contacts with the recipient, family or providers are entered in the Activity Log (CP-2).

- The Case Manager is responsible to maintain appropriate contact with providers of home-based service.

  The Case Manager learns the amount and duration of Home Health Services to be delivered under federal Medicare by contacting the visiting nurse who is responsible for completing the home assessment.

  The Case Manager and the visiting nurse should discuss the total service plan to assure the adequacy and compatibility of the various services.

- The Case Manager will visit the recipient at home within thirty days following the start of Waiver services to reassess the service needs and to make appropriate adjustments in the service mix.

Reassessing Rec Elig and Need

REV: 06/1994

Reassessments of levels of care are completed at least every six months, or by the date indicated on the CP-1/MA510.

Redeterminations of eligibility for the Waiver Program are conducted annually, or more often, as appropriate.

To reassess the level of care, both the CP-1 and CP-1.1 are completed:

- Completion of the CP-1 assures that the individual continues to require the level of services provided in the nursing facility which is an eligibility requirement of the Waiver Program;
- Completion of the CP-1.1documents changes in the individual's functional ability so that the service plan can be modified accordingly.

The original and one copy of Page 1 of CP-1 are sent to the Medical Review Office at Central Office and a copy is kept in the record.

Home-Based For Mental Retarded

REV: 06/1994

Since July, 1983, the Department of Human Services (DHS), in conjunction with the Department of Mental Health, Retardation and Hospitals (MHRH), has offered a program to provide home and community-based services to mentally retarded individuals who would normally receive such services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The program is operated under a Waiver approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services. The Waiver allows the program to deviate from certain MA rules pertaining to eligibility determination and services provided to eligible recipients. This program supplements the existing scope of services already provided under Medical Assistance (MA) and by other programs and service providers. The program has become informally known as the MR Waiver Program.

The goals of the program are:

- To reduce and prevent unnecessary institutionalization by providing home and community-based services to eligible mentally retarded MA recipients; and,

- To provide the services at a cost less or equal to the cost of institutionalization.

Target Population

REV: 11/1994

The program is intended to reach individuals who are (or would be if institutionalized) Categorically Needy or Medically Needy Medical Assistance recipients; and,

1) have requested Waiver services in lieu of admission to an ICF/MR facility, and are determined by MHRH to be at risk of institutionalization; or,

2) are residents of an ICF/MR who will return to the community with services under the Waiver.

MHRH Case Managers identify potential candidates from the population of ICF/MR residents and at risk applicants described in Section 0398.10.20.05 below. The Case Manager at MHRH recommends the candidate for ICF/MR level of care by forwarding a CP-1 to the Medical Review Office. At the same time, for non-SSI recipients, an application and supporting documents are obtained by the MHRH Case Manager, and forwarded to the appropriate LTC/AS district office of DHS for a Determination of Eligibility (DOE).

Waiver Services

REV: 11/1994

Individuals eligible under the Waiver receive the Medical Assistance scope of services provided to Categorically Needy individuals or Medically Needy individuals, as appropriate. In addition to the

normal services, an array of special services is provided under the Waiver. The services are selected, arranged, authorized, re-mixed, monitored, and re-authorized by the Case Manager. In some cases, the individual is required to pay a part of the cost of the special Waiver services.

The special services provided under the Waiver are:

- **CASE MANAGEMENT**

  The coordination of the array of home-based services by Department of Retardation/Developmental Disabilities (DOR/DD) Case Managers who:

  - Establish and update an individual plan of care;
  - Arrange and authorize services;
  - Monitor and adjust the service mix;
  - Reassess the recipient's need for services and for ICF/MR level of care.

- **SPECIALIZED HOMEMAKER SERVICES**

  Household management and personal care services provided by licensed mental retardation agencies.

- **FAMILY LIVING ARRANGEMENTS**

  Household management in foster care homes. The individual's own income pays for room and board. The Waiver provides payment for services needed beyond room and board.

- **HOMEMAKER SERVICES/PERSONAL CARE SERVICES**

  General household duties such as cleaning, meal preparation, laundry, and personal care services (see Sec. 0530) provided when the normal provider (usually the relative with whom the recipient lives) is unavailable.

- **HOMEMAKER/LPN SERVICES**

  The monitoring of a complex or unstable medical condition such as frequent pneumonia, skin prone to breakdown, or cerebral palsy, beyond the level which can be furnished by a homemaker/personal care provider. In addition, patients must require mechanical and/or physiologic supports such as tracheotomy, colostomy, or catheter care. The service requires prior administrative approval at the level of Chief Caseworker Supervisor or above in DOR/DD.

- **RESPITE SERVICES**

  Temporary, care-giving services in the absence of the caretaker relative.

- **EARLY INTERVENTION**

  The provision of developmental activities to infants and toddlers with a developmental disability and the guidance and training offered to their parents.

- **MINOR ASSISTIVE DEVICES**

  Items such as grooming, eating, and cooking aids provided as part of a total case plan to prevent institutionalization.

- **MINOR MODIFICATIONS TO THE HOME**

  Minor modification to the home, such as ramps, grab bars, toilet modifications, etc. to enable the recipient who also has a physical handicap to use toilet facilities and be mobile.

Specific details of the Case Manager's functions are contained in the MHRH Division of Retardation's SOCIAL SERVICE MANUAL.

0398.10.15 DHS Responsibilities

REV: 11/1994

Long-Term Care/Adult Services (LTC/AS) Units conduct determinations and redeterminations of Categorically Needy or Medically Needy eligibility for MA. The LTC/AS units also calculate the amount of a recipient's income to be allocated to the cost of care (if any) and communicate the results of these determinations to individuals through the Case Managers at DOR/DD. The LTC/AS staff authorizes vendor payments for Specialized Homemaker Services. The Long-Term Care Unit at Central Office has the responsibility to review and approve/deny the level-of-care recommendations completed by DOR/DD.

0398.10.15.05 Deter. MA Eligibility, Non-SSI Recipient

REV:11/1994

Long-Term Care/Adult Services (LTC/AS) Units conduct determinations and redeterminations of Categorically Needy or Medically Needy eligibility for individuals considered for this program. Eligibility is determined by the appropriate LTC Staff as if the individual were entering an LTC facility. The individual must meet the normal citizenship/alienage, residency, enumeration, and disability requirements. For Categorically Needy eligibility, the individual must have resources within the Categorically Needy limits, and have monthly income less than the Federal Cap, as adjusted each January.

For Medically Needy eligibility, the individual must have income and resources within the Medically Needy limits.

The cost of services to be provided under the Waiver must be less than the average cost of institutional care. All standard resource and income verification procedures must be completed (including sending of AP-91s).

Form CP-31 is completed to notify the recipient (in care of the DOR/DD Case Manager)of the

decision. The original and one copy are sent to the DOR/DD Case Manager. The third copy is retained in the case file.

In addition, a CP-30 is completed to apprise MHRH of the eligibility decision and amount (if any) of income to be applied to the cost of services. One copy is retained for the DHS case file.

If the case is REJECTED, an AP-167M is completed in duplicate.

The original is sent to the recipient, (in care of the DOR/DD Case Manager) along with the CP-30, and the copy is retained for the DHS case file.

The DHS case file is the MA eligibility record. It is maintained in the LTC/AS field office. It contains all documents relating to the determination of financial eligibility. In addition, the CP-1 received via the Office of Medical Review at Central Office, copies of CP-30s and notices sent to recipients are retained in the case file.

For cases determined to be Categorically Needy by virtue of receipt of SSI, LTC/AS maintains a case file which contains the CP-1 forms which have been routed through and approved/denied by the Office of Medical Review at Central Office and documents relating to assessments of resource transfers, if any.

0398.10.15.10 Inc Alloc, Non-SSI Recip

REV: 06/1994

Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients determined eligible for Categorically Needy Medical Assistance by SSA under 1619(B)) is allocated to the cost of Waiver services. For others, once eligibility is determined, the individual's income is reviewed to determine the monthly amount (if any) that s/he must pay toward the cost of special Waiver services.

Staff of the LTC/AS Unit utilizes the CP-30 to inform the Case Manager at MHRH and the Business Manager of the Division of Medical Services of the recipient's monthly income allocated to the cost of Waiver services. LTC/AS staff used the CP-31 to notify the recipient (in care of the DOR/DD Case Manager) of the amount allocated to the cost of services.

0398.10.15.15 Redetermination of Elig

REV:06/1994

The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

The individual and Case Manager at MHRH are notified of any changes in eligibility status or allocation of income.

MHRH Responsibility

REV: 11/1994

Unlike the Long Term Care Alternatives Waiver Program for the Elderly and Disabled described in Section 0398.05, the case management function rests with staff in DOR/DD.

The case management function does not include determination of Medical Assistance eligibility or allocation of income.

The DOR/DD case management responsibilities include:

- Identifying potential Waiver services recipients;
- Determining need for ICF/MR level of care;
- Ascertaining the status of MA Categorically Needy or Medically Needy eligibility;
- Evaluating the cost-effectiveness of Waiver services;
- Ascertaining amount of income to be applied to cost of Waiver services;
- Coordinating home-based services.

Point of Entry

REV: 11/1994

Case Managers apprise potential recipients of the availability of Waiver services.

Potential recipients are:

- Categorically Needy or Medically Needy individuals who reside in ICF/MR facilities;

- Individuals who have requested services in lieu of admission to an ICF/MR and who are at risk of institutionalization because of one or more of the following conditions:

  - Individual living with only one family member;

  - Individual living with parents or family members over age 60;

  - Certain severely/profoundly retarded or developmentally disabled individuals, i.e. persons requiring total care;

  - Persons with severe behavior problems requiring specific behavior interventions more than once an hour.

0398.10.20.10 ICF/MR Level of Care

REV: ~~06/1994~~ August 2014

The Case Manager at MHRH Division of Retardation and Developmental Disabilities has responsibility to obtain information and evaluate an individual to determine if s/he requires the level-of-care provided in an Intermediate Care Facility/Mentally Retarded facility. If the evaluation indicates that the candidate requires an ICF/MR level of care, form CP-1 is completed by the Case Manager recommending the ICF/MR level of care. The "Waiver" block at the top of the CP-1 is checked, and the form is forwarded to

the Long Term Care Unit at Central Office for review and approval. All CP-1 forms are reviewed and approved by the Long Term Care Unit.

Medical Assistance Eligibility Status

REV: 11/1994

Prior to providing services under the MR Waiver program, and at each reassessment, the Case Manager must ascertain that the applicant is eligible for Medical Assistance. The procedures vary as outlined below.

- **SSI RECIPIENTS**

  SSI recipients are Categorically Needy for MA. Active SSI status must be verified at intake and reassessment. The LTC Unit has the responsibility to determine if a resource transfer exists that will impinge on Medical Assistance eligibility or eligibility for payment of nursing facility services or MR facility services.

- **NON-SSI RECIPIENTS**

  All other individuals are referred to DHS LTC/AS by the Case Manager for a determination of eligibility for MA. The procedures vary depending on whether or not the individual is receiving Social Security Disability Insurance Benefits (DIB).

  If the candidate RECEIVES disability benefits, the Case Manager forwards a completed and signed ~~DHS-1,~~ DHS-2 and CP-30 to the appropriate LTC/AS district office.

  If the candidate DOES NOT receive DIB, the Case Manager obtains a form AP-72.1 from the candidate's physician, and completes form AP-70.1 containing social information and functional abilities. Both forms are forwarded, along with the CP-1 (see above), to the Office of Medical Review at CO. The application for Medical Assistance is sent to the appropriate LTC/AS district office.

  The LTC/AS district office notifies the Case Manager of the eligibility decision by return CP-30. LTC/AS also routes notices to recipients in care of the DOR/DD Case Manager.

0398.10.20.20 Cost-Effective of Waiver Serv

REV: 06/1994

Home and community-based services provided to an individual as an alternative to institutional care must be cost-effective. The cost to Medical Assistance for providing Waiver services to an individual cannot exceed the average cost to provide in an institutional setting.

0398.10.20.25 Inc, Cost of Waiver Services

REV:06/1994

The Case Manager provides the LTC/AS district office with accurate income information, via the

CP-30, whenever there is a change in an individual's income, so that LTC/AS can accurately determine income to be applied to the cost of Waiver services.

Home-Based For Deinstit Elder

REV: 06/1994

Pursuant to Rhode Island General Laws 40-66-4, the Department of Human Services (DHS) and the Department of Elderly Affairs (DEA) jointly operate a program to allow certain institutionalized Medical Assistance recipients to return home with the provision of home-based services. The program is operated under a Waiver approved by the Health Care Financing Administration of the U.S.

Department of Health and Human Services. The Waiver allows the program to deviate from certain MA rules pertaining to eligibility determination and services provided to eligible recipients. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare and other programs and services.

The goals of the program are:

- To reduce unnecessary institutionalization by providing home and community-based services to elderly individuals who reside in Nursing Facilities so that the recipient is able to return to the community; and,

- To provide the services at a cost which is less than or equal to the cost of institutional care.

Target Population

REV: 06/1994

The program is designed to assist individuals who are:

- Over 65 years of age and receive Medical Assistance (as Categorically Needy or Medically Needy);

- Require the level of care provided in a Nursing facility; o Reside in a Nursing Facility at the point of application and are, with home-based services, potential candidates for discharge to the home where they will be homebound.

Case Managers at DEA identify candidates for the program from the population of Nursing Facility residents.

Waiver Services

REV: 06/1994

Waiver services recipients receive the normal scope of Medical Assistance services. In addition to the normal MA services, five special services are provided under the Waiver. Waiver services are provided only in a home setting. In some cases, the recipient may bear a portion of the cost of the Waiver services.

Waiver services are:

- **Case Management**

Case management refers to the identification, authorization and coordination of Waiver services provided to the recipient. Case management begins with the evaluation of the individual's needs and the development of an individual plan of care. The Case Manager arranges for and authorizes the services, and monitors their provision. Adjustments in the service mix are made based on periodic reassessments of the recipient's need for services;

- Homemaker/Personal Care Services as defined in Section 0530 of the DHS Policy Manual;

- Adult Day Care as defined in Section 0514 of the DHS Policy Manual;

- Minor Modifications to the Home

  Minor modifications to the home include such items as portable wheel chair ramps, grab bars, modifications to tubs and toilets.

- Minor Assistive Services

Minor assistive services are services such as cooking and eating aids, grooming aids and other devices which assist in the Activities of Daily Living.

Minor assistive services may include payment of the installation and monthly monitoring fee of a Personal Emergency Response System (PERS). The PERS is an in- home, twenty-four hour electronic alarm system which allows a functionally impaired homebound individual to signal a central switchboard in the event of an emergency. This service is limited to those individuals who are at high risk, physically vulnerable, who must live alone or spend prolonged periods of time alone. In addition, the recipient must be capable of understanding the purpose of the PERS and using it properly.

This service requires prior authorization by the individual's physician via the MA 505, evaluation by the LTC Case Manager and service provider (usually the hospital discharging the patient) and is subject to approval by the Chief of Pharmacy Services in the Division of Medical Services.

DHS Responsibilities

REV: 01/2000

The DHS Long Term Care/Adult Services (LTC/AS) Unit determines eligibility and calculates the recipient's income to be allocated to the cost of care (if any). These determinations are communicated to the individuals and Case Managers at DEA. The Long Term Care Unit at Central Office has the responsibility to review and approve the level of care assessments completed by DEA. Specific responsibilities include:

- Determinations of Eligibility for Medical Assistance SSI recipients are Categorically Needy recipients of Medical Assistance. LTC/AS must determine if the SSI recipient has transferred

resources. If no resource transfer has been made, no further determination of eligibility (or income allocation) is required.

For those individuals who will not be SSI recipients while living at home, the LTC/AS Unit is responsible for eligibility determinations and redeterminations.

- LTC/AS staff will process new and recertification applications forwarded by DEA. Individuals applying for this program may already be Medical Assistance eligible as determined by the appropriate LTC/AS Unit, or automatically eligible as an SSI recipient. Individuals may receive services under this program as Categorically or Medically Needy.

Eligibility determinations are conducted as if the candidates were institutionalized. An applicant who meets the technical and characteristic requirements, has resources within the Categorically Needy limits and income under the Federal Cap (See Section 0386.05), is certified as Categorically Needy. If the individual's income or resources exceed the Categorically Needy limits, s/he may be Medically Needy if resources are within the Medically Needy resource limits, and monthly income is less than the cost of all medical services.

- Recipients who are certified for MA receive a Notice of Eligibility. Individuals who are rejected or closed on Medical assistance are notified in the usual manner. The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

- Maintenance of DHS Case Files

The MA eligibility record that was established for the individual while s/he was institutionalized continues to be the MA eligibility record for the Waiver program. It is maintained in the LTC/AS field office and contains all documents relating to the determination of financial eligibility and income allocated to the cost of care.

- Allocation of Income to the Cost of Waiver Services Once eligibility has been determined, the DEA Case Manager calculates the individual's income to be applied to the cost of care, using forms CP-3 and CP-4. The completed forms are forwarded to the appropriate LTC/AS unit for review and approval.

- Review of Cost Effectiveness and Income Allocation The LTC/AS worker receives the completed CP-3, CP-4, CP-5A and CP-7A from DEA. S/he reviews and approves the DEA case manager's preliminary calculations of the cost effectiveness of Waiver services and the income to be applied to the cost of care. If approved, the LTC/AS worker countersigns the CP-7A and sends it and the CP-5A to the individual. If corrections are needed, the LTC/AS worker consults with the DEA Case Manager to make the necessary changes prior to notifying the individual.

DEA Responsibilities

REV: 04/2007

The case management function rests with DEA. The case management function does not include determination of MA eligibility.

Specific DEA responsibilities are:

- **Point of Entry Identification**

  DEA staff identifies potential candidates in the target population of aged MA recipients residing in Nursing Facilities. The DEA Case Manager evaluates the abilities and needs of the candidate and establishes a comprehensive care plan on Form CP-5A. The patient's attending physician must approve the plan to discharge the patient and provide home-based services.

- **Confirming MA Eligibility Status**

  Prior to providing services under the Waiver program, and at each reassessment, the Case Manager must confirm that the candidate is eligible for Medical Assistance and has an active case number. This is done by direct contact/referral to the LTC/AS unit.

- **Preliminary Calculation of Cost Effectiveness and Allocation of Income**

  The Case Manager at DEA completes a preliminary calculation of the cost effectiveness of program services, and the amount of income to be allocated to the cost of care. These determinations are subject to review and approval by the LTC/AS Unit. Once the individual plan of care is completed, Forms CP-3 and CP-4 are completed. The CP-3 worksheet is designed to assist the Case Manager to compile the monthly cost of the Individual's Plan of care. The CP-4 worksheet is used by the Case Manager to calculate the cost effectiveness of Waiver services compared to institutional services, the maximum amount that can be paid by Medical Assistance for Waiver services and the amount the individual must contribute.

- **Notification to Individuals Accepted into the Program**

  Individuals accepted into the Program are notified by the Case Manager and the LTC/AS worker by use of Form CP-7A. The CP-7A also apprises the individual of the amount of his/her income which must be contributed to the cost of care. Enclosed with the CP-7A is form CP-5A, the Individual's Plan of care. The forms are completed by the DEA Case Manager. The original and one copy are forwarded to the LTC/AS district office along with completed CP-3 and CP-4 for review and approval. If approved, the LTC/AS worker countersigns the CP-7A and sends the CP-7A and CP-5A to the individual.

- **Case Management**

  The case manager is the "hub" of all assessments and services to the recipient. This DEA staff person establishes and maintains the individual plan of care and subsequently monitors the provision of services to assure the individual's needs are met. The monitoring ensures that the health and welfare of the individual is protected.

  Specifically, the Case Manager will:

  - make a preliminary evaluation (using CP-4) of the cost-effectiveness of Waiver services and income to be allocated to the cost of services;

- secure an information release form signed by the candidate allowing DEA and DHS to share information regarding the candidate;

- apprise each candidate in writing of the availability of services in either an institutional setting or in a home-based setting under the Waiver. The candidate's choice is recorded on the CP-12A, forwarded to the LTC/AS for filing in the MA record with a copy retained by DEA for the individual's record;

- reassess the recipient's need for NF care at least every six (6) months;

- coordinate with the individual and LTC/AS the allocation of the individual's income to be applied to the cost of services.

- **Redetermining Need for Nursing Facility Care**

  The Case Manager at DEA has responsibility for re- evaluating every six (6) months the recipient's need for a Nursing Facility level of care. To remain eligible for the Waiver services, the individual must continue to require an institutional level of care. If the evaluation indicates nursing facility care is required, the Case Manager completes Form CP-1 and forwards it to the Long Term Care Unit at Central Office where it is reviewed and approved.

0398.30.05 Assisted Living Waiver Program

REV: 12/2000

Pursuant to R.I.G.L. 42-66.8, the Department of Human Services (DHS) received approval from the Health Care Financing Administration (HCFA) to administer a home and community-based waiver for up to two hundred (200) elderly and disabled individuals residing in Assisted Living Facilities. Initiated through the combined efforts of DHS, DEA, and the Rhode Island Housing and Mortgage Finance Corporation (RIHMFC), this innovative waiver not only utilizes existing facilities but, for the first time, develops and provides publicly financed housing units for assisted living purposes for frail elderly and disabled individuals.

The purpose of the Assisted Living Waiver program is to provide home and community-based services to eligible elderly and disabled individuals in qualified assisted living facilities as an alternative to nursing facility care at a cost which is less than or equal to the cost of institutional care.

Target Population

REV: 12/2000

The program is designed to assist individuals who:

- are over the age of sixty-five (65) or disabled;
- receive SSI or meet the categorically needy MA eligibility requirements for an institutionalized individual (income within the Federal Cap);
- require the level of care provided in a nursing facility; and
- reside or have the opportunity to reside in an Assisted Living Facility.

Waiver Services
REV: 12/2000

In addition to the normal scope of categorically needy services, the following special services are provided under the waiver:

- **Case Management Services**

  Services which assist individuals in gaining access to needed waiver, MA, and any necessary medical, social, or educational services. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care. In addition, they are responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

- **Specialized Medical Equipment and Supplies**

  Includes devices, controls, or appliances specified in the plan of care, which enable individuals to increase the ability to perform activities of daily living (ADLs), or to perceive, control or communicate in the environment in which they live.

  Also includes items necessary for life support, ancillary supplies and equipment necessary to proper functioning of such items, and durable and non-durable medical equipment not available to MA eligible individuals except as provided under this waiver. Items which are not of direct medical or remedial benefit to the individual are excluded. All items must meet applicable standards of manufacture, design and installation.

- Assisted Living Services: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

  Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to such arrangement) which must contain bedrooms and toilet facilities. The consumer has a right to privacy. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

  Also included are medication administration and transportation specified in the plan of care.

  MA payments for assisted living services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement, twenty four (24) hour skilled care or supervision.

Facility Certification Standards

REV: 12/2000

In addition to meeting all requirements of Rhode Island's assisted living licensing regulations, a facility must meet the following criteria in order to participate as a provider under this waiver:

- **Affordability**

  Providers must agree to make available up to 20% of their units to low-income and/or MA waiver individuals subject to demand and availability. Facilities with less than 20% low income/waiver occupancy are required to retain residents who exhaust their resources and convert from private pay to SSI/MA waiver status.

- **Design Guidelines**

  The architectural design of the facility should create a residential setting that emphasizes a "home-like" environment while providing for a supportive service infrastructure.

- **Occupancy requirements**

  Facilities must provide for single occupancy units with private bath and toilet. Double occupancy may be allowed in the case of consumer choice, i.e., spouses or siblings, upon approval of the Department of Elderly Affairs.

- **Service Requirements**

  Each facility must provide at a minimum a service package as follows:

  1. Direct assistance to residents with at least two (2) activities of daily living (ADLs) by a Certified Nursing Assistant (CNA) and including but not limited to assistance with bathing, continence, dressing, ambulation, toileting, eating and transfers.

  2. Assistance with housekeeping, medication management (with M-1 licensure), linen services, laundry services (including personal laundry, exclusive of dry cleaning), and such transportation services as may be specified in the plan of care.

  3. A program of social and recreational activities.

  4. Twenty-four (24) hour on-site staff adequate to meet scheduled or unpredictable needs in a way that promotes dignity and independence while maintaining provider supervision, safety, and security.

- **Participation Requirements**

  Owners of existing assisted living facilities who wish to participate in the Assisted Living Waiver Program must meet the standards stated above. The physical plant, financial capacity, adequacy of services, and commitment to servicing low-income individuals will be evaluated prior to approval of participation in the program.

DHS Responsibilities

REV: 12/2000

The DHS Center for Adult Health has the responsibility to review and approve or deny the level of care assessments completed by DEA.

The Center for Adult Health has the responsibility for:

- initial determinations and annual redeterminations of MA eligibility;
- review and approval of DEA's calculation of the recipient's income to be allocated to the cost of waiver services (if any);
- related InRhodes approval/denial;
- notification of agency action in accordance with 0376.25; and
- maintenance of the DHS case file.

DEA Responsibilities

REV: 12/2000

The case management function rests with DEA and may be performed by DEA or agency staff under contract to DEA. The case management function does not include determination of MA eligibility.

Specific DEA responsibilities are:

1. **POINT OF ENTRY IDENTIFICATION**

   DEA staff or DEA contracted staff identifies potential candidates in the target population of aged and disabled individuals residing in or seeking to reside in Assisted Living Facilities. Individuals may be referred to the
   waiver program by family, friends, facility staff, community based social service agencies, the LTC Ombudsman or through self-referral.

   The case manager contacts the appropriate LTC office and, when necessary, assists the individual in completing an application for Medical Assistance/LTC. The application is then forwarded to the appropriate LTC office for determination of eligibility.

2. **CONFIRMING MA ELIGIBILITY STATUS**

   Prior to providing services under the waiver program, and at each reassessment, the case manager contacts the LTC unit and confirms that the individual is eligible for Medical Assistance and has an active case number.

3. **PRELIMINARY CALCULATION OF COST-EFFECTIVENESS AND CALCULATION OF INCOME ALLOCATION TO COST OF CARE:**

The case manager completes a preliminary calculation of the cost effectiveness of program services, and the amount of income to be allocated to the cost of care. These determinations are subject to review and approval by the LTC unit. Once the individual plan of care is completed, forms CP-3 and CP-4 are completed by the case manager. The CP-3 worksheet is designed to assist the case manager in calculating the monthly cost of the individual's plan of care. The CP-4 worksheet is used by the case manager to calculate the cost effectiveness of waiver services compared to institutional services, the maximum amount that can be paid by Medical Assistance for waiver services, and the amount the individual must contribute towards the cost of care.

4. NOTIFICATION TO INDIVIDUALS ACCEPTED INTO THE PROGRAM

The CP-7A is used to notify individuals of acceptance into the program and to indicate the amount of any income which must be contributed to the cost of care. Enclosed with the CP-7A is form CP-5A, the Individual's plan of care. The forms are completed by the case manager. The original forms and one copy of each are forwarded to the appropriate LTC office along with the completed CP-3 and CP-4 for review and approval. If approved, the LTC worker countersigns the CP-7A and sends the CP-7A and CP-5A, along with forms used to request a hearing (AP-121 and 121A), to the individual.

5. CASE MANAGEMENT

The case manager evaluates and monitors the abilities and needs of the candidate and develops an individual written plan of care based upon the functional assessment used by DEA to measure the abilities, deficits and environmental modifications required. The informal supports that are available for each individual are incorporated into the plan. DEA's recommended plan of care is recorded on the CP-1 and forwarded to the DHS Office of Medical Review for approval. OMR's approval is recorded on the CP-1, and copies of the completed form are returned to DEA and the LTC office for incorporation into the case record.

The plan of care contains at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each services. A copy is retained in individual's record at both DEA and DHS for a minimum period of three (3) years.

Specifically, the case manager:

- makes a preliminary evaluation, using the CP-4, of the cost-effectiveness of waiver services and income to be allocated to the cost of services;

- secures an information release form signed by the candidate allowing DEA and DHS to share information regarding the candidate;

- apprises each candidate in writing of the availability of services in either an institutional or in a community assisted living setting under the waiver. The candidate's choice is recorded on the CP-12A, forwarded to the LTC unit for filing in the case record with a copy retained by DEA for the individual's record;

- assesses, reassesses and updates the recipient's plan of care at least every twelve (12) months to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability;

- monitors the provision of services included in the individual's plan of care; and

- coordinates with the individual, the LTC unit, and the assisted living facility the allocation of the individual's income to be applied to the cost of care.

6. REASSESSMENT OF NEED FOR NURSING FACILITY CARE

The case manager has the responsibility for re-evaluating the recipient's need for a nursing facility level of care at least every twelve (12) months. To remain eligible for the program, the individual must continue to require a nursing facility level of care. If reassessment indicates nursing facility care is required, the case manager completes and forwards form CP-1 to the Center for Adult Health, Long Term Care Unit at Central Office, where it is reviewed and approved.

0398.30.35 Eligibility Determinations

REV: 12/2000

To receive services under this waiver program, the aged or disabled individual must receive SSI or be eligible as a categorically needy institutionalized individual (income must be within the Federal Cap), reside in or have the opportunity to reside in an Assisted Living Facility meeting the certification requirements in Section 0398.30.20, and require a Nursing Facility level of care.

The DEA case manager assists the individual in completing the application and related forms needed to apply for Medical Assistance Waiver Services, and forwards the completed forms to the appropriate LTC office.

Individuals applying for this program may already be eligible for Medical Assistance as determined by the LTC Unit or a community MA unit, or automatically eligible as an SSI recipient. A new application is not required when a DHS-2 has been completed within the past twelve (12) months and the individual is still within a current certification period. In this case, the current case file may be used, together with any additional required documentation (e.g., information relating to trusts and transfers of resources), to determine eligibility for the program.

Eligibility determinations and redeterminations are conducted by appropriate Long Term Care (LTC) staff as if the individual were institutionalized. An applicant must meet the technical and characteristic requirements, have resources within the Categorically Needy limits and income under the Federal Cap in order to qualify.

When the individual has a community spouse, resources are evaluated in accordance with spousal impoverishment rules contained in Section 0380.40 - 0380.40.35. In the application of spousal impoverishment rules to waiver applicants or recipients, all Section 0380 references to institutionalized spouses and continuous periods of institutionalization include individuals receiving assisted living waiver services in lieu of institutional services.

Any transfer of assets must be evaluated in accordance with policy in Section 0384. The look-back period for evaluating transfers of assets is calculated from date the individual began receiving assisted living waiver services or the date of MA application, whichever is later.

Individuals are provided with written notice of eligibility or ineligibility in the usual manner. The LTC unit conducts redeterminations of eligibility each year, unless a change is anticipated sooner.

Individuals are required to report changes in circumstances, such as changes in income or resources, which could affect eligibility.

Maintenance of Case Files

The LTC unit is responsible for maintenance of both the electronic (InRhodes) and paper case file, which contains all documents and information relating to the determination of financial eligibility and income allocated to the cost of care.

Allocation of Income to the Cost of Care

Once eligibility has been determined the DEA Case Manager calculates the individual's income to be applied to the cost of care, using forms CP-3 and CP-4. The completed forms are forwarded to the appropriate LTC unit for review and approval.

Review of Cost-Effectiveness and Income Allocation

The LTC worker receives the completed CP-3, CP-4, CP-5A, and CP-7A from DEA. The LTC worker is responsible for review and approval of the DEA case manager's preliminary calculations of the cost effectiveness of Waiver services and the income to be applied to the cost of care. If approved, the LTC worker countersigns the CP-7A and sends it and the CP-5A to the individual. If corrections are needed, the LTC worker consults with the DEA Case Manager to make the necessary changes prior to notifying the individual.

Allocation of Income to Cost of Care

REV: 12/2000

All individuals receiving services under this waiver program are subject to the post-eligibility treatment of income and allocation of income to cost of waiver services. This includes those individuals receiving the enhanced SSI payment for Residential Care/Assisted Living, providing however that no part of the SSI Federal Benefit Rate (FBR) is allocated to the cost of waiver services.

The individual's income is allocated toward the cost of waiver services as follows:
FOR A SINGLE INDIVIDUAL

From the full gross income of a single individual the following amounts are deducted in the following order:

- **Personal/Maintenance Needs Allowance**

An amount equal to the facility's charge for room and board plus a $100 personal needs allowance, the combined total not to exceed the SSI standard for an individual in residential care/assisted living (See Section 0402.05).

The individual is allowed to retain $100 for personal needs, and is then responsible for paying the facility's charge for room and board.

- **Medical Insurance Premium**

- **Allowable Costs Incurred for Medical or Remedial Care FOR AN INDIVIDUAL WITH A COMMUNITY SPOUSE AND/OR DEPENDENTS**

From the gross income of the individual the following amounts are deducted in the following order:

- **Maintenance Needs Allowance -** as above

- **Spouse/Dependent Allowance**

  An amount of income may be allocated for the support of the community spouse in accordance with policy contained in 0392.15.20 - 0392.15.20.10. The community spouse may reside either with the individual in the assisted living unit or in the community.

  An additional amount of income may be allocated for support of other dependent family members who live with the community spouse following provisions contained in 0392.15.25.

  When there is no community spouse, an amount of income may be allocated for the support of dependent family members in accordance with Section 0392.15.25.05.

- **Medical Insurance Premium**

- **Allowable Costs Incurred for Medical or Remedial Care**

Any balance of income remaining after these expenses are deducted is allocated toward the cost of the waiver services. Note that the individual is responsible for paying the facility's charge for room and board.

0398.35.05 Habilitative Waiver Program

REV: 05/2002

The Department of Human Services received permission from the Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA) to administer a home and community based waiver for up to twenty-five individuals who require daily habilitative and/or ongoing skilled nursing services to a degree that would be otherwise provided in a hospital, and who do not qualify for the home and community based waiver for people with Developmental Disabilities.

The purpose of the Habilitative Waiver is to provide intensive home and community-based services to eligible elderly and disabled adults residing in a community setting as an alternative to

hospital care at a cost that is equal to or less than the cost of institutional care. For purposes of this waiver, hospital level of care is defined as a need for daily habilitative and/or ongoing skilled nursing services that cannot be adequately and/or appropriately provided in a nursing facility. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare and other programs and services.

Target Population

REV: 05/2002

The program is designed to assist individuals age eighteen (18) and older who:

- meet the MA requirement for disability or age (65 or older);
- meet the categorically needy or medically needy MA eligibility requirements for an institutionalized individual;
- require the level of care provided in a hospital; and
- do not meet developmental disability criteria. For purposes of this policy section, an individual is considered to meet developmental disability criteria if found to be developmentally disabled prior to age twenty-one (21) by the RI Department of Mental Health Retardation and Hospitals (MHRH) pursuant to R.I.G.L. 40.1-21-6.1.

Waiver Services

REV: 05/2002

In addition to the full scope of services provided to the Categorically Needy or Medically Needy, as appropriate, the following special services are available under the waiver:

- **Case Management Services**

  Provided by PARI Independent Living Center, these services are any that assist individuals in gaining access to needed waiver, MA, and any necessary medical, social, or educational services. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care, and development and review of plans of care. The Center for Adult Health is responsible for approving all levels of care and plans of care. The case manager is responsible for monitoring provision of services and appropriateness of approved plans of care, and submitting revisions, as needed to the Center for Adult Health.

- **Residential Habilitation**

  Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential Habilitation does not include the costs of room and board. Residential Habilitation Providers must be licensed with the Department of Mental Health, Retardation and Hospitals to be qualified to provide residential habilitation services under this waiver program.

- **Day Habilitation**

  Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the individual resides. Day Habilitation Providers must be licensed with the Department of MHRH to be qualified to provide day habilitation services under this waiver program.

- **Supported Employment Services**

  Paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Any person using this waiver service must be ineligible for an equivalent service funded by the DHS Office of Rehabilitation Services.

- **Environmental Accessibility Adaptations**

  Physical adaptations to the home, required by the individual's plan of care, which are required to ensure the health, welfare and safety of the individual, or which enable the individual to function more independently within the home, and without which, the individual would require institutionalization. Environmental Accessibility Adaptations are subject to approval for medical necessity by the Center for Adult Health.

- **Specialized Medical Equipment and Supplies**

  Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Specialized medical equipment and supplies are subject to approval for medical necessity by the Center for Adult Health.

- **Personal Emergency Response Systems (PERS)**

  PERS is an electronic device, which enables individuals to secure help in an emergency. PERS services are restricted to individuals who live alone, or are alone for significant parts of the day, and have no regular care giver for extended periods of time, and who would otherwise require extensive routine supervision. Individuals can only receive this service from Center for Adult Health qualified PERS providers.

- **Private Duty Nursing**

  Individual and continuous care provided by licensed nurses (Registered Nurses and/or Licensed Practical Nurses) with Physician orders within the scope of Rhode Island licensing guidelines. These services are provided only in an individual's home by Home Care or Home Nursing Care Agencies licensed with the RI Department of Health.

- **Rehabilitation Services**

  Physical, Occupational, and Speech Therapy services may be provided with a physician's

orders by Rhode Island Department of Health licensed Outpatient Rehabilitation Centers. These services supplement Home Health and Outpatient Hospital Clinic rehabilitation services already available under the Rhode Island State Plan when the individual requires a specialized rehabilitation service not available from a Home Health or Outpatient Hospital provider. The Center for Adult Health will approve rehabilitation services under the waiver as part of the plan of care.

DHS Responsibilities

REV: 05/2002

The DHS Long Term Care (LTC) Unit is responsible for determining MA eligibility and approving the amount of the recipient's income to be allocated to the cost of care. These determinations are communicated to the recipients and Case Managers at PARI.

The DHS Center for Adult Health has the responsibility for reviewing and approving level of care assessments and plans of care completed by PARI.

Specific DHS responsibilities related to the waiver are:

- **DETERMINATION OF ELIGIBILITY FOR MEDICAL ASSISTANCE**

  LTC workers have responsibility for processing applications forwarded by PARI and for determining eligibility for waiver services both for new MA applicants and current SSI or MA-only recipients.

  A new DHS-2 is not required if one was completed within the past twelve (12) months, and the individual is within a current certification period. In this case, the current case file is used, together with documentation of any new or additional information (e.g., information relating to transfers of assets) needed to determine eligibility for the program.

  Eligibility determinations for applicants of the Waiver Program are conducted as if the applicant were institutionalized. Any transfers of assets must be evaluated in accordance with policy contained in Section 0384. A recipient who meets the technical and characteristic requirements, has resources within the Categorically Needy limits and income under the Federal Cap (see section 0386.05), is certified as Categorically Needy. Individuals are certified as low income (equivalent to categorically needy) when income is at or below one hundred percent (100%) of the federal poverty level and resources are within the Medically Needy resource limits. If the individual's resources are within the Medically Needy resource limit, s/he may be Medically Needy if resources are within the Medically Needy resource limits, and monthly income is less than the cost of all medical services.

- **REDETERMINATION OF ELIGIBILITY**

The LTC unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

- **MAINTENANCE OF THE DHS CASE FILE**

The DHS InRhodes and paper case files are the MA eligibility record. Case files are maintained in the LTC office and contain all documents relating to the determination of financial eligibility and income allocated to the cost of care. In addition, the CP-1 and plan of care received via the Center for Adult Health, and copies of the CP-40's, the CP-12, and notices to recipients are retained in case files.

- **ALLOCATION OF INCOME TO THE COST OF WAIVER SERVICES**

Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients who are Categorically Needy under 1619(b) of the Social Security Act) may be allocated to offset the cost of Waiver services. For other recipients of Waiver services, once eligibility is determined, the recipient's income is reviewed to determine the monthly amount, if any, the recipient must pay toward the cost of Waiver services.

The LTC worker is responsible for reviewing and approving the calculation of the individual's income to be applied to the cost of care.

- **APPROVING LEVELS OF CARE AND PLANS OF CARE**

The Center for Adult Health will review and approve all Levels of Care and Plans of Care prior to the Plans of Care being implemented. In the event of an urgent situation, the Center can give a verbal authorization.

- **CALCULATING AGGREGATE COST NEUTRALITY**

The Center for Adult Health will review and assure aggregate cost neutrality on an annual basis.

PARI Responsibilities

REV: 05/2002

The case management function rests with PARI. The case management function does not include any determination of MA eligibility or post eligibility treatment of income.

Specific PARI responsibilities are:

- **POINT OF ENTRY IDENTIFICATION**

PARI staff takes referrals and identifies potential candidates in the target population to assure that the essential program criteria are met. The PARI Case Manager evaluates the abilities and needs of the candidate and works with the individual to develop a comprehensive plan of care that assures the candidate's needs are met. The PARI Case Manager is responsible for submitting the Plan of Care to the Center for Adult Health Office for approval.

- **ASSESSING NEED FOR HOSPITAL LEVEL OF CARE**

The case manager at PARI has responsibility for evaluating the applicant's need for a level of care provided in a hospital. If the evaluation indicates the individual requires hospital level care, the Case

Manager completes form CP-1 and forwards it to the Center for Adult Health. Records of evaluations and reevaluations of level of care are maintained by case managers at PARI and at DHS.

When an individual is determined to be likely to require a hospital level of care, the individual is informed of any feasible alternatives available under this waiver, and given the choice of either institutional or home and community based services.

- **CONFIRMING MA ELIGIBILITY STATUS**

Prior to providing services under the waiver program, and at each reassessment, the Case Manager must confirm that the candidate is eligible for the waiver.

- **CASE MANAGEMENT**

The Case Manager is the "hub" of all assessments and services to the individual. The PARI staff person is responsible for the development and implementation of approved plans of care and subsequently monitors the provision of services to assure that individual needs are met. The monitoring assures that the health and welfare of the recipient is protected. The case manager will meet with the individual at least one time each quarter to monitor provision of services.

Specifically, the Case Manager will:

1. Develop and update an individual plan of care. The Case Manager evaluates the candidate's needs in order to reside in the community, designs a plan of care with the candidate that addresses these unmet needs. The plan of care will specify the provider, goals, amount, and duration of any waiver service to be provided. The plans of care must be submitted to and approved by the Center for Adult Health prior to implementation. Copies of the plans of care must be retained by case managers for a period of at least three (3) years.

2. Notify the Center for Adult Health of cases whose plans of care could exceed cost neutrality;

3. Apprise each individual in writing of the availability of services in either an institutional setting or in a community-based setting under the waiver. The individual's choice is recorded on the CP-12A, signed and forwarded to the LTC for filing in the MA record;

4. Arrange authorized services;

5. Reassess the individual's need for hospital level care at least every twelve months;

6. Coordinate with the individual, LTC/AS, and providers of services the allocation of the individual's income to be applied to the cost of Waiver services.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
Code of Rhode Island Rules

DIVISION FOR HEALTH CARE QUALITY, FINANCING AND PURCHASING
MEDICAL ASSISTANCE PROGRAM

Section 0399
MEDICAL SERVICES COVERAGE
MA PROVIDER REFERENCE MANUALS
(EFFECTIVE JANUARY 2, 2002
As amended September 2015)

Medical Assistance *Provider Reference Manuals*: Preamble – 0399.001. The RI Medical Assistance Program established the *Provider Reference Manuals* (PRMs) to centralize information about Medical Assistance (MA) health coverage and payment policies and procedures for participating providers. The PRMs were last published in 1996 and have been updated on an as needed basis, through amendments and supplements, at regular intervals since then. The PRMs cover:

- Rehabilitation, Vision and Waiver Services Providers
- Hospital/Home Health Services Providers
- Podiatry, Long-term Care, Pharmacy and Physician Services Providers
- Ambulance, Laboratory, Dental, DME and Hearing Services Providers
- General Public Assistance Medical Coverage Providers

Duty to Comply – 0399.002. All current and prospective MA providers are bound to follow the applicable policies and procedures governing participation, covered services and payment in the Medical Assistance Program set forth in the appropriate *Provider Reference Manual* (1996), as revised 1997 *et.seq*.

Maintenance and Distribution – 0399.003. The Department of Human Services (DHS), or contractual agents acting on DHS's behalf, are responsible for distributing and maintaining the *Provider Reference Manuals* and ensuring that participating providers receive timely notice of changes in policies or procedures necessitated by federal and State laws and regulations.

Access and Availability – 0399.004. Copies of the *Provider Reference Manual*s may be obtained, upon request, by contacting DHS's fiscal agent by telephone (401-784-3829) or the Center for Adult Health in writing (Hazard Building, 74 West Road, Cranston, Rhode Island, 02920). On-site inspection and review of the PRMs is available, by appointment, at the DHS Office of Policy Analysis, Research and Development, Hazard Building, 74 West Road, John O. Pastore Complex, Cranston, RI 02920. Call 401-462-2018 to make an appointment during business hours from 8:30am — 4:00pm.

0399 THE GLOBAL CONSUMER CHOICE WAIVER

0399.01 OVERVIEW

REV:07/2009

One of the most important goals of the Global Consumer Choice Compact Waiver (Global Waiver) is to ensure that every beneficiary receives the appropriate services, at the appropriate time, and in the appropriate and least restrictive setting. To achieve this goal for long-term care (LTC) services, the waiver provides the state with the authority to collapse its existing section 1915 (c) home and community based service waivers (HCBS), which have different eligibility criteria and services, into its newly approved section 1115 (a) Global Waiver. Under the Global Waiver, the scope of services available to a beneficiary is not based solely on a need for institutional care, but is based on a comprehensive assessment that includes, but is not limited to, an evaluation of the medical, social, physical and behavioral health needs of each applicant.

0399.02 Transition to the Global Waiver

REV: 07/2009

The authority for the State of Rhode Island to provide home and community-based services transitions from the authority found in 1915(c) of the Social Security Act to that found in Section 1115 of the Act on July 1, 2009. The transition in authority allows the State to implement new needs-based levels of care, expand the number of individuals that can access long-term care services, and increase the availability of home and community- based services. On June 1, 2009 letters were sent to all Home and Community-based Waiver participants notifying them of the transition in authority. The agencies with authority to determine access for LTC prior to July 1, 2009, shall retain that authority subsequent to the transition date unless otherwise stated in this rule.

0399.03 ACCESS TO LONG-TERM CARE

REV: 07/2009

For the purposes of this section, Medicaid funded long-term care is defined as institutional services or home and community-based services and supports. Long-term care services are designed to help people who have disabilities or chronic care needs to optimize their health and retain their independence. Services may be episodic or ongoing and may be provided in a person's home, in the community (for example, shared living or assisted living), or in institutional settings (for example, intermediate care facilities, hospitals, or nursing homes).

0399.04 TYPES OF LONG-TERM CARE

REV: 07/2009

To achieve the goal of rebalancing the long-term care system, the Global Consumer Choice Compact Waiver allows beneficiaries to obtain the Medicaid services they need in the most appropriate least restrictive setting. The types of long-term care available to beneficiaries

are categorized as institutional and home and community- based.

0399.04.01 Institutional Long-Term Care

REV: 07/2009

Beneficiaries that meet the applicable clinical eligibility criteria may access institutional long-term care services in the following facilities:

a) Nursing Facilities (NF). A beneficiary is eligible to access Medicaid-funded care in a nursing facility when it is determined on the basis of a comprehensive assessment, as defined in Sections 0399.05.01.02 and 0399.11, that the beneficiary has the highest level of care needs (See Section 0399.12.01).

b) Intermediate Care Facility for the Mentally Retarded (ICF/MR). A beneficiary qualifies for an ICF/MR level of care if the beneficiary has been determined by the MHRH to meet the applicable institutional level of care. Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.

c) Long-term Acute Care Hospital - Eleanor Slater Hospital (ESH).A beneficiary qualifies for a long-term acute care hospital stay if the beneficiary has been determined to meet an institutional level of care by the MHRH and by the DHS.

Beneficiaries residing in an NF, ICF/MR and ESH are considered to be in an institution for the purposes of determining eligibility. The Medicaid payment for institutional care is reduced by the amount of the beneficiary's income after certain allowable expenses are deducted.

Other rules applicable to institutional care and services are located in the Sections of 0378.

0399.04.02 Home and Community Based Long-Term Care

REV: 09/2013

The Global Waiver authorizes the state to offer an array of home and community-based services to members as an alternative to institutionalization. Home and community-based long-term care services and supports (HCB/LTC Services) are in addition to the services otherwise provided under the Medicaid program.

0399.04.02.01 Core and Preventive HCB/LTC Services

REV: 09/2013

1) Core HCB/LTC services include the following broad categories of services:

Homemaker	Adult Companion Services
Environmental Modifications	Personal Care Assistance
	Respite

Minor Environmental Modification Services	
Special Medical Equipment	Day Supports, including Adult Day Services
Home Delivered Meals	Supported Employment
Personal Emergency Response	RIte @ Home (Shared Living) Services
Licensed Practical Nurse (Skilled Nursing)	Private Duty Nursing Services(including Registered Nurse)
Community Transition	Supports for Consumer Direction
Residential Supports	Case Management
Participant Directed Goods and Services	PACE
Assisted Living	

Assisted Living, PACE and RIte @ Home are defined in greater detail in Sections 0399.20.01, and 0399.20.02.

2.) Preventive Services: Persons who are eligible for Community Medical Assistance and who have been determined to meet a preventive level of care, have access to the following services: Homemaker Services, Minor Environmental Modifications, Personal Care Assistance Services, Physical Therapy Evaluation and Services and Respite.

0399.05 ELIGIBILITY REQUIREMENTS

REV: 07/2009

To qualify for Medicaid-funded long-term care services under the Global Waiver, a person must meet the general and financial eligibility requirements as well as meet certain clinical eligibility criteria.

The general eligibility requirements for Medicaid are set forth in Sections 0300.25 and 0300.25.20.05 respectively. Income and resource eligibility rules for Medicaid eligible persons who are likely to be residents of an institution (as specified in Section 0399.04.01) for a continuous period and who have a spouse living in the community are found in Sections 0380.40-0380.40.35 and 0392.15.20- 0392.15.30. See also the applicable income and resource provisions in the long-term care Sections from 0376 to 0399.Clinical eligibility is determined by an assessment of a beneficiary's level of care needs. Under the Global waiver, the income and eligibility rules in these Sections will apply to persons who are likely to receive home and community-based core services for a continuous period. That is, persons meeting the highest or high level of care who reside in the community.

In Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30, all references to institutionalized spouses and continuous periods of institutionalization will include those institutionalized spouses receiving home and community-based services in lieu of institutional services.

0399.05.01 Clinical Eligibility- Scope & Applicability

REV: 07/2009

The level of care criteria that must be met for intermediate care facilities for the mentally retarded and hospitals and community-based service alternatives to these institutions on June 30, 2009 shall remain in effect until such time as needs- based criteria have been adopted and applicable rules promulgated by the department(s) responsible for administering programs serving beneficiaries, as indicated below.

New needs-based clinical criteria have been established to determine access to nursing facilities or community-based alternatives to nursing facilities. The new needs based clinical levels of care DO NOT apply to beneficiaries eligible to receive Medicaid-funded long-term care services who were living in institutions on or before June 30, 2009.

The pre-waiver level of care criteria in effect as of June 30, 2009 applies to beneficiaries who were living in a nursing facility on or before June 30, 2009 unless or until the beneficiary transitions to home and community based services because he or she: (a) improves to a level of care that no longer meets the pre-waiver level of care criteria - that is, the beneficiary no longer qualifies for an institutional level of care under the criteria in effect on or before June 30, 2009; or (b) the beneficiary chooses home and community based services over the institution.

Accordingly, a beneficiary eligible for and residing in a nursing facility on or before June 30, 2009, who chooses to move to the community, shall be assessed using the new needs-based level of care at the time eligibility is re-determined. A beneficiary who makes this choice is eligible for long-term care as "highest need" if the department determines at any time that: (1) the beneficiary meets at least one of the clinical eligibility criteria for highest need; or (2) the beneficiary does not meet at least one of these criteria but nevertheless has a critical need for long-term care due to special circumstances that may adversely affect the beneficiary's health and safety. Such special circumstances include a failed placement as well as other situations that may adversely affect a beneficiary's health and safety specified Section 0399.12.01.01.

The new needs-based levels of care DO apply to beneficiaries eligible to receive Medicaid-funded long-term care services who are living in the community on or before June 30, 2009. The new levels of care will apply beginning with the beneficiary's annual re-assessment. If a person met the institutional level of care criteria in the past, he or she will meet either the highest or high level of care in the future, and eligibility for long-term care services will continue without interruption, providing all other general and financial eligibility requirements continue to be met.

When assessing beneficiaries living in the community using the needs-based level of care criteria, a beneficiary is clinically eligible as highest need if the department determines, as above, that the beneficiary meets at least one of the clinical eligibility criteria for highest need; or, absent that, the beneficiary has a critical need for long-term care due to special circumstances as specified in Section 0399.12.01.01.

The needs-based levels of care will apply to all persons seeking Medicaid funded long-term care services provided in a nursing facility or community alternative to that facility on or

after July 1, 2009.

Persons seeking Medicaid-funded long-term care services and supports administered by the Department of Mental Health, Retardation, and Hospitals (MHRH) will continue to meet the clinical eligibility standards in effect - that is, the level of care of intermediate facility for the mentally retarded/developmental disabled (ICFMR/DD) until such time as a needs-based set of criteria are developed in accordance with the terms and conditions established under the waiver. Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.

Persons seeking Medicaid-funded long-term care services provided in a long-term care hospital or in a community-based alternative to the hospital will continue to need to meet an institutional level of care. This applies to individuals who would have sought services under the 1915(c) Habilitation Waiver.

Beneficiaries currently eligible for community Medical Assistance who are not clinically eligible for long-term care may be eligible for a limited range of home and community based services if they meet the criteria to qualify for preventive care (see "preventive need" in Section 0399.12.03). The availability of such services shall be limited, depending upon funding.

0399.05.01.02 Needs-based LTC Determinations

REV: 07/2009

The processes for determining clinical eligibility are based on a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each beneficiary. The assessment shall be tailored to the needs of the beneficiaries services and, as such, may vary from one process to the next. Based on this assessment, the needs of the beneficiary are classified as "highest" or "high" to reflect the scope and intensity of care required and the range of services available. Beneficiaries already eligible for community MA who do not meet the highest or high level of care but are at risk for institutionalization may access certain short-term preventive services.

There are two general types of services available to beneficiaries - core and preventive (see description in section 0399.10.20). An individual care plan is then developed that identifies the LTC core and preventive services and settings appropriate to meet the beneficiary's needs within the specified service classification.

The scope of services accessible to a beneficiary varies in accordance with individual needs, preferences, availability, and the parameters established in the Global Waiver and/or federal and state regulations, rules or laws. For example, a beneficiary with the highest need may be able to obtain the full range of services he or she needs at home or in a shared living arrangement, but may choose, instead, to access those services in a skilled nursing facility.

Community-based care includes PACE and accessing services through a self-directed model.

A beneficiary determined to meet the high need may have access to care in the home and community based setting - including PACE -- and self- directed care, but does not have the option of nursing facility care.

0399.05.01.03 LTC Level of Care and Service Option Matrix

REV: 07/2009

LTC LEVEL OF CARE AND SERVICE OPTION MATRIX

HIGHEST	HIGHEST	HIGHEST
Nursing Home Level of Care	Hospital level of Care	ICF/MR Level of Care
(Access to nursing to facilities and all community-based	(Access to Hospital, Residential Treatment Centers and all services Community-Based Services)	(Access to ICF/MR and all Community Based Services)
HIGH	HIGH	HIGH
Nursing Home Level of Care (Access to Community- Based Services)	Hospital Level of Care (Access to Community-Based Services)	ICF/MR Level of Care (Access to Community-Based Services)
PREVENTIVE	PREVENTIVE	PREVENTIVE
Nursing Home Level of Care (Access to Community-Based Services)	Hospital Level of Care (Access to Preventive Community-Based Services)	ICF/MR Level of Care (Access to Preventive Community-Based Services)

0399.06 ASSESSMENT & COORDINATION ORGANIZATION (ACO)

REV: 07/2009

The Assessment and Coordination Organization (ACO) is a set of four (4) processes established across the health and human service departments that assist applicants/recipients and their families in gaining access to and navigating the LTC system. In this respect, the ACO is not a separate and distinct entity, but a set of interrelated activities from across the departments that serve the goal of rebalancing the long-term care system.

The four processes included in the ACO are as follows:

a) Information and Referral. The State provides information and referrals about publicly-funded LTC to individuals and families through a variety of sources across agencies. The ACO is responsible for enhancing and coordinating these resources to ensure that every person seeking Medicaid-funded LTC services has access to the information they

need to make reasoned choices about their care. The Department of Human Services shall enter into inter-agency agreements with each entity identified or designated as a primary source of information/referral source for beneficiaries of long-term care.

b) Eligibility Determination. Through the ACO, the Department of Human Services determines financial eligibility for long-term care services provided across agencies.

Clinical eligibility is based on a comprehensive assessment of a person's medical, social, physical and behavioral health needs. Responsibilities for clinical eligibility are as follows:

- Clinical eligibility to receive services in a nursing facility or community alternative to that institution will be determined by DHS, utilizing needs-based criteria.

- Clinical eligibility to receive services in a long-term care hospital or community alternative to the institution will be determined by DHS and MHRH, as appropriate, utilizing an institutional level of care.

- Clinical eligibility to receive services in an intermediate care facility or community alternative to that institution will be determined by the Department of Mental Health Retardation and Hospitals, using an institutional level of care.

- The entities that conduct the assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity.

c) Care Planning. The comprehensive assessment used to determine clinical eligibility and additional information provided by the beneficiary and/or family members is used by the responsible agency to develop an individualized care plan, identifying the scope and amount of services required to meet the beneficiary's needs as well as the full array of service/care setting options. ACO care planning activities include establishing funding levels for the care and/or the development of a budget for self-directed services or the provision of vouchers for the purchasing of services.

d) Case management/evaluation. The activities of the various agencies and/or their contractual agents designed to ensure beneficiaries are receiving scope and amount of services required to optimize their health and independence. The broad range of services includes periodic review of service plans, coordination of services with the beneficiary's acute care management entity (Rhody Health Partners, RIte Care, or Connect Care Choice), and quality assurance. Depending on the agency and the population served, this may be performed by multiple entities working in collaboration or a single entity.

0399.06.01 Initiating Assessment & Coordination Process

REV: 07/2009

A screening tool developed by the DHS in collaboration with the health and human services agencies is used to determine the most appropriate placement and/or service referral for each

applicant for LTC. Based on the results of this screen, referrals proceed as follows:

a) Beneficiaries determined to have a potential need for Medicaid funded long-term services and supports in a NF or the community alternative to a NF are referred to the DHS;

b) Beneficiaries determined to have a potential need for State- only funded long-term services and supports, including transportation and the DEA Co-Pay Program, are referred to the DEA;

c) Beneficiaries determined to have a potential need for services for persons with developmental disabilities are referred to the MHRH;

d) Beneficiaries determined to have a potential need for long- term hospital services are referred to MHRH;

e) Beneficiaries determined to have a potential need for behavioral health services for a child or for an adult are referred to the DCYF or MHRH, respectively;

f) Beneficiaries who are not seeking information on long-term care services are referred to the appropriate agency, unit or entity. For example, information on acute managed care options is currently provided by the RI-DHS Enrollment Hotline.

0399.07 LTC OPTIONS COUNSELING PROGRAM

REV: 07/2009

A long-term care options counseling program is designed to provide beneficiaries and/or their representatives information concerning the range of options that are available in Rhode Island to address a person's long-term care needs. The options discussed include the institutional care available, the home and community-based care that is available and how to access these services. The sources and methods of both public and private payment for long-term care services are addressed.

An initial screening to determine how a person would be most appropriately served is conducted. This screening includes a determination of the need for crisis intervention, the available sources of funding for services, and the need for community services, Medicaid, or other publicly funded services.

A person who applies for Medicaid long-term care services shall be provided with a long-term care consultation.

A person admitted to or seeking admission to a long-term care facility regardless of the payment source shall be informed by the facility of the availability of the long-term care options counseling program and shall be provided with a long-term care options consultation if they so request.

0399.08 COST NEUTRALITY FOR HCB SERVICES

REV: 07/2009

The DHS is responsible for reviewing and approving the aggregate cost neutrality of the home and community based long-term care system on an annual basis. To meet cost neutrality, the average per capita expenditures for home and community-based services cannot exceed one hundred percent (100%) of the average per capita expenditures of the cost of institutional services if the individuals had been institutionalized

The average monthly costs to Medicaid by institution are:

* Nursing Facilities $ 5,531.00
* ICF-MR $18,758.34
* Eleanor Slater Hospital $24,195.00

The DHS uses these average monthly costs to Medicaid to assist in determining whether home and community-based services are cost effective as required under Title XIX of the Social Security Act.

0399.10 OVERVIEW: DETERMINATIONS OF NF LEVEL OF CARE

REV:07/2009

The Global Waiver allows long-term care services to be provided in an institutional or home and community-based setting depending on the determination of the beneficiary's needs, individual plan of care, and the budget neutrality parameters established under the Global Waiver. Beneficiaries with care needs in the NF category also have an option for self-direction.

The service classifications designed to reflect the scope and intensity of the beneficiary's needs in this category are as follows:

a) Highest need. Beneficiaries with needs in this classification have access to all core services defined in Section 0399.04.02.01 as well as the choice of receiving services in an institutional/nursing facility, home, or community-based setting.

b) High need. Beneficiaries with needs in this classification have been determined to have needs that can safely and effectively be met at home or in the community with significant core services. Accordingly, these beneficiaries have access to an array of community-based core services required to meet their needs specified in the individual plan of care.

c) Preventive need. Beneficiaries who do not yet need LTC but are at risk for the NF level of care have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in a skilled nursing facility. Core home and community- based services are not available to beneficiaries with this level of need. Medicaid beneficiaries, eligible under Section 0399.12.03, who meet the preventive need criteria, are not subject to the LTC financial eligibility criteria established in Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30.

0399.10.01 Agency Response for Determining Level of Care

REV:07/2009

Beginning on July 1, 2009, beneficiaries determined to have a potential need for Medicaid-funded long-term services and supports in a nursing facility or in the community are referred to the Assessment and Coordination Organization (ACO) processes administered by the Department of Human Services (DHS).Those applying for state-only funded services and supports are referred to ACO processes administered by the Department of Elderly Affairs (DEA). The agency entities authorized to carry out these ACO processes are responsible for:

a) Coordinating related activities with the Medicaid financial eligibility staff; b) Conducting assessments that determine level of care needs; c) Developing service plans with the active involvement of beneficiaries and their families; d) Establishing funding levels associated with care plans developed for each beneficiary; e) Reviewing service plans on a periodic basis; and f) Working in collaboration with the beneficiary's care management plan or program (Connect Care Choice; PACE; Rhody Health Partners) to ensure services are coordinated in the most effective and efficient manner possible.

Financial eligibility for Medicaid-funded long-term care is conducted by the DHS field staff in accordance with Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30.

Determinations of clinical level of care needs for nursing facilities are made by the DHS Office of Medical Review (OMR) nurses for both DHS and DEA beneficiaries.

0399.11 CLINICAL ELIGIBILITY ASSESSMENT TOOL

REV: 07/2009

In determining clinical eligibility, the OMR staff uses an assessment instrument based on the nationally recognized Minimum Data Set (MDS) 2.0 Tool for NF care. To make the final determination of care needs, the results of this assessment are mapped against the needs-based and institutional level of care criteria. The DHS shall make available to the public the procedural guidelines for use of the assessment as well as the instrument itself.

0399.12 APPLICATION OF NF LEVEL OF CARE CRITERIA

REV: 07/2009

Upon completing the assessment, the OMR staff determines whether a beneficiary's care needs qualify as highest, high or preventive based on a set of criteria that reflect both best practices across the states and the standards of prevailing care within the LTC community in Rhode Island. Clinical eligibility based on these criteria is set forth in the following Sections.

0399.12.01 Highest Need

REV: 07/2009

Beneficiaries shall be deemed to have highest level of care need when they:

a) Require extensive assistance or total dependence with at least one of the following Activities of Daily Living (ADL) - - toilet use, bed mobility, eating, or transferring AND require at least limited assistance with any other ADL; or

b) Lack awareness of needs or have moderate impairment with decision-making skills AND have one of the following symptoms /conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, resists care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; or

c) Have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and training; or

d) Have one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions requiring skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to, at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis, respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding, behavioral or psychiatric conditions that prevent recovery.

0399.12.01.01 Exceptions -- Highest Need

REV: 07/2009

Beneficiaries who do not meet the criteria to establish highest need as indicated in the previous Section may be deemed clinically eligible for this level of care if the OMR determines that the beneficiary has a critical need for long-term care services due to special circumstances that, if excluded from this level of care, may adversely affect the beneficiary's health and safety. These special circumstances include but are not limited to:

1. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse);
2. Loss of living situation (e.g. fire, flood, foreclosure, sale of principal residence due to inability to maintain housing expenses);
3. The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
4. The beneficiary's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.)
5. The beneficiary met the criteria for a nursing facility level of care on or before June 30, 2009 and chose to receive Medicaid LTC at home or in a community setting when, upon reassessment by the department and, when appropriate, in consultation with the Rhode Island Long-term Care Ombudsman, the beneficiary is determined to have experienced a failed placement that, if continued, may pose risks to the beneficiary's health and safety; or
6. The beneficiary met the criteria for highest need on or after July 1, 2009 based on an assessment using the needs-based level of care and chose to receive Medicaid LTC at home or in the community setting when, upon reassessment by the department and, when appropriate, in consultation with the Rhode Island Long-term Care Ombudsman, the beneficiary is placement that, if continued, may pose risks to the beneficiary's health and safety.

The criteria for determining whether a failed placement has or is occurring shall be developed by the department of human services in conjunction with the department of elderly affairs and any other interested state agencies, community agencies, committees and/or consumers and shall be made available to the public once adopted as an amendment to this section and/or a formal procedure.

0399.12.02 High Need

REV: 07/2009

Beneficiaries shall be deemed to have the high level of care need when they:

a) Require at least limited assistance on a daily basis with at least two of the following ADL's: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; or

b) Require skilled teaching or rehabilitation on a daily basis to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; or

c) Have impaired decision-making skills requiring constant or frequent direction to perform at least one of the following: bathing, dressing, eating, toilet use, transferring or personal hygiene; or

d) Exhibit a need for a structured therapeutic environment, supportive interventions and/or medical management to maintain health and safety.

0399.12.03 Preventive Need

REV: 09/2013

Beneficiaries who meet the preventive need criteria shall be eligible for a limited range of home and community-based services and supports along with the health care they are entitled to receive as recipients of Medicaid. Preventive care services optimize and promote beneficiary health, safety and independence through an array of care interventions that alleviate or minimize symptoms and functional limitations.

Accordingly, the goal of preventive services is to delay or avert institutionalization or more extensive and intensive home and community-based care.

To qualify, the OMR must determine that one or more preventive services will improve or maintain the ability of a beneficiary to perform ADL's or IADL's and/or delay or mitigate the need for intensive home and community-based or institutionally based care. Preventive services for beneficiaries include:

a) Homemaker Services- Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

b) Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devises or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles to improve home accessibility adaptation, health or safety.

c) Personal Care Assistance Services – Personal Care Services provide direct hands on support in the home or community to an individual in performing Activities of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided to an individual by:

1. A Certified Nursing Assistant who is employed under a State licensed home care/home health agency and meets such standards of education and training as are established by the State for the provision of these activities.

d) Physical Therapy Evaluation and Services - Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

e) Respite - Respite can be defined as a service provided to a participant unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.

0399.12.03.01 Limitations -- Preventive Need

REV: 07/2009

Access to and the scope of preventive services for qualified beneficiaries may be limited depending on the availability of funding. The DHS may establish wait lists, in accordance with the provisions established in Section 0399.14, if such limitations become a necessity.

0399.13 REASSESSMENTS -- HIGH AND HIGHEST NEED

REV: July 2016

Change in Needs - High and Highest. Beneficiaries determined to have high need at the time of a reassessment, or in the event of a change in health status, shall be determined to have the highest need if they meet any of the clinical eligibility criteria established for that level of care.

0399.13.01 Re-Eval of Beneficiaries with Highest Need

REV: 07/2009

At the time the OMR makes a determination of highest need for a beneficiary who resides in or is admitted to a nursing facility, information indicating whether there is a possibility that the beneficiary's functional or health care condition may improve, within a two month period is identified. The OMR notifies the beneficiary, his/her authorized representative and the nursing

facility that NF level of care has been authorized and that the beneficiary's functional and medical status will be reviewed in thirty (30) to sixty (60) days.

At the time of the review, the OMR confirms that the beneficiary is still a resident of the nursing facility. Once this determination is made, the OMR reviews the most recent Minimum Data Set and requests any additional information necessary to make one of the following determinations:

a) The beneficiary no longer meets the criteria for highest level of need. In this instance, the beneficiary, and/or his/her authorized representative, and the nursing facility are sent a discontinuance notice by the Long Term Care Unit. Prior to being sent a discontinuance notice, the beneficiary will be evaluated to determine whether or not the criteria for high need have been met. Payment for care provided to a beneficiary determined to no longer have the highest need shall continue until the DHS has completed the transition to a more appropriate setting.

b) The beneficiary continues to meet the appropriate level of care, and no action is required.

Beneficiaries residing in the community who are in the Highest and High groups will have, at a minimum, an annual assessment.

0399.14 LIMITATIONS ON THE AVAILABILITY OF SERVICES

REV: 07/2009

Should the demand for home and community-based long-term care services exceed supply or appropriations, beneficiaries with the highest need shall have the option of seeking admission to a nursing facility while awaiting access to the full scope of home and community-based services. Specifically, beneficiaries and applicants in the highest category are entitled to services and shall not be placed on a waiting list for institutional services. If a community placement is not initially available, they may be placed on a wait list for transition to the community.

In the event that a waiting list for any home and community- based service becomes necessary for any reason, the DHS must provide services for beneficiaries determined to be highest need before providing services to beneficiaries that have a high need or preventive need.

Beneficiaries with high need are given priority access to services over beneficiaries qualifying for preventive services.

Additionally, beneficiaries receiving services must continue to have access to and receive such services unless their condition improves and they no longer meet the same clinical eligibility criteria.

0399.15 LIMITATIONS ON ENVIRONMENTAL MODIFICATIONS, MINOR ENVIROMENTAL MODIFICATIONS AND SPECIAL MEDICAL EQUIPMENT

REV: 09/2013

Members who meet the Highest and High Level of Care (LOC) for core Home and Community Based services and have a functional necessity for Environmental Modifications, Minor

Environmental and Special Medical Equipment are subject to limitations and special considerations, therein.

0399.15.01 Environmental Modifications

REV: 09/2013

Environmental Modifications are defined as those physical adaptations to the home of the member or the member's family as required by the member's service plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to attain or retain capability for independence or self-care in the home and to avoid institutionalization, and are not covered or available under any other funding source. A completed home assessment by a specially trained and certified rehabilitation professional is also required. Such adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts. Excluded are those adaptations that are of general utility, are not of direct medical or remedial benefit to the member. Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector.

Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations shall be provided in accordance with applicable State or local building codes and prior approval on an individual basis by EOHHS, Office of Long Term Services and Supports is required.

Items should be of a nature that they are transferable if a member moves from his/her place of residence.

A. Home Modifications Limitations:

- All items require Prior Authorization and do not require a physician's order.
- All items must be recommended by an appropriately trained and certified rehabilitation professional.
- The Home Modification must be documented as the most cost- effective to meet the member's needs for accessibility within the home.
- Items must be necessary to ensure the health, welfare and safety of the individual, or to enable the individual to attain or retain capability for independence or self-care in the home, and to avoid institutionalization.
- Home Modifications shall be made only to the member's primary residence, including rented apartments or houses (with written permission of the owner/landlord, when applicable).
- Exterior access modifications are limited to one ingress/egress route into and out of the home.
- Repair, removal, construction or replacement of decks, patios, sidewalks and fences are not covered.
- Home Modifications do not include those adaptations or improvements to the home that are considered to be standard housing obligations of the owner or tenant.
- Relocation of plumbing and/or bathroom fixtures is not covered.
- Repairs or modifications to equipment purchased under this definition are an allowable expense.
- Examples of items not covered include driveways, decks, patios, hot tubs, central heating and

air conditioning, raised garage doors, standard home fixtures (i.e., sinks, tub, stove, refrigerator, etc.), raised counter tops, roll-in-showers or tub cuts.

- Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector.
- Requirements for Modifications to rental property include:
  - Prior to any modification a determination should be made as to what, if anything, is the legal responsibility of the property owner or landlord.
  - Written approval must be obtained from the property owner or landlord prior to the service being approved.
- Ramps may be covered only if:
  - They meet ADA compliance, and
  - Meet all applicable State and local building code requirements and permits as required.
  - Ramp should be of a nature that it is readily transferable to another dwelling.
- Vertical Platform Lifts may be covered only if:
  - There is not adequate acreage available to install a ramp that meets state and local building codes.
  - The physical topography of the site precludes the installation of a ramp.
- Interior Stairway Lifts (stair glides) may be approved only if:
  - The first floor of the home does not have any toilet facilities.

B. Special Considerations:

An Assessment for Home Modifications is required to determine the most appropriate and cost-effective service requested.

This assessment must be completed by a specially trained and certified rehabilitation professional. Individuals conducting such assessments may include:

- Licensed Physical, and Occupational Therapists experienced in Home and Community Based services
- Assistive Technology Professionals (ATP), certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA - An assistive technology professional is a service provider who analyzes the needs of individuals with disabilities, assists in the selection of the appropriate equipment, and trains the consumer on how to properly use the specific equipment.)

C. Limitation on Service(s)

This is only available to Medicaid members on Core HCBS.

- This service is billable under HCPCS Code S5165.

0399.15.02 Special Medical Equipment

REV: 09/2013

Special Medical Equipment and supplies to include Ceiling or Wall Mounted Patient Lift, Track

System, tub slider system, rolling shower chair and/or Automatic Door Opener, which enable members to increase their ability to perform activities of daily living, including such other durable and non-durable medical equipment not available under the Medicaid-funded primary and acute care system that is necessary to address member functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid-funded primary and acute care system and exclude those items that are not of direct medical or remedial benefit to the member. Medical equipment funded under the primary and acute care system includes items such as wheelchairs, prosthetics, and orthotics. These are services that were provided under the authority of the Rhode Island Medicaid State Plan prior to the 1115 Waiver approval. These items are still available under the 1115 Waiver and are described at:
http://www.dhs.ri.gov/ForProvidersVendors/ServicesforProviders/Provider Manuals/DME/tabid/459/Default.aspx All items shall meet applicable standards of manufacture, design and installation. Provision of Special Medical Equipment requires prior approval on an individual basis by EOHHS, Office of Long Term Services and Supports and a home assessment completed by a specially trained and certified rehabilitation professional. Items should be of a nature that they are transferable if a member moves from his/her place of residence. Excluded are any re- modeling, construction, or structural changes to the home, (i.e. changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector.

A. Limitations:

- Ceiling or Wall Mounted Patient Lifts and Track Systems
  - Must be documented as the most cost-effective method to meet the member's needs.
  - A Patient Lift will be considered for use in one bedroom and/or one bathroom.
  - A Track System is limited to connecting one bedroom and one bathroom.
- Excluded are any re-modeling, construction, or structural changes to the home, (i.e. changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector.
- Rolling shower chair/Tub Slider System
  - Item must have a functional expectancy of a minimum of five (5) years.
  - Must be documented as the most cost-effective method to meet the member's needs.
- Automatic Door Openers, adapted switches and buttons to operate equipment, and environmental controls, such as heat, air conditioning and lights may be approved for a member who lives alone or is without a caregiver for a major portion of the day.
- All items require Prior Authorization by EOHHS, Office of Long Term Services and Supports and do not require a physician's order.
- Repairs or Modifications to equipment purchased under this definition are an allowable expense.
- Items not listed above may be acquired subject to Prior Authorization from EOHHS, Office of Long Term Services and Supports. Determinations will be based on the individual's unique circumstances as they apply to the current service definitions, policies and regulations. Please refer to RI Global Consumer Choice Compact 1115 Waiver Demonstration Attachment B, Core and Preventive Home and Community Based Service definitions.

B. Special Considerations:

An Assessment for Special Medical Equipment is required to determine the most appropriate and cost-effective service requested.

This assessment must be completed by a specially trained and certified rehabilitation professional. Individuals conducting such assessments may include:

- Licensed Physical, Occupational Therapists experienced in Home and Community Based services
- Assistive Technology Professionals (ATP), certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA - An assistive technology professional is a service provider who analyzes the needs of individuals with disabilities, assists in the selection of the appropriate equipment, and trains the consumer on how to properly use the specific equipment.)

C. Limitation on Service(s):

This is only available to Medicaid members on Core HCBS.

- This service is billable under HCPCS Code T2029.

0399.15.03 Minor Environmental Modifications
REV: 09/2013

Minor Environmental Modifications
Minor Environmental modifications may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles to improve home accessibility adaptation, health or safety.

A. Limitations:

- All items require Prior Authorization by EOHHS, Office of Long Term Services and Supports; however items on the EOHHS Approved List do not require a physician's order.
- All items must be recommended by an appropriately trained and certified health care professional or DHS social worker.
- Items must be necessary to ensure the health, welfare and safety of the individual, or must enable the individual to attain or retain capability for independence or self-care in the home, and to avoid institutionalization.
- Items for diversional or entertainment purposes are not covered.
- Items should be of a nature that they are readily transferable if a recipient moves from his/her place of residence.
- Items cannot duplicate equipment provided under the Medicaid- funded primary and acute care system or through other sources of funding (i.e. Medicare, private insurance).
- Items not included on the EOHHS Approved List and priced greater than $500.00 shall be considered Special Medical Equipment and will be subject to the policies and procedures for that service as described in the Core Services section of the Rhode Island 1115 Waiver.
- This service is billable under HCPCS Code T2028, for Core HCBS and/or preventive services.

0399.20 OVERVIEW: LTC RESIDENTIAL SERVICE OPTIONS

REV: 07/2009

There are several community-based service options in residential settings, other than the home and nursing facilities, which may be available to beneficiaries who are determined under Sections 0399.12.01 and 0399.12.02 to have a need for the highest or high level of care.

Beneficiaries will be notified of whether they qualify for one of these residential options in conjunction with the comprehensive assessment specified in Sections 0399.05.01.02 and 0399.11 and the development of the individualized plan of care. Although Medicaid coverage for room and board is typically not included for these options, there are exceptions as is explained in the description of services provided below.

0399.20.01 Assisted Living

REV: 07/2009

Assisted living services are available to qualified long-term care (LTC) beneficiaries who have been determined to have a highest or high level of care need that can be safely and effectively met in a state licensed assisted living residence that has also been certified as a Medicaid provider. The responsibility for certifying licensed assisted living residences as Medicaid providers is shared by the Executive Office of Health and Human Services, the Department of Human Services or the Department of Elderly Affairs. Certification standards adopted by these agencies in effect on June 30, 2009 shall remain in effect under the Global Consumer Compact Waiver until October 1, 2009, by which time the office and the departments shall develop and implement new certification standards that broaden the scope and availability of assisted living services to the full extent permitted by state law and appropriations.

For the purpose of this rule, assisted living services are defined as: personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), transportation to medically necessary appointments, therapeutic social and recreational programming, when specified, provided in a home- like environment in a licensed community care facility in conjunction with residing in the facility. The services provided to beneficiaries by assisted living residences certified as Medicaid providers for the purposes of R.I.G.L. I 42.66.8-3 must also include those set forth in section 0300.20.20. Beneficiaries opting for services in the assisted living residences covered under this section of state law may be subject to waiting lists as the number of beds certified for Medicaid purposes is capped. Such beneficiaries shall have the option of seeking assisted living services in other Medicaid certified residences, depending on the scope of their needs as indicated in the individualized plan of care.

Note: Medical equipment funded under the primary and acute care system includes items such as wheelchairs, prosthetics, and orthotics. These are services that were provided under the authority of the Rhode Island Medicaid State Plan prior to the 1115 Waiver approval. These items are still available under the 1115 Waiver and are described at:
http://www.dhs.ri.gov/ForProvidersVendors/ServicesforProviders/Provider Manuals/DME/tabid/459/Default.aspx

0399.20.02 RIte @ Home (Shared Living)

REV: 09/2013

RIte @ Home is defined as personal care, homemaker, chore, attendant care and related services provided in a private home setting by a care provider who lives in the home. RIte @ Home is a service provided to Medicaid beneficiaries eligible for long-term care services who are elderly or adults with disabilities who are unable to live independently and who meet the highest or high level of care as determined through the evaluation conducted by the Assessment and Coordination Organization as specified in Section 0399.06. Each Medicaid beneficiaries opting for RIte @ Home services will have a RIte @ Home Service and Safety Plan, developed to meet their own unique, individual needs.

RIte @ Home providers approved by EOHHS to serve Medicaid beneficiaries shall be selected in accordance with the standards developed for such purposes under the auspices of the Executive Office of Health and Human Services. These program standards vary by population served so as to ensure services can be tailored to better meet the needs of beneficiaries.

0399.20.02.01 Scope and Limitations

REV: 07/2009

Shared living certification standards and options developed and implemented by the Department of Mental Health, Retardation and Hospitals (MHRH) in effect on June 30, 2009 shall remain in effect under the Global Waiver unless or until such time as the MHRH determines otherwise.

Section 0399.21
Repealed in its Entirety July 2016

July 21, 2016
0399finaljuly2016

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1300:

Overview of Affordable Care Coverage in Rhode Island

December 2013
March 2014 (T)
June 2014

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1300:

Overview of Affordable Care Coverage in Rhode Island

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1300 of the Medicaid Code of Administrative Rules entitled, "Overview of Affordable Care Coverage in Rhode Island"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in the "Access to Medicaid Coverage Under the Affordable Care Act: New and Existing Eligibility Groups" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State as a technical amendment on March 6, 2014.

1300 Affordable Care Coverage in Rhode Island

1301.01 Overview

The goal of the federal Affordable Care Act (ACA) of 2010 is to improve access to high quality health coverage for people of all ages and income levels. In keeping with this purpose, the ACA made several significant changes in Medicaid requirements and offered the states the opportunity to expand eligibility to childless adults and to recast Medicaid as one of the forms of affordable care coverage that consumers can access through state-administered health insurance exchanges. Rhode Island is among the states that elected to take both options shortly after the enactment of the ACA.

The principal focus of ACA implementation in Rhode Island over the last two years has been building a unified, web-based information processing system with the capacity to determine eligibility for both publicly and privately-financed forms of affordable coverage, including Medicaid. To maximize access, the ACA required the adoption of a single standard for evaluating the income-eligibility of anyone applying for affordable coverage, irrespective of payer – that is, whether paid for in whole or in part by Medicaid, federal premium tax credits or cost-sharing subsidies, or by an employer or some other payer. This standard – modified adjusted gross income (MAGI) – uses information from federal tax filings to determine income and, in doing so, the range of affordable coverage choices available to an applicant. Accordingly, Rhode Island's new unified health information system uses this standard and is, as such, designed to be the eligibility engine for accessing affordable coverage through the State's health insurance benefit exchange, HealthSourceRI, as well as Medicaid.

On October 1, 2013, HealthSourceRI and the affordable care eligibility system that provides its functionality went live. Medicaid-eligible members of the ACA expansion group – adults 19 to 64 without dependent children – were able to access the system and use a single, stream-lined application to apply for Medicaid and all other forms of affordable coverage available through the ACA. On January 1, 2014, Medicaid eligibility for most other people under the age of sixty-five (65) also will be determined through this system. Over the course of the next two years, the functionality of the system will be gradually expanded to cover Medicaid eligibility determinations for individuals who are aged, blind or disabled or in need of long-term services and supports.

1300.02 Scope and Purpose

The January 1, 2014 start date for implementing the Medicaid provisions of the ACA, expanding coverage and transitioning to the new MAGI-based eligibility system have all required the State to make significant changes in the program requirements for the Medicaid-eligible individuals and families that will be affected. Taken together, these changes will result in a fundamental redesign of many aspects of the Medicaid program and render the rules that govern them obsolete. Rather than overhauling the applicable rules already on the books, the State has elected use to establish a new chapter in the Medicaid Code of Administrative Rules (MCAR) that sets forth in plain language the rules governing access to affordable coverage through the Medicaid program beginning on January 1, 2014. The purpose of this rule is to establish the role and responsibilities of the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, in implementing the provisions in the rules in each section of the new code, and to provide a general summary of the changes that will take effect on January 1, 2014.

1300.03 Applicability
REV: June 2014

Effective January 1, 2014, the rules in this chapter govern Medicaid eligibility for all NEW applicants subject to the MAGI standard in the following Medicaid Affordable Care Coverage (MACC) groups:

(01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

Individuals and families eligible to receive Medicaid in these coverage groups are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 and, if eligible, at annual renewals thereafter.

Excluded Medicaid-eligible Coverage Groups

The rules in this chapter to do not apply to:

- ACA Exemption – The ACA excludes certain Medicaid coverage groups from MAGI-based eligibility determinations. These groups are referred to as "Non-MAGI Coverage Groups" throughout this chapter. The ACA exemption applies to persons who are aged, blind, or with disabilities and eligible under MCAR sections 0582 or in need of long-term services and supports (LTSS) under the eligibility requirements in MCAR 0376. The exemption also extends

to individuals who qualify for Medicaid based on their eligibility for another publicly funded program, such as children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Payment Program.

Special Provisions

MCAR section 1315 applies exclusively to parents/caretakers with income between 133% and 175 % of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended). All other rules in this chapter do not apply.

1300.04 The Medicaid Single State Agency –

RI Executive Office of Health and Human Services (EOHHS)

Rhode Island General Laws section 42-7.2-2 created the Rhode Island Executive Office of Health and Human Services (EOHHS) in 2006. EOHHS sits within the executive branch of State government and serves "as the principal agency of the executive branch of state government for managing the departments of children, youth and families, health, human services, and behavioral healthcare, developmental disabilities and hospitals."

The EOHHS is designated as the "single state agency", authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq.*), and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program. The agency is headed by a Secretary, appointed by the Governor with the advice and consent of the Senate.

01. General Duties -- The EOHHS has been delegated the following duties and responsibilities in leading the State's four (4) health and human services departments in order to:

- Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting and financing;
- Design strategies and implement best practices that foster service access, consumer safety and positive outcomes;
- Maximize and leverage funds from all available public and private sources, including federal financial participation, grants and awards;
- Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments;
- Ensure that State health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf. (See Rhode Island General Laws section 42-7.2-2 *et seq.*).

The four state agencies under EOHHS possess and maintain the legal authority to execute their respective powers and duties in accordance with their statutory authority.

02. Single State Agency – In its capacity as the Single State Agency, the responsibilities of the EOHHS are as follows:

(01) Federal law and regulations. As the designated Single State Agency, federal law and regulations, the EOHHS must:

- Administer or supervise the administration of the Medicaid program in accordance with the Medicaid State Plan;
- Maintain sole authority for the promulgation of rules governing the administration of the State Plan that are binding on the EOHHS and any entities delegated with the responsibility to administer any facet of the program;
- Assure eligibility determinations are performed in accordance with all applicable State Plan requirements and federal and State laws and rules and regulations whether performed by the EOHHS or another public agency approved in the State Plan to serve this purpose;
- Determine which providers are "certified" as qualified to furnish Medicaid covered benefits;
- Establish the rates and methods for making payment to certified providers who deliver covered benefits;
- Administer a system for collecting and paying claims in a timely manner;
- Assure the quality of care provided to Medicaid members;
- Institute control mechanisms designed to minimize improper payments resulting from unintended errors, as well as fraud and abuse; and
- Provide a system for resolving grievances by applicants, beneficiaries, and providers.

(02) State law and regulations. In addition to the responsibilities of the Medicaid agency set forth in federal law and regulations, Secretary of EOHHS, as the chief executive of the Medicaid Single State Agency, has the following duties:

- Coordinate the administration and finance of Medicaid-funded benefits and services provided under the Medicaid State Plan and the State's Medicaid Section 1115 demonstration waiver;
- Serve as the Governor's chief advisor and liaison to federal policymakers on Medicaid reform issues as well as the principal point of contact in the state on any such related matters.
- Review any Medicaid State Plan amendments, waiver extensions, amendments or requests, and initiatives requiring Medicaid funding to assess their overall impact and to ensure they are legally and fiscally sound and in the best interest of consumers,

- Prepare an annual Medicaid expenditures report;

- Develop and submit and integrated Medicaid budget; and

- Ensure Medicaid program quality and integrity.

03. Agency organization -- The EOHHS is organized into five units, each of which focuses on one of the agencies core functions: Office of the Secretary, Financial Management, Policy and Innovation, Legal Services, Program Integrity and Publicly Financed Health Care (Medicaid). The units work in collaboration with one another and with the leadership of the departments to achieve greater efficiency in the organization, finance, design and delivery of services.

04. Medicaid programs and operations – The Medicaid program is located in the Office of Publicly Financed Health Care and operates under the general supervision of the Secretary of EOHHS. The Department of Human Services (DHS) has been designated through an interagency agreement with the EOHHS to perform eligibility determinations for Medicaid-eligible adults who are aged, blind or disabled as well as persons seeking Medicaid-funded long term services and supports. The DHS also is responsible for providing assistance to individuals and families applying for Medicaid in the Medicaid Affordable Care Coverage (MACC) groups identified in MCAR section 1301. A full description of the Medicaid program and the responsibilities of the EOHHS, and its designees, in the organization, finance and delivery of services are located on the agency website at: www.eohhs.ri.gov.

1300.05 The Medicaid Section 1115 Waiver

The EOHHS is the principal agency with responsibility for implementing the Rhode Island's Section 1115 demonstration waiver (formerly the Global Consumer Choice Compact Waiver). The waiver gives the State the authority to make changes in Medicaid requirements to pursue initiatives that promote the goals. The EOHHS has used the flexibility the waiver affords the State to:

- Continue efforts to re-balance the system of long term services and supports by assisting people in obtaining care in the most appropriate and least restrictive setting;

- Achieve greater utilization of care management models that offer a health home and provide an integrated system of services;

- Use smart payment and purchasing strategies that encourage and reward quality outcomes to finance and support Medicaid initiatives that fill gaps in the integrated system of care; and

- Recognize and assure access to the non-medical services and supports, such as peer navigation and employment and housing stabilization services that are essential for optimizing a person's health, wellness and safety and reducing or delaying the need for long term services and supports.

The Section 1115 waiver also provides the EOHHS with the authority to obtain federal matching funds for Medicaid services to individuals who are at risk of becoming eligible for high cost long term care.

1300.06 EOHHS and ACA Implementation

The EOHHS is responsible for implementing the program expansions the State has elected to pursue under the ACA as well as working with the Lieutenant Governor's Task Force and other State agencies, offices and departments that have been involved in establishing the affordable care eligibility system. Additionally, the EOHHS has been collaborating with the departments to expand the capacity of the eligibility system to include other health and human services programs and to explore opportunities under the ACA to support this effort and other initiatives that improve health care quality, access and affordability for eligible Rhode Islanders.

Every unit within the EOHHS has been involved to some degree in performing these and other tasks related to the implementation of the ACA. Principal duties of the EOHHS include collaboration, as appropriate, with other State agencies in:

- Developing ACA-related changes in policies, procedures and rules;
- Preparation and submission of State Plan and Section 1115 waiver amendments;
- Coordinating application and eligibility procedures for affordable coverage;
- Providing the public with adequate notice and the opportunity for comment on ACA-related changes in policies, rules, procedures and State Plan and Section 1115 waiver amendments;
- Assuring easy access to Medicaid coverage by implementing a "No Wrong Door" policy;
- Instituting a state-wide readily accessible Contact Center to facilitate ease of application, enrollment and renewal;
- Offering consumers the help of highly trained Navigators and personal assistors to guide them through the application process; and
- Ensuring there are adequate resources to sustain ACA-related innovations and reforms.

1300.07 Significant ACA-Related Changes in the Medicaid Program

The following provides a summary of the major changes in the Medicaid program authorized or mandated by the ACA and the applicable rules in this chapter:

- Consolidation and simplification of Medicaid coverage groups subject to MAGI-based eligibility determinations – MCAR section 1301.
- Elimination of Medicaid eligibility for parents/caretakers with income from 133% to 175% of the FPL – MCAR 1301.

- Expansion of Medicaid eligibility to adults, ages 19 to 64, without dependent children and establishment of a new Medicaid affordable care coverage group – MCAR section 1301.

- Streamlined application process through the automated affordable care eligibility system – MCAR 1303.

- Standardization of Medicaid eligibility requirements for MACC coverage groups – MCAR Section 1305.

- Establishment of passive renewal process for making determinations of continuing eligibility – MCAR section 1306.

- Implementation of the MAGI-based income standard – MCAR section 1307.

- Automated verification of eligibility requirements through federal and State data sources – MCAR section 1308.

- Elimination of premiums in the RIte Care managed care delivery system and redefinition of RIte Care coverage groups – MCAR section 1309.

- Enrollment of the MACC coverage group for adults without dependent children in a Rhody Health Partners managed care plans with a modified benefit package – MCAR section 1310.

- Modifications of the managed care enrollment system to complement changes in the application and eligibility determination processes – MCAR section 1311.

- Changes in the RIte Share premium assistance program to complement ACA initiatives, remove premiums, and add a buy-in requirement – MCAR section 1312.

- Extension of the Communities of Care requirement to MACC expansion group – MCAR section 1314.

- Implementation of a limited subsidy program for parents/caretakers with income from 133% to 175% of the FPL who are no longer eligible for Medicaid affordable care coverage – MCAR section 1315.

1300.08 One Application, No Wrong Door, Medicaid First

- One application --The State's affordable care system uses one streamlined application to evaluate eligibility for all types of coverage, including Medicaid.

- No Wrong Door -- Applicants can apply on-line on their own through links on the EOHHS and DHS websites or HealthSourceRI.com, or with the assistance of a Navigator, or DHS agency or Contact Center representative. Applications are accepted through the web-portal, in person at the Contact Center and DHS field offices and by mail and telephone.

- Medicaid First -- Once an application is submitted, the system tests for Medicaid eligibility first. If an applicant is found ineligible for Medicaid, the system applies the eligibility rules for federal premium tax credits, cost-sharing reductions and other subsidies. When no forms of assistance apply, the applicant still has the option to shop for a qualified health plan through HealthSourceRI that meets the applicant's coverage needs.

1300.09 Outreach and Enrollment Support Program: Assistors and Navigators

The ACA requires state-based exchanges to establish a navigator program to assist prospective enrollees with understanding the availability of coverage through the Exchange; the availability of federal premium tax credits and cost-sharing subsidies; and eligibility for Medicaid. Rhode Island's Outreach and Enrollment Support Program (OESP) includes both navigators and in-person assisters.

01. Navigators --The functions of Navigators include:

- Conduct public education activities to raise awareness of the availability of QHPs;
- Distribute fair and impartial information concerning enrollment in QHPs, and the availability of premium tax credits and cost-sharing reductions;
- Facilitate enrollment in QHPs;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

02. In-person Assistors -- In addition to navigators, guidance issued in July 2012 by the federal Center for Consumer Information and Insurance Oversight (CCIIO), permits states to utilize in-person assistors (IPAs) to extend the reach of the OESP, particularly in the initial 18 months of outreach and education when enrollment needs are expected to peak. In Rhode Island, the role of an in-person assistor generally mirrors that of a navigator.

1300.10 Contact Center

As a federal requirement in the implementation of the Affordable Care Act (ACA), the State must provide consumers assistance with enrollment into affordable health insurance. To meet this requirement, Rhode Island engaged the services of a professional "call center" to handle inbound calls, make outbound calls, and engage Rhode Islanders who need assistance applying for or enrolling in affordable health coverage. The Contact Center supports both HealthSourceRI and EOHHS, in its role as the Medicaid State Agency and is open seven (7) days a week, from 8:00 am-9:00 pm Monday-Saturday and 12:00-6:00 on Sunday. The phone number is 855-840-4774. Customers can call at (855) 840-4774 or come to the Walk-In Center for in-person assistance at 70 Royal Little Drive in Providence. The Contact Center is prepared to answer a variety of questions ranging from health care basics, product and benefit information, cost and how to enroll in coverage.

1300.11 HealthSourceRI
REV: March 2014

HealthSourceRI (HSRI) is the State's health insurance marketplace created in conjunction with implementation of the ACA. HSRI uses the same affordable coverage eligibility system as Medicaid. As such, applicants who apply through HSRI will be tested for Medicaid eligibility as well as for federal premium tax credits, cost-sharing reductions and any other subsidies that might apply. HSRI also serves as health insurance market for small businesses and individuals and families who do not qualify for help paying for coverage.

- To apply for affordable coverage on-line, healthsourceri.com
- To enroll, or talk to an expert, call **1-855-840-HSRI (4774)**.
- To meet with an expert for a free consultation, visit the Contact Center at **70 Royal Little Drive Providence, RI 02904**
- For all other inquiries, contact the Administrative Offices at **RI State House, Room 124 Providence, RI 02903**
- Administrative Offices phone number: **401-222-5194**.

1300.12 For Further Information or to Obtain Assistance

Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

Applicants may also apply in person at one of the Department of Human Services offices and the Contact Center or by telephone, fax or the U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

1300.13 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1301:

Medicaid Affordable Care

Coverage Groups

December 2013
March 2014 (T)
March 2015

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act:

Rules and Regulations: Section 1301 Medicaid Affordable Care Coverage Groups

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1301 of the Medicaid Code of Administrative Rules entitled, "Medicaid Affordable Care Coverage Groups"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in "Section 1301: "Coverage Groups" promulgated by the Executive Office of Health and Human Services and filed with the Rhode Island Secretary of State.

1301.

Medicaid Affordable Care Coverage Groups

1301.01 Scope and Purpose

The principal purpose of the federal Affordable Care Act of 2010 is to increase access to health care by leveraging resources, expanding choice, and removing the administrative, financial, and legal barriers that have prevented people from obtaining the coverage they need. Toward this end, the federal government has assisted the states in building state-of-the-art eligibility systems with the capacity to evaluate whether a consumer qualifies for affordable coverage funded in whole or in part through Medicaid, tax credits, and/or other subsidies. To ensure these eligibility systems function in the most efficient and consumer friendly manner possible, a single income standard – Modified Adjusted Gross Income or "MAGI" – must be used to determine the eligibility of all applicants for affordable coverage, including Medicaid. Accordingly, the federal government has eliminated distinctions in the financial criteria and standardized the eligibility requirements to the extent feasible for the Medicaid populations subject to the MAGI. This, in turn, made it possible for the states to reorganize the MAGI-eligible populations with similar characteristics into distinct, easily identifiable, Medicaid affordable care coverage (MACC) groups.

The purpose of this rule is to describe the Medicaid affordable care coverage groups. Any applicants for Medicaid in these groups will be subject to the MAGI standard and must apply using the eligibility system the State established in conjunction with implementation of the ACA. It is important to note that the provisions in federal (Title XIX and Title XXI of the U.S. Social Security Act) and State law (various chapters) that serve as the basis for the eligibility of members of the MACC groups has remained the same in most instances. Similarly, the State's authority to collect financial participation for the Medicaid coverage provided, whether under the Medicaid State Plan, Children's Health Insurance Program State Plan, or the Section 1115 demonstration waiver, also has not changed. However, for the sake of clarity, this rule will identify the appropriate legal bases and authorities for the populations included in each of the Medicaid affordable coverage groups described herein.

1301.02 Definitions.

For the purpose of this rule, the following definitions apply:

"C**orrectional facility (jail and prison)"** means any place operated by the Rhode Island Department of Corrections designated as a place for the confinement of persons under sentence of imprisonment or persons committed for failure to pay a fine; a place for the confinement of persons duly committed to secure their attendance as witnesses in any criminal case; charged with a crime and committed for trial or examination; awaiting the availability of a court; duly committed for any contempt or upon civil process, convicted of any offense and sentenced to imprisonment therein; or pursuant to any other applicable provisions of law.

"**Foster Care Independence Act**" means the Act that amends Part "E" of Title IV of the Social Security Act to provide States with more funding and greater flexibility in carrying out programs designed to help children make the transition from foster care to self-sufficiency.

"**Medicaid Affordable Care Coverage (MACC) Group**" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"**Medicaid Code of Administrative Rules (MCAR)"** means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State's Administrative Procedures Act (R.I.G.L. §42-35).

"New Applicant" means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date of this rule. The term does not apply to individual and families who were receiving coverage and were disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-citizen**" means anyone who is not a U.S. citizen at the time of application including lawfully present immigrants and persons born in other countries who are present in the U.S. without documentation.

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"**Qualified non-citizen"** means a person lawfully present in the United States on the basis of immigration status who, if otherwise eligible for Medicaid, is prohibited or "barred" under federal law from receiving Medicaid coverage for a period of five (5) years from the date the immigration status was secured from the U.S. Immigration and Naturalization Service (INS). Certain qualified non-citizens are exempt from the ban, as specified in the Medicaid Code of Administrative Rules section 1305.

"Rhody Health Partners" means the Medicaid managed care delivery system for health coverage to eligible adults without dependent children, ages 19 to 64 (see section 1310 of the Medicaid Code of Administrative Rules), and adults with disabilities eligible under sections 0394 and 0395 of the Medicaid Code of Administrative Rules.

"**RIte Care**" means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

"RIte Share" means the premium assistance program for individuals and families who have access to cost-effective commercial coverage (see section 1312 of the Medicaid Code of Administrative Rules).

"**Section 1115 Demonstration Waiver"** means the authorities granted by the federal government that gives the State the flexibility to expand eligibility to people who are not otherwise eligible,

provide new services that are typically not covered, and use innovative service delivery systems/approaches that improve care, increase efficiency, and reduce costs. Rhode Island currently operates nearly all facets of its Medicaid program under a Section 1115 waiver.

"Section 1931" means the Section of Title XIX of the Social Security Act that established the family category of coverage subsequent to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) which severed the historical link between eligibility for cash assistance -- formerly called Aid to Families with Dependent Children (AFDC) -- and automatic Medicaid eligibility.

"Title XIX" means the section of the U. S. Social Security Act that established the Medicaid program and provides the legal basis for providing services and benefits to certain populations in each MACC group.

"Title XXI" means the section of the U. S. Social Security Act that established the Children's Health Insurance Program (CHIP) and provides the legal basis for providing services and benefits to certain targeted low income children and pregnant women through Medicaid.

"**Transitional or Extended Medicaid**" means the program that continues Medicaid coverage for up to twelve (12) months for MACC group families covered under Section 1931 when income exceeds the 110% of the FPL threshold.

1301.03 Types of Medicaid Affordable Care Coverage Groups
REV: March 2015

Federal law allows the states considerable flexibility to configure and administer their Medicaid and CHIP programs, including choosing which optional populations to cover, by what delivery system, and even whether to administer CHIP as a separate program, a Medicaid expansion or some combination of the two. As a result, every state's program is different; the way each organizes its Medicaid coverage groups is also somewhat unique.

Rhode Island's Medicaid affordable care coverage groups are comprised of individuals and families who share an eligibility characteristic, such as age or relationship. An applicant must meet the requirements to be included in one of the MACC groups to be eligible for Medicaid.

01. Description of MACC Groups – The Medicaid affordable care coverage groups are as follows:

(01) Families and Parents (caretaker relatives). The defining characteristic of this coverage group is a relationship with a child up to age 18, or 19 if enrolled in school full-time, who is eligible for Medicaid, as specified in section 1301.05 of the Medicaid Code of Administrative Rules (MCAR). Parent/caretaker eligibility is a function of how the eligible child is claimed for tax purposes as a dependent when constructing a MAGI household rather than where the child resides (See section 1307 of the Medicaid Code of Administrative Rules). The coverage group includes families with income up to 110% of the Federal Poverty Level (FPL) who are eligible under the Medicaid State Plan as well as parents/caretaker relatives with income from 110% to 133% of the FPL who are eligible under the State's Section 1115 demonstration waiver.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

(05) Incarcerated Beneficiaries. Federal law and regulations prohibit the use of federal matching funds for health care provided on the premises of correctional facilities to otherwise Medicaid-eligible persons while incarcerated. Accordingly, full Medicaid health coverage of such persons is suspended during periods of incarceration. While the suspension remains in effect, the Medicaid agency is responsible for reimbursing costs related to acute care hospital stays of twenty-four (24) or more hours, but only when the otherwise Medicaid-eligible incarcerated person receives that care off the premises of the correctional facility.

- Reinstatement upon Release. Medicaid health coverage that has been suspended due to incarceration must be reinstated promptly by the Medicaid agency upon the person's release from a correctional facility.

- Residency. Suspension of Medicaid health coverage is limited to Rhode Island residents while incarcerated in correctional facilities. Medicaid health coverage for Rhode Islanders incarcerated in the correctional facilities of other states or in a federal penitentiary is terminated in accordance with the residency requirements set forth in MCAR 1305.11.

- Infants. An infant born to an incarcerated pregnant woman with suspended eligibility is qualified to receive Medicaid health coverage until the end of the month of the infant's first birthday in accordance with MCAR 1305.14.

02. MACC Group Eligibility Thresholds – The table below summarizes the MACC coverage groups and eligibility thresholds:

MAC Coverage Groups	*FPL Threshold*
Families and Parents/Caretakers	133%
Pregnant Women	253%
Children and Young Adults	261%
Adults 19-64 without children	133%

03. FPL Thresholds and MAGI Adjustments – The income levels for MACC groups identified in section 1301.03.01 above are eligibility thresholds that do not reflect adjustments made during the MAGI calculation. When applying the MAGI standard, income is reduced by about five (5) percentage points for household size to maximize eligibility. The FPL levels identified in this rule and other sections of the Medicaid Code of Administrative Rules applicable to MACC groups should be viewed by consumers accordingly.

1301.04 Medicaid Coverage Groups Excepted from the MAGI
REV: March 2015

There are currently multiple Medicaid coverage groups that are not subject to the MAGI. The income, resource, and non-financial criteria for populations within these coverage groups will remain the same. Relevant sections of the Medicaid Code of Administrative Rules are noted as appropriate.

Non-MAGI Coverage Groups
Anyone whose eligibility does not require an income determination by the Medicaid agency. Includes those eligible on the basis of : • Women eligible under the Breast and Cervical Cancer Treatment Act; • SSI (Medicaid Code of Administrative Rules section 0370); • Participation in a DCYF foster care, kinship or guardian program whether in a home-based, residential or institutional setting, including young adults aging out of foster care in Rhode Island (“Chafee youth”) (Medicaid Code of Administrative Rules sections 0342/1309); • Adoption assistance participants (Medicaid Code of Administrative Rules sections 0342/1309); • Infants born to Medicaid-covered women.
Anyone who is seeking eligibility for Medicaid coverage on the basis of age, disability, or blindness (Medicaid Code of Administrative Rules section 0352)

Non-MAGI Coverage Groups
Any person who is in need of Medicaid-funded long term services and supports (LTSS) in the home and community based setting or an institution. Includes: • Children seeking Medicaid coverage under the Katie Beckett provision (Medicaid Code of Administrative Rules section 0370.20) • Persons with developmental disabilities with a level of need requiring LTSS in a group home, shared living environment, at home, or an institute for persons with such disabilities. (Medicaid Code of Administrative Rules section 0398.10) • Adults and persons with disabilities with a level of need requiring LTSS in any approved setting (Medicaid Code of Administrative Rules section 0378)
Any person eligible as medically needy under the Medicaid State Plan
Adults over age 65 and adults with disabilities eligible for Medicare Premium Payment Program

1301.05 MACC and Non-MAGI Coverage Groups: Distinctions and Overlaps

Although the federal Affordable Care Act eliminated many of the distinctions between populations within coverage groups, certain differences remain within the MACC groups in Rhode Island that may affect eligibility and/or the scope of services.

01. Families: State Plan v. Section 115 Waiver Eligibility. The basis of eligibility for individuals and families in this coverage group differs. Families with income up to 110% of the FPL are eligible under the Medicaid State Plan through Section 1931 of Title XIX. Section 1931 parents and caretakers with income up to 133% of the FPL are eligible under the State's Section 1115 demonstration waiver.

    (01) Similarities -- The basis of eligibility – State Plan v. waiver – has no impact on the way eligibility is determined, the scope of coverage families receive or the way services are delivered. A family must have a Medicaid eligible child up to age 18, or 19 if in school, in the MAGI household to qualify under this MACC group. All eligible families receive services through the RIte Care delivery system (section 1309 of the Medicaid Code of Administrative Rules), unless access to affordable coverage requires enrollment in the RIte Share Premium Assistance Program (Medicaid Code of Administrative Rules section 1312).

    (02) Differences -- Families eligible under Section 1931 are treated differently than those eligible under the Section 1115 waiver when they reach the income threshold of 110% percent. The State must test any family covered under Section 1931 for an additional twelve months (12) of extended or transitional Medicaid (see Medicaid Code of Administrative Rules section 0342.50) when their income rises above the 110% FPL threshold. By contrast, when a family's income rises above the 133% Section 1115 waiver threshold, the transitional Medicaid option does not apply. Eligibility for parents/caretakers and children

is redetermined to assess whether they qualify under another Medicaid income threshold, or tax credits or subsidies for a plan available through the HealthSourceRI insurance marketplace. Details of the transitional/extended Medicaid program are as specified in Medicaid Code of Administrative Rules section 0342 until such time as the State receives further guidance from our federal partners on implementation through the ACA.

02. Pregnant Women: State-funded Group -- Pregnant women with income above the 253% FPL but below 350% of the FPL are State-funded only and, as such, are not part of the MACC group. However, members of this group are enrolled in RIte Care and qualify for the same MCO in-plan benefits as pregnant women eligible in the MACC group for pregnant women. Additional information on members of this coverage group is located in section 1309 of the Medicaid Code of Administrative Rules.

03. Newborns—Under the ACA, infants born to pregnant women covered under the MACC group for pregnant women on the date of delivery are automatically eligible for Medicaid (known as "deemed newborns"). Medicaid eligibility continues until the child's first birthday. (See section 1305.15 of the Medicaid Code of Administrative Rules).

04. Young Adult Former Foster Children -- The Medicaid eligibility of foster children is based on their participation in the programs administered by RI Department of Children, Youth and Families (DCYF). In Rhode Island, continuing Medicaid eligibility for youth aging out of foster care was provided through the federal Foster Care Independence Act of 1999 (Chafee Act). Distinctions in eligibility of these young adults were based on whether or not the services they received through DCYF were authorized and paid for under Title IV-E of the federal Social Security Act. Enactment of the ACA amended the Chafee Act to eliminate these distinctions and change Medicaid eligibility for youths aging out as follows, effective January 1, 2014:

(01) Basis for Eligibility. All young adults who were in DCYF foster care at the time they turned 18 years of age are eligible for continued Medicaid coverage, irrespective of whether they were receiving Title IV-E authorized services.

(02) Age. The age limit for coverage under the Chafee Act was raised from 21 to 26.

(03) Alternative Coverage. A provision was added to the Chafee Act specifying that young adults only qualify for Medicaid under this group if not otherwise eligible through SSI or as aged, blind or disabled and/or in need of long term services and supports.

(04) Residency. Young adults are now only eligible in the state where they resided at the time they aged out of foster care. Accordingly, to be eligible in Rhode Island, a young adult must be a current state resident and have been in foster care in Rhode Island at the time of aging out.

(05) Income. The eligibility of members of this population is not subject to a specific income threshold and, as a result, is exempt from the MAGI.

(06) Scope of Services. Young adults in this population must receive the same benefit package as Medicaid eligible children, including EPSDT up to age 21.

Although eligibility of young adults aging out of foster care was considerably altered by the ACA, members of this population are not included in a MACC group for income eligibility purposes.

05. Options for Adults 19-64 -- The MACC group for adults is distinct from the existing, non-MAGI Medicaid State Plan coverage group for adults who are aged, blind or disabled. There are individuals between the ages of 19 and 64 with chronic illnesses and disabling conditions who may be eligible under the MACC group on the basis of age and income. Adults seeking eligibility under the MACC group are not required to meet the disability criteria and assets set forth in the Medicaid Code of Administrative Rules sections 0351/0374, and must receive their determination within thirty (30) days rather than the ninety (90) days allowed for Non-MAGI coverage as blind or disabled, permitted under federal law. New applicants between the ages of 19 and 64 who apply using the new eligibility system must be evaluated on the basis of the MACC group income threshold for adults of 133% of the FPL first and then, if found ineligible under this group, must be referred to a Department of Human Services (DHS) agency representative for a full financial and clinical disability determination review.

1301.06 Covered Services

Members of all MACC groups are eligible for the full range of Medicaid benefits under the Medicaid State Plan and the State's Section 1115 waiver. A summary of covered services is as follows:

Doctor's office visits	Home health care
Immunizations	Skilled nursing care
Prescriptions	Nutrition services
Lab tests	Interpreter services
Mental health services	Childbirth education programs
Drug or alcohol treatment	Parenting classes
Referral to specialists	Smoking cessation programs
Hospital care	Transportation services
Emergency care	Dental care

NOTE: The services available to MACC group members varies by delivery system. See below for identification of delivery system and applicable Medicaid Code of Administrative Rules sections for full details on benefits.

1301.07 Delivery Systems

Eligible individuals and families receive coverage through a Medicaid managed care plan or their own commercial plan through the RIte Share Premium Assistance Program with fee-for-service wrap around coverage. Delivery systems for MACC groups are as follows:

MAC Coverage Groups	***Delivery System***
Families and Parents/Caretakers	RIte Care or RIte Share
Pregnant Women	RIte Care or RIte Share
Children and Young Adults	RIte Care or RIte Share
Adults 19-64 without children	Rhody Health Partners or RIte Share

The sections of the Medicaid Code of Administrative Rules pertaining to RIte Care (1309), RIte Share (1312) and Rhody Health Partners (1311) explain the organization of coverage through each of these programs. Enrollment provisions are located in the Medicaid Code of Administrative Rules section 1311.

1301.08 Information
REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1301. 09 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act:

Section 1303:

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1303 of the Medicaid Code of Administrative Rules entitled, "Application Process for Medicaid Affordable Coverage"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in "Section 1303: Application Process for Medicaid Affordable Coverage" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State on June 23, 2014.

1303. Application Process for Medicaid Affordable Coverage: No Wrong Door

1303.01 Scope and Purpose
REV: April 2015

One of the central goals of the federal Affordable Coverage Act of 2010 was to improve access to and the availability of affordable health coverage. Toward this end, the State of Rhode Island is committed to making the process of applying for affordable health coverage easy to navigate and understand. In keeping with this commitment, the State established a new on-line system for determining eligibility for affordable coverage that enables consumers to apply on-line, or in-person, by telephone or through the mail from a variety of settings.

The Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency (hereinafter the Medicaid agency), accepts applications through the State's on-line eligibility system for all consumers in the following Medicaid coverage groups:

- **Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL)** – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

- **Pregnant women**. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

- **Children and Young Adults.** Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

- **Adults 19-64.** This is the Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

The purpose of this rule is to describe the application process for members of these coverage groups and to set forth the respective roles and responsibilities of the Medicaid agency and applicants. Applicants using the new eligibility system will be evaluated for affordable coverage paid for in whole or in part by Medicaid, tax credits, and other forms of subsidies. The process of determining eligibility through the system is fully automated and, as such, provides applicants with greater access to coverage irrespective of the application starting point.

1303.02 Definitions

"**Application Access Points"** means the various contact points where consumers or their representatives can access the application process either directly through the eligibility system's web portal (on-line) or with the assistance of EOHHS, DHS, or Contact Center representatives or an application entity designated by the state for such purposes (in-person, by telephone or a mail-in application).

"**Application Entity**" means an organization or firm acting on a State agency's behalf that provides applicants for affordable coverage with an application access point including the EOHHS, the Department of Human Services (DHS), the HealthSourceRI (HSRI) benefits exchange, the Contact Center and any organizations designated for such purposes that maintain a staff of certified navigators or in-person assistors.

"Attestation" means a person authenticates by signature that a statement or document is genuine and true.

1303. 03 Application Access Points
REV: March 2014

Both the State's "No Wrong Door Policy" and the federal law stipulate that the Medicaid agency must provide consumers with a choice of application access points. New applicants for affordable coverage may access the eligibility system and complete the application process through application entities that have been designated for this purpose and on their own or with assistance, if necessary, through any of the following access points:

01**. On-line Self-Service Portal** -- Applicants have the option of accessing the eligibility system and applying on-line using a self-service portal through links on the EOHHS (eohhs.ri.gov) and DHS (dhs.ri.gov) websites or directly through HSRI (HealthSourceRI.com). There are also kiosks located in DHS field offices that provide direct access to the on-line self-service portal. The information applicants provide on-line is entered directly into the eligibility system and is processed electronically in real-time. For these reasons, the Medicaid agency encourages all new applicants to select the on-line option and complete and submit the application electronically whenever feasible. NOTE: Applicants using the on-line system will have to establish their identity electronically to create an account. If an identity match cannot be completed on-line, documentation may be provided via upload, fax, mail, or in-person.

02. **In-person or by Telephone** – Applicants may apply in-person at DHS field offices with the assistance of an agency representative or on their own using kiosks established for this purpose. The Contact Center also provides access to walk-in applicants and consumers who make contact by telephone. If an applicant is unwilling or unable to apply on-line, an agency or Contact Center representative must enter the information into the eligibility system portal on the applicant's behalf.

03. **On-paper** – Applicants may submit paper applications in-person or by U.S. mail, e-mail transmissions, and facsimile transmissions to the address specified on the application. Paper applications are available on-line, through the U.S. Mail upon written request or telephone request (1-855-609-3304 or 1-888-657-3173 (TTY), or in-person at any DHS field office or the Contact Center. Upon receipt, an agency or Contact Center representative must enter the

information provided on the paper application directly into the eligibility system portal and submit the application for a determination on the applicant's behalf.

04. **Application Entities** – Applicants may access the eligibility system with the assistance of application entities that provide navigators or other in-person assisters (IPAs). Members of these entities assist applicants in completing paper applications or applying through the on-line portal. A list of these application entities is available from the Contact Center or on-line by visiting the EOHHS website (www.eohhs.ri.gov).

1303.04 Completing and Submitting the Application
REV: April 2015

In general, the process of completing and submitting an application proceeds in accordance with the following:

01. **Account Creation** -- To initiate the application process, the applicant, agency or Contact Center representative, or application entity assisting the applicant must create a login and establish an account in the eligibility system.

(01) The applicant must provide personally identifiable information for the purpose of creating an on-line account as a form of identify proof during this process. Verification of this information is automated through the federal data hub (see section 1308). Documentation proving identity may be required if the automated verification process is unsuccessful. Acceptable forms of identity proof include a driver's license, school registration, voter registration card, etc. Documents may be submitted via mail, fax, on-line upload, to a DHS Office, or the Contact Center. (See the Medicaid Code of Administrative Rules section 1308 for additional information).

(02) Once identity is verified, the Medicaid agency must conduct account matches in accordance with section 1308 of the Medicaid Code of Administrative Rules to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits. It is the Medicaid agency's responsibility to resolve account matching issues and notify the applicant of any necessary actions.

02. **Account Duration** – An application account is open for a period of ninety (90) days. Applicants must restart the process if they have not completed and submitted an application within that period.

(01) Applications may be started at any time. Once started, progress can be saved at any point and the application returned to at a later time. Incomplete applications not submitted within ninety (90) days are automatically deleted in the eligibility system.

(02) Eligibility determinations for Medicaid. Determinations must be made in no more than thirty (30) days from the date the completed application is received. The application remains open after that period if the Medicaid agency or its eligibility designee (DHS) or agents (application entities) are responsible for delays in the determination.

(03) Temporary eligibility period. If there are discrepancies between an applicant's attestations and electronic data matches on immigration or citizenship eligibility factors, eligibility is

granted for a period of no more than ninety (90) days. The application remains open during this period to allow the applicant sufficient time to obtain necessary documentation. (See Medicaid Code of Administrative Rules sections 1308.09 and 1308.10).

03. **Application Materials** – Applicants must answer all the required questions for each member of their household. Application questions focus on the need for all types of affordable coverage and specific Medicaid eligibility criteria related to the applicable MACC group. In general, applicants will be able to provide answers to the application questions with information used when filing federal tax forms and/or documents commonly used for identification and income verification purposes. When applying through the web portal on-line, electronic verification through data matches will limit the applicant's need to refer to these materials. However, when using a paper application, access to these materials may be necessary. Materials that may be of assistance in such instances include, but are not limited to:

- Federal tax filing status
- Household/family size
- Social Security Numbers
- Birth Dates
- Passport or other immigration numbers
- Federal tax returns
- Information about any health coverage available to you or your family, including any information you have about the health insurance your current employer offers even if you are not covered by your employer's insurance plan
- W-2 forms with salary and wage information if you work for an employer
- 1099 forms, if you are self-employed

04. **Application Completeness** – Before a determination of eligibility is made, all questions on the application must be completed. Applicants must be informed and offered the opportunity to provide any additional documentation or explanations necessary to proceed to the determination of eligibility. Such information will be provided to applicants immediately through a notification from the eligibility system when using the self-service portal. The agency or Contact Center, or application entity entering the information into the eligibility system on the applicant's behalf, must provide this information to the applicant immediately once it becomes available, by letter or phone if the applicant is not present. Applicants must be informed that they have the option to submit any additional documentation or materials that may be required to complete the determination of eligibility through an on-line upload, by email, U.S. mail, fax, telephone or in-person.

05. **Voluntary Withdrawal.** An applicant may request that an application for Medicaid health coverage be withdrawn at any time either through their secure on-line account or by submitting the request in writing via the U.S. Mail or fax to the EOHHS or DHS agency or a Contact Center representative. Withdrawal of the application may also be made by telephone to the Contact Center. The Medicaid agency sends a notice to the applicant verifying the time and date of the voluntary withdrawal and indicating that the applicant may reapply at any time.

1303.05 Attestation of Application Information

All questions on the application must be answered in a truthful and accurate manner. Every applicant must attest to the truthfulness and accuracy by providing an electronic signature under penalty of perjury. The Medicaid agency must verify information electronically to the fullest extent feasible and must verify applicant attestations in accordance with the procedures set forth in the Medicaid Code of Administrative Rules section 1308.

01. **Electronic Matches** – Federal and State Data Sources**:** The eligibility system verifies attestations through electronic data matches with external sources such as the U.S. Social Security Administration and Internal Revenue Service and RI agencies such as the Division of Motor Vehicles, the Office of Vital Statistics and the Department of Labor. The eligibility factors subject to verification are specified in the Medicaid Code of Administrative Rules section 1305; the verification process is located in section 1308 of the Medicaid Code of Administrative Rules.

02. **Attestation** -- Before an application can be submitted, the applicant, or the person/entity acting on the applicant's behalf, must provide the necessary attestations. When applying on-line, the attestation is conducted electronically. An agency or Contact Center representative or an authorized application entity must verify that the application was signed (e.g., mail application), a voice signature was obtained (telephone application), or that the applicant signed a declaration in-person. The signature provided by the applicant in these instances is an attestation to both the applicant's identity and the truthfulness and accuracy of the information on the application. After a complete application with a declaration has been submitted, the applicant will receive an eligibility determination for each household member seeking coverage. There are circumstances when an applicant's attestations and verification data matches show discrepancies. (See section 1308 of the Medicaid Code of Administrative Rules for the provisions governing reconciliation of such differences).

1303.06 Privacy of Application Information

Application information must only be used to determine eligibility and what types of coverage a person is qualified to receive. Accordingly, the Medicaid agency, Contact Center, or application entity must maintain the privacy and confidentiality of all application information and in the manner required by applicable federal and state laws and regulations.

1303.07 Notice of Determination of Eligibility
REV: April 2015

Once an application is completed and the required verifications are performed, eligibility for Medicaid and other forms of affordable coverage is made for each member of the household. (For information on other forms of affordable coverage, see www.HealthSourceRI.com or call the Contact Center at 1-855-609-3304).

Household members determined Medicaid-eligible may enroll immediately in the health plan of choice. A formal notice will be generated after the determination indicating which household members are eligible for Medicaid or other forms of affordable coverage, the legal basis for the determination of eligibility, and the plan in which each household member is enrolled, if applicable. The notice will be sent via the applicant's secure on-line account if opting to receive agency communications in such a manner or by mail in a reasonable time period. A "reasonable time"

period usually will not exceed ten (10) business days, but in no instance will it extend beyond the 30-day application period.

The notice must also advise the applicant of the right to appeal and request a hearing, in accordance with MCAR section 0100.

1303.08 Agency and Applicant Roles and Responsibilities
REV: April 2015

The Medicaid agency and applicants have shared and distinct responsibilities in the application process.

01. **Medicaid agency** -- Under current state and federal laws, the Medicaid State Agency is required to:

    (01) Assist applicants in completing all necessary forms.

    (02) Provide applicants with an interpreter or translator services upon request.

    (03) Assure all information applicants provide is kept confidential unless otherwise authorized to share with other state and federal agencies for the purposes of verification and enrollment.

    (04) Make timely determinations of eligibility in accordance with applicable laws and regulations.

    (05) Accept appeals and hold hearings on agency actions related to eligibility decisions in accordance with MCAR Section 0110 and the Department of Human Services' rule #0110. (Note: the health insurance marketplace is referred to as the "RI Health Benefits Exchange" in Section 0110 of the Medicaid Code of Administrative Rules).

    (06) Provide a mechanism for beneficiaries to voluntarily withdraw eligibility for Medicaid health coverage at any time by submitting a written request via the U.S. Mail or fax to the EOHHS or DHS agency or a Contact Center representative.

02. **Applicant Rights and Responsibilities** -- All applicants have the following:

    (01) **Applicant Rights** --The right to obtain help in completing forms; to an interpreter or translator, upon request; to be treated free from discrimination on the basis of race, color, national origin, sex, gender identity or sexual orientation, age or disability; to have personal information remain confidential; and to file an appeal and request a hearing on eligibility actions.

    (02) **Applicant Responsibilities** -- The responsibility to:

    (03) Disclose certain information including Social Security numbers and proof necessary to determine eligibility;

(04) Report changes in income, family size and other application information as soon as possible; and

(05) Sign the application and thereby agree to comply with any applicable laws related to the type of eligibility requested and the coverage received.

1303.09 For Further Information or to Obtain Assistance
REV: March 2014

01. Applications for affordable coverage are available online on the following websites:
    - www.eohhs.ri.gov
    - www.dhs.ri.gov
    - www.HealthSourceRI.com

02. Applicants may also apply in-person at one of the Department of Human Services offices or by U.S. mail. Request an application by calling 1-855-609-3304 or TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1303.10 Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1305:

Eligibility for Medicaid Affordable Care

Coverage Groups

December 2013
March 2014 (T)
June 2014
February 2015

Rhode Island Executive Office of Health and Human Services
Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1305:

Eligibility for Medicaid Affordable Care Coverage Groups

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1305 of the Medicaid Code of Administrative Rules entitled, "Eligibility for Medicaid Affordable Care Coverage Groups"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in "Section 1305: Eligibility for Medicaid Affordable Care Coverage Groups" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State.

1305 Eligibility for Medicaid Affordable Care Coverage Groups

1305.01 Overview
REV: February 2015

Rhode Island created a new eligibility system to implement the federal Affordable Care Act of 2010. This new system has the capacity to determine whether an individual or family qualifies for affordable coverage paid for by Medicaid, or in whole or in part, by federal tax credits or other subsidies. Toward this end, the system uses a distinct income standard – Modified Adjusted Gross Income or MAGI – to determine eligibility for affordable coverage across populations. Use of the system is being phased in over the course of several years. All applicants in the Medicaid affordable care coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR) are required to apply using the new eligibility system in accordance with the provisions set forth in MCAR section 1303.

1305.02 Scope and Purpose

Income eligibility for MACC groups -- families and parent/caretakers, children and young adults, pregnant women and adults age 19 to 64 – is determined on the basis of the MAGI, as indicated in MCAR section 1307. The purpose of this rule is to provide an overview of the income eligibility thresholds for each MACC group and to establish all other non-financial requirements that MACC group members must meet to be determined eligible for Medicaid affordable coverage. The rule also sets forth the respective roles and responsibilities of applicants for Medicaid and the Executive Office of Health and Human Services (EOHHS) in its capacity as the Medicaid Single State Agency ("Medicaid agency").

1305.03 Definitions
REV: February 2015

"**Caretaker or caretaker relative**" means any adult living with a Medicaid-eligible dependent child that has assumed primary responsibility for that child inclusive of the categories of caretaker relatives established in MCAR section 0328.10.

"**Dependent child**" means a child under the age of eighteen (18) or under age nineteen (19), if enrolled full-time in school.

"Enrollee" means a Medicaid member or beneficiary is enrolled in a Medicaid managed care plan.

"Hospital Presumptive Eligibility" means Medicaid eligibility granted on a temporary basis to a person who meets certain criteria during a defined period.

"Managed Care Organization (MCO)" means a health plan system that integrates an efficient financing mechanism with quality service delivery and a "medical home" to assure appropriate preventive care and deter unnecessary services.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility.

"**Medicaid Code of Administrative Rules (MCAR)"** means the compilation of rules governing the Rhode Island Medicaid Program, promulgated in accordance with the State's Administrative Procedures Act (RIGL §42-35).

"Medicaid member" means a person who has been determined to an eligible Medicaid beneficiary.

"**Modified Adjusted Gross Income or (MAGI)"** means income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income. The MAGI is the standard for determining income eligibility for all Medicaid affordable care coverage groups (MCAR section 1301).

"Navigator" means a person working for a State-contracted organization that provides certified assisters who have expertise in Medicaid eligibility and enrollment.

"New Applicant" means an individual or family who was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date of this rule. The term does not apply to individual and families who were receiving coverage and were disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-citizen**" means anyone who is not a U.S. citizen at the time of application including lawfully present immigrants and persons born in other countries who are present in the U.S. without documentation.

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Qualified non-citizen" means a person legally present in the United States on the basis of immigration status who, if otherwise eligible for Medicaid, is prohibited or "barred" under federal law from receiving Medicaid coverage for a period of five (5) years from the date the immigration status was secured from the U.S. Immigration and Naturalization Service (INS). Certain qualified non-citizens are exempt from the ban, as specified in MCAR section 1305.15.

"Rhody Health Partners" means the Medicaid managed care service delivery system for eligible adults without dependent children, ages 19 to 64 (see MCAR section 1310) and adults with disabilities eligible (see MCAR section 0374).

"**RIte Care**" means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

"RIte Share" means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial health insurance plans coverage.

"Self-Attestation" means the act of a person affirming through an electronic or written signature that the statements the person made when applying for Medicaid eligibility are truthful and correct.

"**Title XIX"** means the section of the U. S. Social Security Act that established the Medicaid program and provides the legal basis for providing services and benefits to certain populations in each MACC group.

"Title XXI" means the section of the U. S. Social Security Act that established the Children's Health Insurance Program (CHIP) and provides the legal basis for providing services and benefits to certain targeted low income children and pregnant women through Medicaid.

"Transitional or Extended Medicaid" means the program that continues Medicaid coverage for up to twelve (12) months for MACC group families covered under Section 1931 when income exceeds the 110% of the FPL threshold.

1305.04 Overview MACC Groups

This rule applies to new applicants who are members of the Medicaid affordable care coverage groups described in MCAR section 1301. All MACC group members are subject to the MAGI standard set forth in MCAR 1307. The chart below provides a brief description of each of the MACC groups and the applicable income eligibility thresholds:

MACC Coverage Groups	Federal Poverty Level (FPL) Income Thresholds
Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.	133%
Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.	253%
Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.	261%
Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.	133%

The income levels for MACC groups identified above are eligibility thresholds that do not reflect adjustments made during the MAGI calculation. The FPL levels identified in this rule and other sections of the MCAR applicable to MACC groups should be viewed by consumers accordingly. For more detailed information, see MCAR sections 1301.03 and 1307.

1305.05 Non-MAGI Excluded Medicaid Coverage Groups
REV: June 2014

Consumers seeking Medicaid coverage who are members of any of the following groups are not subject to MAGI-based determinations on or after January 1, 2014, until notified otherwise by the Medicaid agency:

- Any person for whom the Medicaid agency is not required to make an income determination, such as foster care, adoption assistance, Supplement Security Income beneficiaries.

- Persons seeking eligibility under sections MCAR 0352, 0374, and 0375 who are 65 and older or between the ages of 19 and 64 and seeking eligibility based upon blindness or a disability.

- Anyone applying for eligibility under MCAR section 0378 who is seeking long term services and supports in an institutional or home or community based setting.

- Persons seeking eligibility as "medically needy" due to excess income.

- Anyone eligible for Medicare cost-sharing assistance through the Medicare Premium Payment Program.

- Any reported changes affecting eligibility or the discontinuation of coverage will require reapplication in accordance with section 1303. This excludes parents enrolled in RIte Care with income from 133% to 175% of income who are disenrolled because they are no longer Medicaid eligible under Rhode Island law effective January 1, 2014.

1305.06 Application Process for New Applicants – MACC Groups
REV: February 2015

All new applicants for Medicaid in the MACC groups identified above and in greater detail in MCAR section 1301 must apply using the automated eligibility system established in conjunction with the federal Affordable Care Act. Consumers seeking coverage may apply by accessing the eligibility system web portal through links on the EOHHS (www.eohhs.ri.gov) or Department of Human Services (DHS) (www.dhs.ri.gov) websites or through the HealthSourceRI (healthsourceri.com), the State's health insurance exchange or marketplace. MCAR section 1303 identifies other channels for applying for coverage through the eligibility system in person and by mail or by telephone through a DHS field office or the Contact Center.

1305.07 MAGI-based Income Eligibility Determination

Income eligibility determinations are based on MACC group income thresholds. The MAGI uses federal tax filings to construct an applicant's household and calculate income, which is then adjusted

for family size and compared to the FPL thresholds summarized in section 1305.04 above. The provisions governing MAGI income eligibility determinations for MACC groups are set forth in section 1307.

1305.08 Overview of MACC Group Non-Financial Requirements

All applicants for MACC Group eligibility must meet citizenship and residency requirements. These two requirements apply to all Medicaid applicants. There are also certain cooperation requirements. Adults must typically meet the cooperation requirements, whether applying for themselves or on behalf of a dependent child. Verification of these requirements is an automated process conducted through the federal data hub (see MCAR section 1308) and Rhode Island's own data-based matches. Failure to meet Medicaid non-financial eligibility requirements or provide supporting documentation thereof typically results in the denial or discontinuation of eligibility. Children are typically exempt from sanctions due to non-cooperation. The scope and application of each the non-financial eligibility requirements are set forth in the succeeding provisions of this rule.

1305.09 Age

"**Age"** is one of the principal factors affecting eligibility for Medicaid and assignment to the appropriate Medicaid service delivery system MACC group.

01. **MACC Group Age Limits** –The age requirements associated with each of the MACC groups is as follows:

MACC Coverage Groups	Age Requirements
Families and Parents/Caretakers with income up to 133% FPL	• Parents/Caretakers of any age • Dependent child up to age 18 or 19 if enrolled in school full-time
Pregnant Women	• Any age
Children and Young Adults	• Up to age 19
Adults without children	• Ages 19 to 64

Note: Certain children and young adults in non-MAGI coverage groups remain eligible after age 19. Young adults eligible on the basis of participating in the Non-IV-E Adoption Subsidy Program or Supplemental Security Income (SSI) are covered up to age 21; former foster children remain eligible up to age 26.

02. **Verification** – An applicant's self-attestation of age and identity is accepted at the time of application. Post-eligibility electronic verification of date of birth is conducted through the U.S. Social Security Administration (SSA) and/or the RI Department of Health, Division of Vital Statistics. This information is used to determine capitation rates for enrollees in Medicaid managed care plans; these rates vary by age. If electronic verification is unsuccessful, submission of paper documentation may be required for these purposes. See MCAR section 1308.10 for satisfactory forms of documentation.

1305.10 Social Security Number

Each individual (including children) applying for Medicaid must have a Social Security Number (SSN) as a condition of eligibility for the program.

01. **Condition of Eligibility** – Applicants must be notified prior to or while completing the application that furnishing an SSN is a condition of eligibility. Only members of a household who are applying for Medicaid coverage are required to provide a SSN. A SSN of a non-applicant may be requested to electronically verify income. However, unwillingness on the part of a non-applicant to provide a SSN upon request cannot be used as a basis for denying eligibility to an applicant who has provided a SSN. If unavailable, other proof of income must be accepted.

02. **Limits on Use** – Applicants must also be informed that a SSN will be utilized only in the administration of the Medicaid program, including for use in verifying age and income eligibility.

03. **Verification** – A SSN is verified through an electronic data-match with the SSA. Applicants must provide documentation of SSN if the data match fails. Acceptable forms of documentation are identified in MCAR section 1308.10.

Note: The provisions governing SSNs for newborns, sometimes referred to as enumeration, are located in section 1305.14.

1305.11 State Residency

The Medicaid program exists primarily to meet the needs of residents of Rhode Island. Therefore, as a factor of eligibility, anyone who is applying for eligibility must be a resident of the State. Any person living in the State voluntarily, who intends to reside in Rhode Island for any reason is a resident of the State. Under federal regulations implementing the Affordable Care Act, a person does not need a fixed address in the State to be considered a Rhode Island resident. Therefore, homelessness is not a bar to eligibility.

01. For individuals over age 21, or under 21 and capable of expressing intent as emancipated or married — If the applicant is not living in an institution, the state of residence is the state where the applicant is living voluntarily with the intention to reside; or entered voluntarily with a job commitment or seeking employment, whether or not currently employed.

02. For individuals under age 21 who are not emancipated or married – If the applicant is not living in an institution, the state of residence is the state where the child/young adult resides or the state of the parent/care-taker with whom the child lives. The residence of a pregnant women's unborn child is, under the terms of this provision, the state in which the pregnant women resides. A non-citizen pregnant woman who lives in Rhode Island is considered to be a resident, irrespective of whether the woman's immigration status indicates she is in the country permanently or for a limited time (i.e., in the United States on a temporary visa of any kind).

03. For individuals living in institutions – Most Medicaid applicants living in institutional settings are not included in the MACC groups. For applicants in these non-MAGI coverage groups, the applicable provisions are set forth in section 0304.10.05.25.

04. **Disputes** – If there is a dispute over residency for determining Medicaid eligibility, the applicant is a resident of the state in which the applicant is physically located. The MAGI standard of the state where the applicant is physically located applies when determining eligibility.

05. **Verification** – Self-attestation of the intent to remain in the State is accepted. Evidence that an applicant is receiving public benefits in another state may result in a denial of eligibility if paper documentation of residency is not provided. Further information on residency is set forth in MCAR section 1308.10.

1305.12 Citizenship and Immigration Status

The citizenship requirements for Medicaid eligibility for individuals and families in MACC groups vary depending on the basis of eligibility. All applicants must provide information about citizenship, whether U.S. citizens or lawfully present non-citizens.

01. Categories of Non-citizens Qualified v. non-qualified non-citizens – Under federal law, non-citizens are categorized into two groups – qualified and non-qualified non-citizens.

    (01) **Qualified non-citizens.** The qualified non-citizens category includes persons who are citizens of other nations who are lawfully present in the United States. Qualified non-citizens are barred from Medicaid for a period of five (5) years under federal law. Certain exemptions from the bar apply:

    - Qualified non-citizen children up to age 19 who are lawfully present in the United States but were born in another nation are eligible for Medicaid as members of the MACC group for children and young adults. The State elected to offer children in this subcategory of qualified non-citizens eligibility during the five (5) year bar under an option in Title XXI, the Children's Health Insurance Program (CHIP). Qualified non-citizen pregnant women are also eligible for Medicaid in the MACC group, again under an option in CHIP.

    - There are several other subcategories of non-citizens who are exempt from the five (5) year bar as specified in MCAR section 0304.05.15.

    - All non-exempt qualified non-citizens are eligible to obtain coverage through state and federal health insurance marketplaces, such as HealthSourceRI.com in Rhode Island, and may be qualified for certain tax credits.

    (02) **Non-qualified non-citizens**. The non-qualified category of non-citizens includes citizens of other nations who are not considered to be immigrants under current federal law, including those in the United States on temporary or time-limited visa (such as visitors and students) and those who are present in the country without proper documentation (includes people with no or expired status).

    - Non-qualified non-citizens are not eligible for Medicaid, except in emergency situations (see MCAR section 0304). Non-emergency services may be obtained through Federally Qualified Community Health Centers. See Rhode Island Community Health Association at www.richa.org.

    - Non-qualified non-citizen pregnant women in the applicable MACC group are eligible for Medicaid coverage. The pregnant woman's eligibility is tied to the eligibility of the baby she is carrying. For the purposes of MACC group eligibility,

the baby *in utero* is deemed to be a United States citizen and Rhode Island resident and remains so as a newborn as long the birth occurs in Rhode Island.

More detailed information on the citizenship and immigration status is located in MCAR section 0304.05

02. **Verification of status** — Any members of a household who are applying for Medicaid coverage must provide their immigration and citizenship status. Non-applicants are exempt from the requirement. Any information provided by an applicant or electronically must be used only for verifying state. Under the ACA, citizenship and immigration status are verified:

    (01) **Electronically**. The Medicaid agency must use electronic verification through the federal hub (see MCAR section 1308.08.04 d) to the full extent feasible through:

    - Social Security Administration (SSA) or RI Department of Health, Division of Vital Statistics for citizens.

    - U.S. Citizenship and Immigration Services (USCIS) for non–U.S. citizens via the Systematic Alien Verification for Entitlements (SAVE) database.

    (02) **Non-electronic**. If unable to verify immigration status electronically, enrollees have an opportunity to provide other documents or to fix the records.

    (03) **Self-Attestation.** An applicant's attestation is accepted without electronic verification providing appropriate paper documentation is provided to the Medicaid agency within ninety (90) days of the eligibility determination. Failure to provide the required documentation within that period results in a termination of Medicaid and the initiation of the Medicaid recoupment process.

1305.13 Relationship
REV: February 2015

To facilitate implementation of the ACA and the transition to the MAGI standard in the most efficient way possible, many of the eligibility requirements separating Medicaid eligible populations into discrete coverage groups were eliminated outright or consolidated and/or revamped. The non-financial eligibility criteria related to relationship for parents and caretaker relatives and dependent children established in Title XIX that incorporated Aid to Families with Dependent Children (AFDC) standards were among the requirements changed as part of this process. The State will evaluate the eligibility of members of the MACC group for families and parent/caretakers using the more inclusive definitions that follow:

01. **Caretaker Relative** – For the purposes of MACC group eligibility, parent/caretaker is any adult living with a Medicaid-eligible dependent child who has assumed primary responsibility for that child. This definition includes, but is not limited to:

    - Father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece;

- The spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

- Another relative of the child based on blood, adoption or marriage; domestic partner of parent or other caretaker relative.

If the parents are in the household, it is presumed that other members in the household are not assuming primary responsibility for the child's care.

02. **Dependent child** – For the purposes of determining eligibility the members of the MACC group for families and parents/caretakers, a dependent child is a child under the age of eighteen (18) or under age nineteen (19) if enrolled full-time in school. The provisions related to deprivation of child set forth in section 0328.15 are no longer applicable and have been repealed.

03. **Verification** – Attestation on the application is accepted as verification of relationship.

1305.14 Newborn Eligibility

Babies born to Medicaid members who are pregnant are deemed eligible from the date of birth.

01. **Newborn deeming** – The eligibility of a child born to a woman who is a Medicaid enrollee on the date of the child's birth is based on the following:

(01) **Date of eligibility**. The newborn is deemed eligible for Medicaid on the date of birth.

(02) **Continuing eligibility**. Once the deem eligible as a newborn, the infant remains eligible for one (1) year providing that the infant resides continuously in the mother's household and the mother remains eligible for Medicaid or would have remained eligible if she were still pregnant.

(03) **Discontinuation of eligibility**. If at any time it is determined that the mother would not remain eligible if she were still pregnant, or that the infant is not residing in the mother's household, the infant loses deemed eligibility. In such instances, the Medicaid agency must determine whether the infant is eligible for Medicaid on any other basis.

02. **Enumeration** – A Medicaid enrollee who is the parent of a newborn must obtain a SSN for a newborn. Failure to enumerate the child results in a sanction against the mother, not the child. The child will remain eligible even if lacking an SSN because of mother's failure to cooperate. The sanction against the mother is loss of her eligibility for failure to cooperate. This sanction will be removed once the mother meets the enumeration requirements.

03. **Verification** – The birth may be reported by the mother, or another family member or friend, the mother's Medicaid managed care plan, or the hospital in which the child was born. See section 0342.40.10 for information pertaining to the hospital record of birth.

1305.15 Hospital Presumptive Eligibility
REV: February 2015

Under the implementing regulations for the federal Affordable Care Act at 42 Code of Federal Regulations (CFR) 435.1110, states must offer Medicaid coverage to individuals who are not already Medicaid members for a limited period. This form of "presumptive eligibility" is only available in certain circumstances when a qualified hospital determines, on the basis of preliminary information, that an individual has the characteristics for Medicaid eligibility. Such individuals are "presumed eligible" for Medicaid until the end of the following month or the date full eligibility is determined, whichever comes first.

01. **Implementation** –The State will be making presumptive eligibility available to individuals who have been determined by a qualified hospital to meet the characteristics of one of the MACC groups identified in MCAR section 1301 eligible for Title XIX coverage. Persons eligible under CHIP are excluded. A qualified hospital is, for these purposes, any licensed hospital in the State participating in the Medicaid program that makes a written request to conduct PE determinations, participates in training and certification and remains in good standing with State protocols.

02. **Governing Provisions** – See Section 1318 of the Medicaid Code of Administrative Rules entitled, "Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals" promulgated by EOHHS for additional detail on the provisions governing hospital presumptive eligibility determinations in Rhode Island.

1305.16 Special Eligibility Considerations
REV: February 2015

Until further notice by the Medicaid agency, eligibility for these coverage groups is as indicated below.

01. **Section 1931 Transitional Medicaid** – As indicated in MCAR section 1303, families eligible for Medicaid under section 1931 of Title XIX, the federal Medicaid law, may be eligible for an extension of Medicaid for up to twelve (12) months when their income exceeds the income thresholds for their coverage group. Until further notice, eligibility for transitional/extended Medicaid will be conducted in accordance with the provisions set forth in MCAR section 0342.50.

02. **Refugee Medicaid** - Until further notice, eligibility for Medicaid refugees will be conducted in accordance with the provisions of MCAR section 0342.90.

1305.17 Cooperation Requirements
REV: February 2015

All applicants are required to provide truthful information. In addition, applicants must cooperate with the following requirements as a condition of obtaining or retaining (post-eligibility) eligibility in terms specified:

01. **Third Party Liability (TPL)** – Third Party Liability refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of a Medicaid applicant's coverage. Under Section 1902(a)(25) of the Social Security Act, the Medicaid agency is required to take all reasonable measures to identify legally liable third parties and treat

verified TPL as a resource of the Medicaid member once determined eligible. Applicant must furnish information about all sources of TPL. The health plan and the State are responsible for identifying and pursuing TPL for individuals covered by employer-sponsored health insurance plans through the RIte Share program. Failure to cooperate with the TPL requirement or to enroll in a RIte Share plan as required in section 1312 results in the ineligibility of the parent.

02. **Referral to Office of Child Support Services (OCSS**) – All applicants reporting an absent parent are referred to the Office of Child Support Services within the Department of Human Services, once they have been determined eligible for Medicaid and received appropriate notice. Compliance with the OCSS requirement is a condition of retaining eligibility. As a condition of eligibility, an applicant who can legally assign rights for a dependent child born out of wedlock is required to do so and cooperate in establishing the paternity of that child for the purposes of obtaining medical care support and medical care payments for both the applicant and the child. Failure to cooperate in assigning rights results in a determination of ineligibility for the parent, unless a good cause exemption has been granted by the Medicaid agency. In instances when domestic violence may be the basis for an exemption to the cooperation requirement, referral to the Family Violence Option Project may be made to assist the parent seeking an exemption.

03. **RIte Share Premium Assistance Program** – Individuals and families determined to have access to cost-effective employer-sponsored health insurance (ESI) are required to enroll in the ESI plan if so directed by the Medicaid agency. Members of the MACC groups with access to ESI who are eligible for Medicaid will be permitted to enroll in a Medicaid managed care plan, as appropriate. The Medicaid agency will conduct a post-enrollment review of those members with access to ESI to determine whether participation in RIte Share is required. The provisions governing the RIte Share program are located in section 1312.

04. **Duty to Report** – All Medicaid applicants and beneficiaries have a duty to report changes in income, family size, address, and access to ESI within ten (10) days of the date the change takes effect. Failure to make timely reports may result in the denial or discontinuation of Medicaid eligibility.

1305.18 Good Cause for Non-Cooperation

A Medicaid applicant or member must have the opportunity to claim good cause for refusing to cooperate. Good cause may be claimed by contacting a DHS or EOHHS agency representative. To claim good cause, a person must state the basis of the claim in writing and present corroborative evidence within twenty (20) days of the claim; provide sufficient information to enable the investigation of the existence of the circumstance that is alleged as the cause for non-cooperation; or, provide sworn statements from other individuals supporting the claim.

A determination of good cause is based on the evidence establishing or supporting the claim and/or an investigation by Medicaid agency staff of the circumstances used as justification for the claim of good cause for non-cooperation.

The determination as to whether good cause exists must be made within thirty (30) days of the date the claim was made unless the agency needs additional time because the information required to verify the claim cannot be obtained within the time standard. The person making the claim must be notified accordingly.

Upon making a final determination, notice must be sent to person making the claim. The notice must include the right to appeal through the EOHHS Administrative Fair Hearing Process specified in section 0110.

1305.19 Voluntary Termination of Medicaid Eligibility
EFF: February 2015

01. A Medicaid beneficiary may terminate Medicaid eligibility at any time. Such requests must be made in writing and submitted to a state agency or Contact Center representative in-person, via U.S. Mail, fax, on-line via the beneficiary's secure account, or made by telephone to the Contact Center when telephonic recording capabilities exist.

02. The Medicaid agency is responsible for providing the Medicaid beneficiary with a formal notice of the voluntary termination of Medicaid eligibility that indicates the effective date, the impact of terminating eligibility for each member of the household, and the right of the beneficiary to reapply for Medicaid health coverage at any time.

1305.20 Information
REV: February 2015

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1305.21 Severability
REV: February 2015

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

30 January 2015
1305finalfeb2015

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1306:

Renewal of Eligibility for Medicaid Affordable Care Coverage Groups

December 2013
March 2014 (T)
June 2014

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1306:

Renewal of Eligibility for Medicaid Affordable Care Coverage Groups

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1306 of the Medicaid Code of Administrative Rules entitled, "Renewal of Eligibility for Medicaid Affordable Care Coverage Groups"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in "Section 1306: "Renewal of Eligibility for Medicaid Affordable Care Coverage Groups" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State as a technical amendment on March 6, 2014.

1306 Renewal of Eligibility for Medicaid Affordable Care Coverage Groups

1306.01 Overview

One of the longstanding federal Medicaid policies is that eligibility must be redetermined once every year and the scope of these annual reviews must be limited to eligibility factors that are subject to change – income or residency, for example. State Medicaid agencies are also prohibited under federal Medicaid law from requiring beneficiaries to provide information unrelated to either continuing eligibility or a factor that is not subject to change, such as date of birth or United States citizenship. The onus for discontinuing Medicaid eligibility in this process thus falls to the State. The federal Affordable Care Act of 2010 not only reaffirmed these policies but took them a step further by requiring the states to automate continuing eligibility reviews to the full extent feasible and to recast the process as eligibility *renewal* instead of redetermination or recertification. Accordingly, effective January 1, 2014, the Medicaid agency is implementing a new automated eligibility renewal process for all individuals and families subject to the Modified Adjusted Gross Income (MAGI) standard set forth in section 1307 of Medicaid Code of Administrative Rules (MCAR).

1306.02 Scope and Purpose
REV: June 2014

All Medicaid members will be subject to MAGI-based redeterminations, based on the requirements for the appropriate MACC group (MCAR section 1305), if there is a change in any eligibility factor. Such factors include changes in income, household composition or family size (e.g., due to death, marital status, birth or adoption of child), and/or immigration status. Disenrollments for any reason that are followed by requests for eligibility reinstatements are also subject to redeterminations through this process for members of the MACC groups irrespective of whether eligibility was established prior to or beginning on January 1, 2014.

1306.03 Limitations

The provisions of this rule do not apply to parents with income between from 133% to 175% of the Federal Poverty Level (FPL) who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

Medicaid-eligible individuals in non-MAGI coverage groups identified in MCAR 1301 are not subject to this rule and should refer to the redetermination requirements for their specific coverage group in the applicable sections of the MCAR.

1306.04 Definitions

For the purposes of this rule, the following definitions apply:

"Active Renewal" means a method for determining continuing eligibility which requires the Medicaid beneficiary/member to take an action or engage directly with the Medicaid agency as a

condition of renewal. Includes requiring Medicaid members to reapply, provide written or electronic consent allowing access to protected personal information, and/or updating, signing and resubmitting pre-populated paper or on-line forms pertaining to eligibility factors.

"Enrollee" means a Medicaid member or beneficiary who is enrolled in a Medicaid managed care plan.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 as follows:

(01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

"Medicaid Code of Administrative Rules (MCAR)" means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State's Administrative Procedures Act (R.I.G.L. §42-35).

"Medicaid member" means a person who has been determined to be an eligible Medicaid beneficiary.

"Modified Adjusted Gross Income or (MAGI)" means income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income. The MAGI is the standard for determining income eligibility for all Medicaid affordable care coverage groups (MCAR section 1301).

"Navigator" means a person working for a State-contracted organization with certified assisters who have expertise in Medicaid eligibility and enrollment.

"New Applicant" means an individual or family who was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date of this rule. The term does not apply to individual and families who were receiving coverage and were disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Passive Renewal" means a method for determining continuing eligibility that does not require the Medicaid member to take an action or engage directly with the Medicaid agency as a condition of renewal. Electronic review and verification of eligibility factors subject to change is conducted by using the Medicaid member's prior consent to access protected personal information. The Medicaid agency may require members to resolve discrepancies in pre-populated forms or on-line accounts.

1306.05 Responsibilities of the Medicaid Agency

It is incumbent on the Medicaid agency to ensure that Medicaid renewal process occurs at least once every twelve (12) months, and no more frequently than every twelve (12) months for all MACC group members. Toward this end, the Medicaid agency must meet the following requirements:

01. **Basis of Renewal** – The eligibility renewal must be based on information already available to the Medicaid agency to the full extent feasible. Accordingly, the Medicaid agency must use information about the Medicaid member from reliable sources including, but not limited to, the member's automated eligibility account, current paper records, or data bases that may be accessed through the federal data hub or the State's own affordable care coverage eligibility system (MCAR section 1308).

02. **Restrictions** – The Medicaid agency must not request or use information when conducting renewals pertaining to: eligibility factors that are not subject to change or concern matters

that are not relevant to continuation of Medicaid eligibility. Eligibility factors subject to change include income, household or family size, and immigration status. Factors that are not subject to change include, but are not limited to, U.S. citizenship, date of birth, and Social Security Number.

03. **Notice** – The Medicaid agency must provide timely notice of:

(01) **Renewal Date.** A notice of the date of the annual renewal must be sent at least thirty (30) days prior to the renewal date. The notice must provide the Medicaid member with information on the renewal process along with instructions on how to complete any actions that are conditions of renewal. A statement of the consequences for not taking necessary actions, if any, and the right to appeal and request an administrative fair hearing must also be included. As indicated in section 1306.05.04 below, the scope of the Medicaid member's direct participation in the process varies depending on whether the Medicaid agency is implementing an active versus passive approach to renewal.

(02) **Agency Action.** The Medicaid agency must provide Medicaid members with a notice stating the outcome of the renewal process and explaining the basis for any agency action. In instances in which continuation of eligibility depends on the Medicaid member taking action, such as providing paper documentation or reviewing information, the notice must state the nature of the action required, establish a timeline for completing the action and indicate the consequences for failure to do so, and indicate how the Medicaid beneficiary can obtain assistance from the Medicaid agency, whether through the representative of the Contact Center or the Department of Human Services (DHS) field offices. The right to appeal and request an administrative fair hearing in accordance with MCAR section 0110 must also be included.

03. **Consent** – The Medicaid agency must obtain the consent of the Medicaid member to retrieve and verify electronically information related to eligibility factors subject to change including any federal tax information required to review income eligibility. Such consent may be obtained during the initial application for Medicaid eligibility when the Medicaid member signs the application (see MCAR section 1303) under penalty of perjury or at the first time a Medicaid member is subject to a MAGI-based renewal.

04. **Renewal Strategy** – The Medicaid agency will use both active and passive renewal methods until all MACC group members have been subject to a MAGI-based income eligibility determination at least once. Accordingly, the Medicaid agency will conduct renewals as follows:

(01) **Active Renewals.** The Medicaid agency will use an active renewal method for all individuals and families who are seeking continuing eligibility using the MAGI standard for the first time. In this process, Medicaid members will be required to ensure the accuracy and completeness of any information on record related to an eligibility factor subject to change. In addition, the Medicaid member must provide consent to the Medicaid agency permitting automated retrieval of federal tax

information for income verification purposes for all subsequent renewals. A pre-populated form containing relevant eligibility information will be provided to the member to review and update and return with consent necessary to use passive method for future renewals.

(02) **Passive Renewals.** After the initial determination using the MAGI standard, whether at the time of application or first renewal, the Medicaid agency will use a passive renewal method. Medicaid members will be provided with timely notice of the annual renewal and a pre-populated form containing information about eligibility factors subject to change. The form will developed, with the Medicaid member's prior consent, by retrieving applicable protected personal information electronically to update eligibility records and conducting verification through the federal hub and State data bases. The Medicaid agency must advise the Medicaid member of the duty to report any changes related to these factors before the date of the annual renewal. Eligibility is continued unless such a report is received or any discrepancies that may surface in the data matches remain unresolved. Such changes may be self-reported through the eligibility system web-portal or in-person, via fax, on-line, or by mail or telephone with the assistance of a Contact Center or DHS agency representative, or Navigator.

05. **Enrollment** – A Medicaid member whose eligibility has been continued through the annual renewal process must remain in the same Medicaid health plan unless the renewal occurs during an open enrollment period. If an open enrollment process is not underway at the time of renewal, the provisions set forth in MCAR section 1311 prevail.

06. **Access** – The Medicaid agency must ensure that any application or supplemental forms required for renewal are accessible to persons who have limited proficiency in English or who have a disability.

1306.06 Responsibilities of Medicaid Members

Medicaid members must ensure that the Medicaid agency has access to accurate and complete information about any eligibility factors subject to change at the time of the annual renewal. Accordingly:

01. **Consent** – At the time of the initial application or first MAGI-based renewal, Medicaid members must provide the Medicaid agency with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's affordable overage eligibility system. Once such consent is provided, the Medicaid agency may retrieve and review such information when conducting all subsequent annual renewals.

02. **Duty to Report** -- Medicaid members are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system on-line portal. Medicaid members also may report such changes in person, via fax, by mail, or telephone with the assistance of

Contact Center or DHS agency representative, or Navigator. Failure to report in a timely may result in the discontinuation of Medicaid eligibility.

03. **Cooperation** – Medicaid members must provide any documentation that otherwise cannot be obtained related to any eligibility factors subject to change when requested by the Medicaid agency. The information must be provided within the timeframe specified by the Medicaid agency in the notice to the Medicaid member stating the basis for making the agency's request.

04. **Voluntary Termination** -- A Medicaid member may request to be disenrolled from a Medicaid health plan or to terminate Medicaid eligibility at any time. Disenrollment results in the termination of Medicaid eligibility. Once Medicaid coverage is terminated, the penalties established under the individual mandate in the federal Affordable Care Act of 2010 apply unless the former Medicaid member obtains an alternate form of health insurance coverage.

05. **Reliable Information** – Medicaid members must sign under the penalty of perjury that all information provided to the Medicaid agency at the time of application and any annual renewals thereafter is accurate and truthful.

1306.07 Information
REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

    www.eohhs.ri.gov
    www.dhs.ri.gov
    www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1306.08 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1307:

"MAGI" Income Eligibility Determinations

December 2013
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Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1307:

"MAGI" Income Eligibility Determinations

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1307 of the Medicaid Code of Administrative Rules entitled, ""**"MAGI" Income Eligibility Determinations**"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in Section 1307 of the Medicaid Code of Administrative Rules entitled, "'MAGI' Income Eligibility Determinations" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State as a technical amendment on March 6, 2014.

1307 "MAGI" Income Eligibility Determinations

1307.01. Scope and Purpose

To implement the federal Affordable Care Act (ACA), Rhode Island took the option under the law to establish its own new web-based eligibility system with the capacity to determine whether an individual or family qualifies for affordable health care coverage paid for by Medicaid or in whole or in part by federal tax credits or other subsidies. The Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, and the recently established Rhode Island Health Benefits Exchange, known as HealthSourceRI (HSRI), are using this new eligibility system to make determinations for all forms of affordable coverage available under the ACA, including Medicaid.

One of the principal goals of the ACA is to improve access to affordable coverage by simplifying and streamlining the application and eligibility determination process. Toward this end, the Act established a distinct income standard – Modified Adjusted Gross Income or MAGI – to determine eligibility for affordable coverage across payers (e.g., Medicaid, tax credits, state subsidies, employers) and populations (families, pregnant women, children, adults without children). Effective January 1, 2014, the MAGI standard will be used to determine eligibility for all new applicants for Medicaid coverage in the Medicaid Affordable Care Coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR). The process for applying for Medicaid affordable coverage using the new eligibility system is located in MCAR section 1303.

The purpose of this rule is to: describe the MAGI and explain how it will be applied; and establish the role and responsibilities of the Medicaid agency and consumers when determining MAGI-related eligibility.

1307.02. Definitions

"Advance payments of the premium tax credit (APTC)" means payment of the federal health insurance premium tax credit on an advance basis to an eligible person enrolled in a qualified health plan through a health insurance exchange.

"Affordable Care Act (ACA)" means the federal Patient Protection and Affordable Care Act of 2010. The law is also sometimes referred to as "Obamacare" and federal health reform.

"APTC/CSR eligibility" APTC/CRS eligibility means the application of the IRS-based measure of income known as "Modified Adjusted Gross Income" for determining eligibility for affordable health care through health insurance exchanges/marketplaces established under the ACA. Also, APTC means advanced premium tax credits and CSR means cost sharing reductions.

"Attestation" means the act of a person affirming through an electronic or written signature that the statements the person made when applying for Medicaid eligibility are truthful and correct.

"Caretaker or caretaker relative" means any adult living with a Medicaid-eligible dependent child that has assumed primary responsibility for that child as defined in MCAR section 1305.13.

"Current Household Monthly Income" means average monthly income from all members determined to be part of the household, received from all sources, and derived during the six-month period ending on the last day of the month preceding application date.

"Custodial parent" means a relationship that is defined by a court order or binding separation, divorce or custody agreement establishing physical custody of a minor child. If no order or agreement exists, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

"Federal poverty level" or "**FPL**", as used herein, means the most recently published federal poverty level by the U.S. Department of Health and Human Services.

"MAGI" means modified adjusted gross income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income.

"**Medicaid Affordable Care Coverage (MACC) Group**" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"**Medicaid Code of Administrative Rules (MCAR)"** means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State's Administrative Procedures Act (R.I.G.L. §42-35).

"Medicaid member" means a person who has been determined to an eligible Medicaid beneficiary.

"New Applicant" means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Relationship-based Household Rules" means the Medicaid household composition rules that consider the living and familial relationships of the applicants without regard to their taxpayer household. Special Medicaid household composition rules result in exceptions to general application of the MAGI Standard.

1307.03. Applicability of the MAGI Income Standard
REV: June 2014

On January 1, 2014, individuals and families seeking affordable health coverage may be eligible for a Medicaid-funded plan if they meet requirements set forth in MCAR section 1305 and the MAGI income standard for the program established in this rule.

01. **Subject to the MAGI** - This rule applies to all new applicants and beneficiaries in the following Medicaid Affordable Care Coverage (MACC) groups:

(01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

A detailed description of each of these Medicaid coverage groups is located in MCAR section 1301; eligibility criteria are established in MCAR 1305.

02. **Exempt from the MAGI** --The MAGI income eligibility standards IS NOT applicable to:

(01) Parents with income between 133% and 175% of the FPL under Rhode Island law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended) are subject to the MAGI if seeking non-Medicaid subsidized coverage as indicated in MCAR section 1315.

(02) Any persons eligible for Medicaid based on participation in another program or that the Medicaid agency is not whom the state agency is not required to make an income determination, such as adoption assistance, Supplement Security Income beneficiaries;

(03) Persons seeking eligibility under MCAR sections 0351 or 0374 who are 65 and older or who are seeking eligibility based upon blindness or a disability;

(04) Persons seeking eligibility under MCAR section 0378 who need long-term services and supports in an institutional or home or community based setting;

(05) Persons seeking eligibility as "medically needy" due to excess income; and

(06) Persons eligible for Medicare cost-sharing assistance through the Medicare Premium Payment Program.

1307.04 MAGI Household Construction

Applications for MACC groups are processed by the new eligibility system. The system can be accessed directly on-line through the links on the EOHHS or DHS websites, the HSRI website, the Contact Center or kiosks located at Department of Human Services (DHS) field offices. Details of the application process are located in MCAR section 1303. Eligibility is determined through the electronic eligibility system as indicated in this rule and MCAR section 1308. The eligibility system uses this information to both assess whether an applicant meets residency, citizenship and other such requirements and perform all MAGI calculations. The principal factor for determining MAGI-based eligibility is household composition and size based on the rules for household construction.

01. Household composition and size --The ACA requires that states use the same general household composition rules focusing on the tax relationship of individuals when determining eligibility for affordable care. In general, the applicant's household members are identified as part of the application process; income is then determined by comparing the standards cited below with the FPL for a household of the same size. There are certain areas in which Medicaid household construction rules diverge to assure all eligible family members have access to coverage.

02. General rules of household construction -- For the purposes of calculating MAGI, a household consists of an applicant and the people the applicant claims as a deduction for a personal exemption when filing federal income taxes. Under IRS rules, the taxpayer may claim a personal exemption deduction for him/herself, a spouse, and tax dependents. Non-family members may be included as tax dependents under certain circumstances and are treated as part of the tax household accordingly.

03. Special Medicaid rules of household construction – The following rules for constructing a household are applied when making MAGI-based Medicaid eligibility determinations:

    (01) "Relationship-based" rules are used when an applicant is not filing taxes or is a custodial parent who, although living with a child, does not claim that child as a dependent for federal income tax purposes.

(02) Medicaid household rules are "individual specific" within a family. Therefore, a Medicaid household must be constructed for each person within a family.

(03) For married couples living together, each spouse must be included in the household of the other spouse, regardless of whether they expect to file a joint federal tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(04) If a pregnant woman is applying for coverage or is part of another applicant's household, the household size must be adjusted to reflect the number of children that she is expecting. Specifically, the pregnant woman is counted as one plus the number of children she expects to deliver. This pregnancy-adjusted household size must be used to determine the applicable FPL used when assessing Medicaid eligibility.

1307.05 Exceptions Requiring Application of Relationship Household Rules

Relationship-based household composition rules must be applied when an applicant meets the criteria for an exception from the tax-based household rules. These alternative relationship-based rules must be used to determine both household size and the income of the household members included as part of total household income.

01. Relationship-based rules --The household is determined based upon the family members who live with the applicant. The rules vary slightly for children versus adults.

(01) Adults. The relationship-based rules for adults require that the household consist of the following individuals:

- The adult applying for coverage;
- The applicant's spouse, if living with the applicant;
- The applicant's natural, adopted, and step-children under age 19 years, if living with the applicant.

(02) Children under age 19. The relationship-based rules for minor children require that the household consist of the following individuals:

- The child applying for coverage; any of the child's parents (including step-parents), if living with the child;
- Any of the child's siblings (including step-siblings), if living with the child.

02. Triggers --The exceptions that trigger the use of relationship-based rules are as follows:

(01) Applicant is not planning to file taxes. The relationship-based rules are used for applicants who do not plan to file taxes and who do not expect to be claimed as a tax dependent by another tax filer. For example, some very low-income people do not plan to file taxes because they do not meet the tax filing threshold. Full information

on who is required to file taxes under federal law is located in IRS Publication 501 (IRS Publication 501 is available at: http://www.irs.gov/publications/p501/ar02.html#en_US_2012_publink1000220851).

(02) Tax dependents meet specified criteria. In situations in which an applicant will be claimed as a tax dependent on another person's federal tax form, the relationship-based rules apply if the tax dependent meets any of the following criteria:

- Applicant is claimed or expects to be claimed by a grandparent or other relative who is not is not the applicant's parent or step-parent.

- Child lives with both parents, but only one parent will claim the child as a tax dependent. If the applicant is a child up to age 19 living with two parents, but only one parent plans to claim the child as a tax dependent, then the relationship-based rules apply.

- Child lives with a custodial parent, but will be claimed as a tax dependent by a non-custodial parent, the relationship-based rules must be used to construct the child's household. This ensures that custodial parents can apply for and secure MAGI Medicaid coverage on behalf of the children who live with them and for whom they are responsible. A custodial parent is defined by a court order or binding separation, divorce or custody agreement establishing physical custody. If no order or agreement exists, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

Summary of Application of Relationship-Based Rules
Applicant is not planning to file taxes
Individual is claimed by a grandparent or other relative who is not a parent
Child lives with both parents, but only one parent will claim the child as a tax dependent
Child lives with a custodial parent, but will be claimed as a tax dependent by the non-custodial parent

1307.06 Determination of Household Income

To be eligible for Medicaid using the MAGI standards, an applicant's current monthly household income must meet the standard applicable to the applicant's MACC group when converted to the federal poverty level as shown below:

MACC Groups	***FPL Eligibility Threshold***
Adults	133%
Children and Young Adults	261%
Families	133%
Pregnant Women	253%

When calculating whether an applicant is income-eligible for Medicaid under one of these coverage groups, the following factors must be considered: the members of the applicant's household that must be included; types of countable income; current income and reasonably predicted changes; and conversion of monthly income to the federal poverty level (FPL) standards.

01. Countable household income --There are several differences in the way certain types of income are treated when using the MAGI for Medicaid eligibility just as there are with the rules of household construction. The subsection below identifies all forms of countable income included when determining MAGI-based Medicaid eligibility, including those that are specific to Medicaid eligibility only.

(01) Adjusted Gross Income (AGI). Adjusted gross income is gross income adjusted by "above-the-line" deductions. AGI includes wages and salaries and income from a broad array of other sources, such as unemployment benefits, alimony, taxable interest, and capital gains. "Above-the-line" deductions are the adjustments people can make to their gross income. These include alimony payments, interest on student loans, and other items that appear on page one of Form 1040. However, they do not include charitable contributions, mortgage interest and other "below-the-line" deductions.

(02) Social Security benefits. All Social Security income benefits are considered countable income when using the MAGI to determine eligibility for affordable coverage. This includes Social Security benefits that considered both taxable and non-taxable income for federal tax purposes.

(03) Interest Income. Income received from bank accounts, money market accounts, certificates of deposit, and deposited insurance dividends are considered countable taxable income. Additionally, interest on some bonds issued by and used to finance state and local government operations is also counted for the MAGI even though treated as tax-exempt for federal tax purposes.

(04) Foreign earned income. Foreign earned income is countable for the MAGI. This includes all income received from sources within a foreign country or countries earned for services when either performed by: a U.S. citizen and a bona fide resident of a foreign country for an uninterrupted period of time that includes an entire tax year; or a U.S. citizen or resident who, during any period of 12 consecutive months, is present in a foreign country for at least 330 full days during that period.

(05) Medicaid specific adjustments to income. Special Medicaid adjustments are as follows:

- Lump sum payments (i.e., gifts, prizes, income and property tax refunds) are counted only in the month received.

- Educational scholarships, awards or fellowships used for education purposes are excluded from consideration as income.

- Certain types of income for American Indian/Alaska Native individuals are excluded.

- Treatment of other sources of income for Medicaid eligibility are summarized in the table that follows:

MAGI-Based Medicaid Eligibility Rules	
Income Source	***Treatment of Income on and after January 1, 2014***
Self-employment income	Counted with deductions for most expenses, depreciation, and business losses
Salary deferrals (flexible spending, cafeteria and 401(k) plans	Not counted
Child support received	Not counted
Alimony paid	Deducted from income
Veterans' benefits	Not counted
Workers' compensation	Not counted
Gifts and inheritances	Not counted
TANF and SSI	Not counted

02. Household members included in MAGI calculation -- In general, the MAGI income of all individuals in an applicant's household must be counted toward household income with the following two exceptions:

    (01) Exception for the income of children. Unless a child is "expected to be required" to file a tax return, a child's income is not counted toward household income. The child's income does not count as part of household income when evaluating both the child's eligibility and the eligibility of other household members. This treatment of children's income also applies to adult children -- not just those under age 19 -- if they are tax dependents.

    (02) Exception for the income of most other dependents. The income of dependents who are not children or spouses is included as countable in the household income of the person who is claiming them (i.e., the claiming tax filer) only if they "are expected to be required" to file a tax return. The exception for most other tax dependents does not apply to spouses who are claimed as a tax dependent.

These exceptions are based on whether or not a person is "expected" to be required to file a tax return; it does not matter whether they eventually do so or not.

03. Use of current income & accounting for reasonably predicted changes -- For new Medicaid applicants, the Medicaid agency must use a household's current monthly income and household size when evaluating eligibility. A prorated portion of reasonably predictable changes in income, if there is a basis for anticipating the changes, such as a signed contract for employment, a clear history of predictable fluctuations in income, or other indications of future changes in income may be considered in determining eligibility. Future changes in income and household size must be verified in accordance with the verification and reasonable compatibility requirements are delineated in MCAR section 1308.

04. Comparing household income to the Federal Poverty Level (FPL) – To determine income eligibility for Medicaid based on the MAGI calculation, the Medicaid agency must compare a household's current monthly income to the FPL guidelines for the appropriate household size. The Medicaid agency must use the most recently published FPL level in effect in the month during which an applicant applies for coverage. If an applicant's FPL level is within five (5)

percentage points over the FPL for the coverage group for which they would be eligible, a disregard of five (5) percentage points of the FPL shall be added to the highest income eligibility standard listed above for that coverage group.

1307.07. For Further Information or to Obtain Assistance
REV: March 2014

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1307. 08. Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1308:

Verification of Medicaid Affordable Care Coverage Group Eligibility Factors

December 2013
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Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1308:

Verification of Medicaid Affordable Care Coverage Group Eligibility Factors

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1308 of the Medicaid Code of Administrative Rules entitled, "Verification of Medicaid Affordable Care Coverage Group Eligibility Factors",** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous regulations related to access to Medicaid coverage under the Affordable Care Act entitled, "Verification of Medicaid Affordable Care Coverage Group Eligibility Factors", promulgated by EOHHS and filed with the Rhode Island Secretary of State.

1308 Verification of Medicaid Affordable Care Coverage Group Eligibility Factors

1308.01 Overview
REV: June 2015

Section 1411 of the federal Affordable Care Act ("Affordable Care Act" or "ACA") requires the states to verify information for anyone applying for coverage through their health insurance exchanges. In Rhode Island, this provision covers any individuals and families who must apply for Medicaid through the web portal developed to support both Medicaid and HealthSourceRI.

To achieve the ACA's goal of improving and streamlining access to all forms of affordable coverage, including Medicaid, the federal government established a data hub containing information related to various eligibility factors. The data hub facilitates the electronic information exchange necessary to verify eligibility both at the time of initial application and during annual renewals thereafter. States have the flexibility to augment the electronic verification process the federal data hub uses with any additional data bases deemed appropriate. Rhode Island elected to use state level databases to verify income first as they tend to be more correct, but still uses the federal data hub, as appropriate.

1308.02 Scope and Purpose
REV: June 2015

All new applicants in the Medicaid Affordable Care Coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR) are required to complete the same single, streamlined application as all other persons seeking coverage through the web portal that serves both Medicaid and HealthSourceRI. The application seeks basic information about everyone who is applying for affordable coverage, irrespective of payer – that is whether the coverage is paid for in whole or in part by Medicaid, tax credits, subsidies, the applicant, and/or an employer. Applicants must provide basic information related to the eligibility determination for all members of their household that includes, but is not limited to: names; household composition; Social Security Numbers (if they have one and wish to provide it), residency; and Modified Adjusted Gross Income (MAGI).

The purpose of this rule is to identify the principal facets of the verification process, including the electronic matches made through the federal data hub, and State-automated data bases and alternatives. In addition, the provisions of this rule also set forth the respective roles and responsibilities of the Executive Office of Health and Human Services (EOHHS), in its capacity as the Single State Medicaid Agency (Medicaid agency), and applicants in assuring this process functions in the most secure, effective, and efficient manner possible.

1308.03 Definitions
REV: June 2015

For the purposes of this rule, the following definitions apply:
"Attestation" means the act of a person affirming through an electronic or written signature or telephonically that the statements the person made when applying for Medicaid eligibility are truthful and correct.

"Federal data hub or data hub" means the database of the United States population built by the U.S. Internal Revenue Service (IRS) and Health and Human Services (HHS) used to facilitate determinations for coverage, including Medicaid, under the Affordable Care Act of 2010.

"HealthSourceRI" means the entity that allows individuals, families, and small businesses to access insurance, as well as federal subsidies to assist in the payment of that coverage.

"Household composition" means, for the purposes of determining MAGI eligibility, the person(s) filing taxes, whether jointly or separately, and anyone included as a tax dependent of the person(s) filing taxes. Special relationship rules for household composition may apply when the person filing taxes is not the custodial parent of the tax dependent.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 as follows:

(01) **Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL)** – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18, or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) **Pregnant women.** Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) **Children and Young Adults.** Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) **Adults 19-64.** This is the new Medicaid State Plan expansion coverage group established in conjunction with ACA implementation. This group consists of citizens and certain qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicare Part "A" or "B" or Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

"**Modified Adjusted Gross Income (MAGI**)" means income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. The MAGI is the standard for determining income eligibility for all Medicaid affordable care coverage groups (See MCAR section 1307 for application of the MAGI).

"**Reasonable compatibility"** means a situation when a discrepancy between an applicant's attestation and the information obtained from federal and State data sources in the electronic verification process does not affect the eligibility of the applicant. (See also section 1308.06 herein).

"**Reasonable explanation"** means information or documentation required to reconcile a discrepancy or difference between an applicant's attestation and federal and/or State data sources on an eligibility factor.

"Reconciliation" means the point in the verification process when discrepancies between an applicant's attestation and information from data sources are resolved.

1308.04 Synopsis of Verification Process
REV: June 2015

New individuals and families seeking coverage must attest to the truthfulness and accuracy of the information they provide when applying by signing the completed application form under penalty of perjury. The Medicaid agency requires varying degrees of verification of the applicant attestations – sometimes referred to as self-attestations – depending on the eligibility factor (see Section 1308.05 for details). For example, self-attestations are accepted without verification for residency, household composition, pregnancy and caretaker relative status. For all other eligibility factors, the Medicaid agency requires electronic verification of applicant attestations through one or more federal and/or State data sources. In instances in which an applicant's attestations on an eligibility factor conflict with data from the electronic data source, the Medicaid agency uses several different approaches to reconcile the differences. Paper documentation may be required. A beneficiary's income self-attestation is also subject to a post-eligibility verification process. In general, this verification process proceeds as follows:

01. **Data matching** – The Medicaid agency must assure that an applicant's information is entered into the eligibility system and matched electronically to the full extent feasible through the federal data hub and State data sources.

(01) **Federal Data Hub**. The federal data hub contains electronic information from various agencies of the United States government, including the IRS, Social Security Administration (SSA), HHS (Centers for Medicare and Medicaid Services (CMS) and other agencies), Department of Homeland Security (USDHS), Department of Veterans Affairs (VA), Department of Defense (DoD), Peace Corps, and Office of Personnel Management (OPM). Various categories of data from these sources are used to match on income, employment, health, entitlements, citizenship, and criminal history. A full list of the data included in the federal hub and the rules governing its use are located in 42 Code of Federal Regulations (CFR) 435.948/949.

(02) **State data sources.** The State draws from databases from an array of public agencies including the RI Department of Labor and Training (DLT), the Department of Health (DOH), Division of Vital Statistics, the Department of Corrections (DOC), Divisions of Revenue and Motor Vehicles, and EOHHS agencies including DHS. Specific databases include State Wage Information Collection Agency (SWICA) and state unemployment compensation information (UI).

02. **Reasonable compatibility** – The Medicaid agency must use a reasonable compatibility standard to match data sources with self-reported application information. Attestation and data sources are reasonably compatible if any differences that emerge during the verification process are insufficient to affect the eligibility of the applicant. If the data sources match the applicant's

attestation, or are found "reasonably compatible," the Medicaid agency must ensure that the eligibility system bases the determination on the information in the application. The Medicaid agency uses this standard for income verification and may apply it to other eligibility factors in the future. (See also section 1308.06 herein).

03. **Reasonable explanation** – The Medicaid agency must provide the applicant with the opportunity to provide an explanation and documentation if the data sources do not match the attestation, or are not reasonably compatible. Accordingly, the automated eligibility system issues a request to the applicant for this information and provides a list of reasonable explanation options.

04. **Reconciliation process** – The explanation provided by an applicant must be used to determine whether it is feasible to reconcile a discrepancy between an attestation and data matches to determine whether reconciliation is feasible. If the applicant provides a reasonable explanation, the final determination of eligibility will be based on the information the applicant provided. If the applicant is unable to provide a reasonable explanation, documentation will then be required to verify or correct the attestation and reconcile the discrepancy.

05. **Privacy** – The verification process utilizes personally identifiable information (PII) from both the federal data hub and State data sources. An account is maintained for each person who completes and submits an application through the State's eligibility system. This account includes PII and other eligibility-related information used in the determination and annual renewal process. The Medicaid agency must assure the privacy of the information in these accounts in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information and Rhode Island General Laws 40-6-12 and 40-6-12.1. Also, the Medicaid agency must limit any use of account information to matters related to the administration of the Medicaid program including eligibility determinations, Medicaid health plan enrollment, appeals, and customer services.

06. **Account Duration**-- Once an account in the eligibility system is established, a person seeking Medicaid has ninety (90) days to complete and submit the application for a determination. The eligibility system eliminates the account and all eligibility information from all sources, federal and State, if an application has not been completed by the end of that period. The Medicaid agency must determine eligibility within thirty (30) days from the date the competed application is submitted.

07. **Post-eligibility verification** – see section 1308.12 herein.

1308.05 Eligibility Factors and Medicaid Verification
REV: June 2015

The following lists key eligibility factors, indicates the types of verification required for attestations, if any, and the verification sources:

- **Identity.** An applicant must provide proof of identity when applying through the eligibility system web-portal or when filing a paper application. To apply on-line, an applicant must first create an account; proof of identity is required to activate the account. Requests to establish an applicant's identity – "identity proofing" – are processed through one of the federal hub data sources that maintains information about individuals based on date-of-birth and address, among

other factors. Applicants who have no fixed address (e.g., homeless) or are transient, or who have moved recently or often (e.g., students), may not be able to obtain electronic identity proofing through the federal hub due to data limitations. Pre-eligibility verification is required in these instances to establish an account. Applicants may up-load, fax, e-mail, or provide in-person any of the acceptable documents of identity listed in Section 1308.10.

- **Income.** Electronic verification of self-attested income is required by the Medicaid agency. Multiple electronic data sources may be used for this purpose. In general, State data sources (e.g., State Wage Information Collection Agency [SWICA] and State Unemployment Compensation [UI] will be used first. The reasonable compatibility standard (section 1308.06.) applies when there are discrepancies between the applicant's income self-attestation and information from electronic data sources. When no electronic data source(s) are available at the time of initial determination to verify income, a self-attestation is accepted in the post-eligibility income review if the difference between the attestation and income eligibility level for the applicable MACC group is less than or equal to ten percent (10%). Additional information on this process is located in Section 1307.06.

- **Social Security Numbers, Age, Citizenship, Death, Date of Birth, and Incarceration**. Information on these eligibility factors is verified against various state and federal data sources. Immigration status is verified against data from the USDHS. Paper documentation may be required as well as several other secondary sources (e.g., Rhode Island Department of Health, Division of Vital Statistics, Department of Corrections) for verification purposes if these primary electronic data sources are not available.

- **Residency, Household Composition, Pregnancy, Caretaker Relative Status**. Self-attestation is accepted for these factors, except when there is a wide discrepancy with available information (e.g., a 60 year old pregnant woman).

1308. 06 Medicaid Reasonable Compatibility Standards
REV: June 2015

When information obtained through the federal data hub and State data sources is found reasonably compatible with the applicant's attestation, no further verification is required (including documentation) and the eligibility determination will proceed, provided all other eligibility criteria are met.

The reasonable compatibility standards set forth below by the Medicaid agency are applicable to income verification. Note: The term "data" refers to information obtained through electronic data matches across federal and State sources.

Medicaid Reasonable Compatibility Standards for Income	
Attestation and Data Scenario	***Reasonable Compatibility Standard***
Attestation and SWICA and UI data are below Medicaid eligibility levels	Reasonably Compatible: Individual eligible for Medicaid
Attestation and SWICA and UI data are above Medicaid eligibility levels	Individual ineligible for Medicaid; eligibility for a qualified health plan (QHP) is determined
The attestation is lower than the SWICA and UI data and the difference between the attestation and data is 10% or less	Reasonably Compatible: Individual eligible for Medicaid

Medicaid Reasonable Compatibility Standards for Income	
Attestation and Data Scenario	***Reasonable Compatibility Standard***
The attestation is lower than the SWICA and UI data and the difference between the attestation and data is greater than 10%	Not Reasonably Compatible: pursue discrepancy reconciliation Individual may provide a reasonable explanation and/or provide the Medicaid agency with documentation of current income.
Attestation and income data (e.g., house rentals, death benefits) are both at the applicable income level	Reasonably Compatible: Individual eligible

01. Income attestation and data are both below Medicaid eligibility levels -- Attestation and data sources are reasonably compatible if the difference or discrepancy between the two does not affect the eligibility of the applicant. In other words, even if there is a difference between what an applicant says he or she earned and what the data shows was actually earned, the data are considered reasonably compatible, but only if both are below Medicaid eligibility levels.

02. Attestation and data are both above Medicaid eligibility levels -- Attestation and data sources are reasonably compatible if they are both above the Medicaid eligibility levels. Under such a scenario, the individual would be found ineligible for Medicaid. For example, this would occur if an applicant attests to income above the eligibility ceiling for the applicable MACC group and electronic data based verification indicates that the applicant's income is higher than that amount. The applicant is not eligible for Medicaid in either case. Eligibility for affordable care with federal advance premium tax credits and cost-sharing reductions is then reviewed.

03. Income attestation -- the difference between the income attestation and the data is less than 10% -- An income attestation and data from electronic sources are considered reasonably compatible if the difference between the applicant's attestation and the data sources is less than 10%. The applicant is eligible, provided all other eligibility criteria are met.

04. Income attestation -- the difference between the income attestation and data sources is greater than 10%. An income attestation and data on income sources are considered to be not reasonably compatible if the difference between the applicant's attestation and data sources is greater than 10%; a reasonable explanation is pursued.

1308.07 Reasonable Explanations
REV: June 2015

When attestation and data sources are not reasonably compatible, the eligibility system provides the applicant with prompts for resolving any identified discrepancies. The applicant is asked first to provide an explanation. Before an eligibility determination is made, the applicant will be afforded an opportunity to explain any discrepancies between their income attestation and the income source data.

The following chart is a list of acceptable explanations when there is a discrepancy between an income attestation and data sources. If the applicant provides any one of these explanations, eligibility will be based on their attestation and no further verification is required. Note: The Medicaid agency has only implemented reasonable explanation options for income discrepancies.

Reasonable Explanations for Discrepancy in Income	
• Lost job • Decrease in hours • Multiple employers • Self-employed • Do not file taxes • Have not filed taxes yet • Homeless • Victim of domestic violence • Victim of natural disaster	• Fluctuating income • Work on commissions • Income from capital gains • Income from dividends • Income from royalties • Seasonal worker • Divorce or marriage • Death in family • Victim of identity theft

1308.08 Reconciliation Period
REV: June 2015

If the applicant's data verification is not reasonably compatible and the applicant has been unable to provide a reasonable explanation for discrepancies related to income eligibility, applicants will be given a thirty (30) day application period to submit satisfactory documentation. Medicaid eligibility is only available during the reconciliation period as specified in section 1308.09 below.

1308.09 Limited Temporary Eligibility
REV: June 2015

An applicant who meets all other eligibility requirements will be deemed temporarily eligible for up to ninety (90) days during the reconciliation period only in circumstances in which the applicant is required to submit documentation to verify citizenship or immigration status.

If the discrepancy is related to an eligibility factor other than citizenship or immigration status, there is no temporary eligibility and applicants must submit documents within ten (10) days beginning on the fifth day from the date the request for information was mailed in order to proceed with the eligibility determination.

1308.10 Satisfactory Documentation

During the reconciliation process, applicants will be asked to submit satisfactory documentation to verify eligibility. The following charts summarize acceptable documentation when verifying eligibility.

Identity (First Name/Last Name)	
• Birth Certificate • U.S. Passport • Naturalization Certificate • Social Security Card • Military ID	• Driver's License • State-issued Photo ID • School Photo ID • Voter registration card

Social Security Number	
• Social Security Card • Social Security Records	• Tax Return or other documentation showing SSN

Date of Birth	
• Birth certificate • U.S. Passport • Naturalization Certificate • Hospital Birth Records • RSDI Award Letter if DOB of child is included • Adoption Records • Affidavit of a Third Party • School Records • Military Service Records • Physician Records • Social Security Card	• Driver's License • State-issued Photo ID • Social Security Records • Baptismal Certificate • Voter Registration Card • Confirmation Papers • Family Bible • Marriage License • State/Federal Census Record • Life Insurance Policy • Immigration Papers

Residency	
• Rent Receipt • Letter from Landlord • Lease • Mortgage Papers • Utility Bill • Property Tax Bill	• Home Insurance Bill • Letter from Person Whom Applicant Pays Room and Board • Mortgage Books/Records • Sewer and Water Bills • Non-Heating Utility Bills • Telephone Bills

Income	
• Pay stubs representative of the last four (4) weeks of income • Earnings Statement • Employment Letter • Book Keeping Records • Property Unit Proof • Owner Occupied Proof • Monthly Rental Income Proof • Mortgage Breakdown Proof • Income Tax Returns	• Reports from Social Security Veteran's Administration and other agencies • When the applicant is unable to obtain the information requested, Departmental forms (Wage Report, AP-50; Bank Clearance, AP-91; Clearance with VA, AP-150 and AP-151) are used.

Citizenship	
Primary Evidence: The following evidence must be accepted as satisfactory documentary evidence of <u>both identity and citizenship:</u>	
• A U.S. Passport • A Certificate of Naturalization • A Certificate of U.S. Citizenship • A valid State-issued driver's license, if the State issuing the license requires proof of U.S. citizenship or a social security number to issue a license • Documentary evidence issued by a federally recognized Indian Tribe	
Secondary Evidence: Only if the above documents are not available, the applicant can provide two of the following as secondary evidence:	
One of the following documents to <u>show citizenship</u>:	**PLUS One of these documents to <u>prove identity</u>:**
A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (CNMI local time)).	For individuals 16 years of age or older, any of the following Identity documents (described in 8 CFR 274a.2(b)(1)(v)(B)(1)):
Evidence of birth in Puerto Rico, the U.S. Virgin Islands or the Mariana Islands after they became part of the	A driver's license or identification card containing a photograph, issued by a state

Citizenship	
United States or an applicant's statement that they were resident in one of these locations when they became part of the United States.	
At state option, a cross match with a State vital statistics agency documenting a record of birth.	School identification card
A Certification of Report of Birth	Voter's registration card
A Report of Birth Abroad of a U.S. Citizen	U.S. military card or draft record
A Certification of birth issued by the Department of State	Identification card issued by the Federal, State or local government
A U.S. Citizen I.D. card	Military dependent's identification card
A Northern Mariana Identification Card (I-873)	U.S. Coast Guard Merchant Mariner card
A final adoption decree showing the child's name and U.S. place of birth	For children under age 19, a clinic, doctor, hospital or school record, including preschool or day care records
Evidence of U.S. Civil Service employment before June 1, 1976	Two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees and property deeds or titles
U.S. Military Record showing a U.S. place of birth	Finding of identity from a Federal or State governmental agency including, but not limited to, public assistance, law enforcement, internal revenue or tax bureau or corrections agency, if the agency has verified and certified the identity of the individual.
A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens	A finding of identity from an Express Lane Agency
Documentary evidence of Child Citizenship Act status for adopted or biological children born outside the United States	If the applicant does not have any of the above listed documents, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity
Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth	
Official religious record recorded in the U.S. showing that the birth occurred in the United States	
School records including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth	
Federal or State census record showing U.S. citizenship or a U.S. place of birth	
If the applicant does not have one of the documents listed above, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship and that contains the applicant's name, date of birth and place of U.S. birth. The affidavit does not have to be notarized	

Immigration Status
• Birth Certificate (if born in the U.S.) – otherwise this does not show immigration status in the U.S. • U.S. Passport • Naturalization Certificate

Immigration Status
• Military Service Records • Alien Resident Card (I-155) (also known as a Green Card) • Employment Authorization Card (I-688B) • For recent arrivals, a temporary I-551 stamp in a foreign passport or on USCIS Form I-94 • Unexpired Re-entry Permit (Form I-327) • Forms AR-3 and AR-3a, Alien Registration Receipt Card • USCIS Form I-94 with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry • USCIS Form I-688B (or USCIS employment authorization card) annotated 274a.12(a)(3); • USCIS Form I-766 annotated A3. • For lawful permanent residents who are victims of domestic violence - IRS form I551 or I551B coded IB1 through IB3, IB6 through IB8, B11, B12, B16, B17, B20 through B29, B31 through B33, B36 through B38, BX1 through BX3, BX6, BX7 or BX 8 • For victims of domestic violence petitioning for legal status who are considered as "qualified aliens" under PROWORA - IRS Form 797 showing an approved 1-360 or 1-13 self petitioning as a spouse or child of a U.S. citizen or lawful permanent resident; OR USCIS Form 797 showing a Notice of Prima Facie Determination • USCIS Form I-94 with date of admission and annotated with unexpired status as listed in Section 0304.05.45.05 • Dated USCIS letter or court order indicating a lawfully residing status listed in Section 0304.05.45.05 • An unexpired USCIS employment authorization document (I-688-B) annotated with status code • Applicants for asylum: I-94, I-589 on file, I-688B coded 274a.12(c)(8) • Applicants for suspension of deportation: I-94, I-256A on file, I-688B coded 274a.12(c)(10) • Non-citizens granted stays of deportation by court order statute or regulation or by individual determination of USCIS whose departure the USCIS does not contemplate enforcing: letter or Granted a stay of deportation, I-688B coded 274.12(c)(12) • Non-citizens granted suspension of deportation pursuant to Section 244 of INA (8 USC 1254) whose departure the USCIS does not contemplate enforcing: letter/order from the immigration judge and a Form I-94 showing suspension of deportation granted • Non-citizens residing in the United States pursuant to an Order of Supervision: USCIS Form I-220B, I-688B coded 274a.12(c)(18) • Temporary Protected Status: I-94 "Temporary Protected Status" and/or I-688B employment authorization coded 274a.12(a)(12) • Deferred Enforced Departure: Letter from USCIS; I-688B coded 274a.12(a)(11) • Family Unity: USCIS approval notice, I-797, and/or I-688B coded 274a.13 • Non-citizens granted deferred action status: Letter indicating that the non-citizen's departure has been deferred and/or I-688B coded 274a.12(c)(14) • Non-citizens who have filed applications for adjustment of status whose departure the USCIS does not contemplate enforcing: Form I-94 or I-181 or passport stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant"; and/or I-688B coded 274a.12(c)(9) • USCIS Form I-94 annotated with stamp showing entry as a refugee under Section 207 of the INA and date of entry • USCIS Form I-688B (or USCIS Employment Authorization Card) annotated 274a.12(a)(3) • USCIS Form I-766 annotated A3 • USCIS Form I-571 • USCIS Form 551 (Resident Alien Card) coded RE-6, RE-7,RE-8, or RE-9 • USCIS Form I-94 annotated with stamp showing a grant of asylum • Grant letter from the Asylum Office of the USCIS • USCIS Form I-688B annotated with 274a.12.(a)(S) • USCIS Form I-766 annotated • Order from Immigration Judge granting asylum • Order from an Immigration Judge showing the date of a grant of deportation withheld under Section 243(h) of the INA • USCIS Form I-688B (or USCIS employment authorization card)annotated 274a.12(a)(10) • USCIS Form I-766 annotated A10 • USCIS Form 551 with codes CU6, CU7, or CH6 • Unexpired temporary I-551 stamp in a foreign passport or USCIS Form I-94 with codes CU6 or CU7 • USCIS Form I-94 with stamp showing the individual paroled as a Cuban/Haitian Entrant under Section 212(d)(5) of the INA • An USCIS Form I-94 annotated with a stamp showing grant of parole under 212(d)(5) of the INA and a date showing

Immigration Status
granting of parole for at least one (1) year is acceptable verification of this status • ORS issues a certification letter to adults and a letter of benefit eligibility pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000 to children under eighteen (18) years of age: For adult, the ORS certification letter is proof of qualified non-citizen status; For children under age eighteen (18), the ORS letter of benefit eligibility is proof of qualified non-citizen status

1308.11 Alternative Verification Process
REV: June 2015

The Medicaid agency may provide an alternate verification process. This alternative process is available when one or more of the following conditions apply:

- The IRS's only tax data for the applicant is over two years old;
- The applicant attests that the family size or family members have changed since the tax information being used for the determination was filed;
- The applicant attests that a change in circumstances has occurred or is reasonably expected to occur that may affect eligibility;
- The applicant attests to a change in tax filing status that has or is reasonably expected to change the tax filer's annual income; or
- An applicant in the tax filer's family has applied for unemployment benefits.

1308.12 Post-Eligibility Verification by the Automated Eligibility System
EFF: June 2015

01. The automated eligibility system will conduct post-eligibility verification of the beneficiary's information.

02. The automated eligibility system runs post-eligibility verifications on the following beneficiary information:

    - Incarceration status (Rhode Island Department of Corrections data)
    - Death data (Department of Health Vital Records data)
    - Current Income - Wages (Department of Labor and Training – SWICA)
    - Current Income - Unemployment Income (UI) (Department of Labor and Training – UI)

    (01) Post-eligibility verification for incarceration, death data, and current unemployment insurance information will be checked monthly.

    (02) Post-eligibility verification for current income/wages runs approximately every ninety (90) days (e.g., February, May, August, and November).

03. If the automated eligibility system finds all information about the beneficiary is current and accurate and the difference between the total attested income supplied by the beneficiary and

the information supplied by an external data source(s) is less than ten percent (10%), no action on the part of the Medicaid agency or the beneficiary is required. The beneficiary continues to receive benefits without interruption.

04. If the total attested income supplied by the beneficiary is more than ten percent (10%) above the information supplied by an external data source(s), the automated eligibility system will check each line of income (e.g., unemployment insurance) and send out a notice to the beneficiary(ies) indicating the source of income that cannot be verified and requesting that it be reviewed and verification documentation related to current income be provided.

05. The beneficiary will have ten (10) days to respond to such a notice. The ten day period begins on the fifth day after the notice was mailed by the Medicaid agency. The beneficiary may either log onto the automated account (www.healthyrhode.ri.gov) and change information, send via U.S. mail, or bring the documentation to a local DHS office. Upon receipt of the verification documentation, the Medicaid agency will redetermine eligibility. This may alter Medicaid eligibility.

06. After the time period to provide documentation has elapsed, if the individual has not provided documentation or reported a change, the Medicaid agency will redetermine eligibility using the data from external sources. This may alter Medicaid eligibility.

07. If any member of the beneficiary's household has died or if there is a change in the household composition, the Medicaid agency will seek further information from the beneficiary before terminating coverage. If terminated, the beneficiary will then have to re-apply (i.e., log onto the automated account (www.healthyrhode.ri.gov); send via U.S. mail; or bring the documentation to a local DHS office).

08. A notice of the beneficiary's new eligibility status will be sent, along with a Medicaid termination notice with appeal rights (section 0110 of the Medicaid Code of Administrative Rules), as applicable.

09. A beneficiary will not be terminated by the Medicaid agency based on a change in income without first considering other possible eligibility factors including age, disability status, and level-of-care needs.

1308.13 Information
REV: June 2015

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1308.14 Severability
REV: June 2015

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

Tuesday, June 02, 2015
1308filingljune2015

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1309:

RIte Care

December 2013
March 2014 (T)
June 2014
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Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1309:

RITE CARE

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1309 of the Medicaid Code of Administrative Rules entitled, "RIte CARE"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in Section 1309 of the Medicaid Code of Administrative Rules entitled, "RIte CARE" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State.

1309 RIte Care Program

1309.01 Overview

RIte Care was initially established as a statewide managed care demonstration project in 1994 under a Medicaid Title XIX Section 1115 waiver. The project's goal was, and continues to be, to use a managed care delivery system to increase access to primary and preventative care for certain individuals and families who otherwise might not be able to afford or obtain affordable coverage. Medicaid members participating in RIte Care are enrolled in a managed care organization (MCO), a type of health plan which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Medicaid agency contracts with MCOs to provide these health services to members at a capitated rate or fixed cost per enrollee per month.

Individuals and families who have access to employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program in accordance with provisions contained in MCAR section 1312. Adults in these families are required to enroll any Medicaid-eligible family members in a RIte Share approved plan as a condition of retaining Medicaid eligibility.

1309.02 Scope and Purpose
REV: June 2014

Effective on January 1, 2014, Rhode Island is implementing a new eligibility system for individuals and families seeking affordable coverage funded in whole or in part by Medicaid, tax credits, and/or other public subsidies. The new system uses a single standard – modified adjusted gross income (MAGI) – to determine income eligibility for affordable coverage across populations. To facilitate the transition to the MAGI, the RI Medicaid agency has reconfigured these populations into four distinct Medicaid affordable care coverage (MACC) groups: families, pregnant women, children and adults without dependent children (See MCAR Section 1301.03). Eligible members of three of these four coverage groups – all but adults 19-64 otherwise ineligible for Medicaid – will be enrolled in a RIte Care health plan or, as applicable, RIte Share.

The purpose of this rule is to describe the RIte Care delivery system and the respective roles and responsibilities of the Medicaid agency and the individuals and families that are receiving affordable coverage through a RIte Care MCO.

1309.03 Program Management

Title XIX of the U.S. Social Security Act provides the legal authority for the RI Medicaid program. The RIte Care program operates under a waiver granted by the Secretary of Health and Human Services (HHS) pursuant to Section 1115 of the Social Security Act. The RIte Care Managed Care

Consumer Advisory Committee was established by Executive Order in February 1994. The Committee is available to RIte Care consumers to address suggestions, complaints, or related issues.

1309.04 Definitions

For the purposes of this rule, the following definitions apply:

"Communities of Care (CoC)" means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RIte Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

"Managed Care Organization (MCO)" means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 as follows:

- Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

- Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

- Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

- Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not

otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

"Medicaid Code of Administrative Rules (MCAR)" means the collection of administrative rules governing the Medicaid program in Rhode Island.

"Medically Needy" means a classification of persons eligible to receive Medicaid based upon similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"Member or enrollee" means a Medicaid-eligible person receiving benefits through a RIte Care managed care organization.

"New Applicant" means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly-funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Prudent Lay Person Standard" means the standard used to determine the need for an emergency room visit. An "emergency" is defined as a condition that a prudent lay person "who possesses an average knowledge of health and medicine" expects may result in: (1) placing a patient in serious jeopardy; (2) serious impairment of bodily function; or (3) serious dysfunction of any bodily organs.

"Rhody Health Partners" means the Medicaid managed care program that delivers affordable health coverage to eligible adults without dependent children, ages 19 to 64, under MCAR section 1311 and adults with disabilities eligible under section 0374.

"**RIte Care**" means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

“RIte Share” means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial coverage.

"Urgent Medical Problem” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

1309.05 Coverage Groups in RIte Care

The RIte Care population consists of members of: certain Medicaid affordable care coverage (MACC) groups; coverage groups whose eligibility is NOT based on the MAGI standard (non-MAGI) and several non-Medicaid coverage groups.

01. Medicaid Affordable Care Coverage (MACC) Groups -- RIte Care plans provides coverage for individuals and families in the following MACC groups:

(01) Families with income up to 110% of the FPL and parents and caretaker relatives with income between 110% and 133% of the FPL who have dependent children up to age 18 or, if attending school full-time, up to age 19.

(02) Pregnant women with family income up to 253% of the FPL, including non-citizen pregnant women.

(03) Children up to age 19 with family income up to 261% of the FPL, including qualified non-citizen children.

02. Non-MAGI Coverage Groups – RIte Care MCOs also provide health services to:

(01) Children up to age 18 or 19 if completing school who are in foster care and/or receiving adoption subsidy under the applicable provisions of Title IV-E of the federal Social Security Act (See MCAR sections 0342.70 through 0342.75).

(02) Children up to age 21 who are Medicaid eligible as result of receiving Supplementary Security Income (SSI). Individuals in the SSI eligible group under age twenty-one (21) who are enrolled in RIte Care managed care may continue enrollment in a RIte Care health plan when they turn twenty-one (21) years of age until such time as SSI eligibility is discontinued.

(03) Young adults aging out of foster care between the ages of 18 and 26. Young adults who were in participating in foster care, kinship, and guardianship programs authorized by the RI Department of Children, Youth and Families (DCYF) on the date they turned 18 are eligible, without regard to income, for continued Medicaid coverage until the age of 26 under the Foster Care Independence Act of 1999, as amended by the Affordable Care Act of 2010. Members of this population are only eligible in Rhode Island if they were residing in the State at the time they aged out of DCYF foster care. EPSDT services continue only up to age 21 for members of this non-MAGI coverage group.

03. Non-Medicaid funded Coverage Groups – The RIte Care coverage groups in this category are not eligible for federal Medicaid federal financial participation (matching funds).

- Pregnant women with income between 253% and 350% of the FPL. Women who qualify for coverage in this group receive the same MCO in-plan benefits as pregnant women eligible under Title XIX and Title XXI. This group is composed of women with income above 253% but not exceeding 350% of the FPL. Women in this category are not entitled to any fee-for-service coverage for medical services, including those rendered prior to enrollment in a health plan.

- Pregnant women with income exceeding 350% of the FPL. Uninsured or under-insured pregnant women with countable income above 350% of the FPL are allowed to purchase coverage directly from the MCO. The pregnant woman must pay a monthly premium directly to the health plan providing coverage. This premium includes the monthly negotiated capitation rate and the supplemental delivery payment. Eligibility is verified by the applicant furnishing the health plan with the EOHHS notice of denial due to excess income.

1309.06 Excluded Medicaid Coverage Groups
REV: July 2016

There are Medicaid-eligible children and families who receive coverage on a fee-for-service basis rather than through a RIte Care plan, as follows:

(01) Members of these coverage groups who are covered by employer-sponsored or other third party health insurance, may receive Medicaid on a fee-for-service basis, rather than through enrollment in a RIte Care health plan:
- IV-E foster children and children receiving adoption subsidy (Section 0342.70).
- SSI recipients under age twenty-one (21) (Section 0370.05).
- Children with disability - Katie Beckett Eligible. (Section 0370.20 and 0394.35). Children under age nineteen (19) who: are living at home; require a hospital, nursing

home or ICF-ID level of care; and would qualify for Medicaid if in a licensed health care institution.

- SSI recipients over age twenty-one (21).

(02) Medically needy populations. Flex-test cases (see MCAR section 0336) are included in the RIte Care program but receive services in the fee-for-service system. The income deeming methodology permitted by the waiver is applied to new medically needy flex-test applicants. With the exception of Katie Beckett children, long-term care coverage groups (Section 0394) do not receive services through a RIte Care managed care plan.

(03) Extended family planning group. Individuals in this RIte Care waiver group are entitled to a limited scope of services rather than comprehensive benefits. The group consists of women who meet the following conditions: income must be above the Medically Needy income limit; if pregnant, income must not exceed 253% of FPL; the women must be sixty (60) days postpartum or sixty (60) days post-loss of pregnancy and, as a result, subject to discontinuation of Medicaid eligibility. Coverage is available for up to twenty-four (24) months.

1309.07 Retroactive Coverage

Requests for retroactive eligibility are evaluated at the time of application, but must not delay a decision on prospective eligibility. Retroactive eligibility is not available to MACC groups enrolled in RIte Care. Foster and adoption subsidy children in Non-MAGI coverage groups are eligible for retroactive coverage if eligible for SSI. Retroactive coverage is also available to SSI-related eligible individuals and SSI-related medically needy flex-test cases. If eligibility exists, retroactive payment for services is on a fee-for-service basis.

1309.08 Co-Payment Requirements

State-funded pregnant women with income above 253% of the FPL and extended family planning participants who have income above 185% of the FPL are required to make point-of-service copayments as listed below. Copayments are per person/per episode and are payable to the health care provider at the time of service.
Co- Pays for State-funded Pregnant Women, Income 253%-350% FPL --

- $ 5.00 - Office visits for all ambulatory encounters except for prenatal and preventative visits
- $15.00 - Ambulatory surgical procedures
- $ 2.00 - Prescriptions
- $25.00 - Unauthorized non-emergency use of the emergency room
- $35.00 - Non-emergency use of emergency transportation

Copayments for Extended Family Planning, Regardless of Income Level –

- $ 2.00 - Health care provider visits
- $ 1.00 - Thirty (30) day supply of contraceptives
- $15.00 - Voluntary sterilization procedures

1309.09 Overview of RIte Care Services

Individual and families enrolled in RIte Care receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider. Rules of prior authorization apply to any service required by the Medicaid agency. The extended family planning group is entitled only to family planning services.

Each RIte Care member selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care physician orders treatment determined to be medically necessary in accordance with MCO policies. Individuals in the Extended Family Planning (EFP) coverage group do not require a PCP.

01. Access to Benefits – Unless otherwise specified, members of all RIte Care coverage groups (MACC, Non-MAGI, and Non-Medicaid Funded) are entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. State-funded pregnant women are eligible for in-plan services only while pregnant and in the two month postpartum period. All other pregnant women are eligible for the comprehensive benefit package through delivery and for two months postpartum or post-loss of pregnancy. In-plan services are paid for on a capitated basis (fixed cost per enrollee per month). The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

02. Delivery of Benefits – The coverage provided through the RIte Care is categorized as follows:
    - In-Plan Capitated Benefits, including: RIte Care Comprehensive Benefit Package; Extended Family Planning Services; Special Services for Severely and Persistently Mentally Ill (SPMI)
    - In-Plan Fee-for-Service Benefits
    - Out-of-Plan Benefits
    - Early Periodic Screening, Diagnosis and Treatment (EPSDT) Out-of-Plan Services.

03. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to Medicaid-covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention,

diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either medical or mental health status. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

04. Early Periodic Screening, Diagnosis and Treatment (EPSDT) -- The EPSDT provision in Title XIX mandates that the Medicaid agency must provide coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening or at any other occasion, whether or not those services are covered by the State Medicaid Plan or the State's Medicaid Section 1115 waiver. This applies to members of the MACC group up to age nineteen (19), SSI-eligible children and young adults up to age twenty-one (21), including adults aging out of foster care up to age twenty-one (21). A young adult over age nineteen (19) who transitions from the MACC group for children and young adults to the MACC group for adults from age 19 to 64 also receives EPSDT services until age 21.

1309.10 RIte Care In-Plan Capitated Benefits

REV: July 2016

The following are the benefits which the health plan provides or arranges within the capitated (fixed cost per enrollee per month) benefit. In-Plan benefits subject to the capitated rate are organized as follows: the RIte Care comprehensive benefit package and the extended family planning benefit package. Adults who are found to be severely and persistently mentally ill have access to a modified comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the health plan when beneficiaries in this group receive coverage through the RIte Care managed care delivery system.

01. RIte Care comprehensive benefit package --The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

RIte Care Health Plans – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
Inpatient hospital care	Up to 365 days
Outpatient hospital services	Includes physical therapy, occupational therapy, and speech, hearing, and language services
Physician services	Includes surgical services including reconstructive surgery as medically necessary. Second surgical opinion to an in network or out-of-network physician, as ordered by a plan physician
Family planning services	Services include family planning counseling, (available to eligible men and women) extended family planning services, (see section 1309.14) with the exception of certain non-prescription family planning materials that are not Medicaid covered benefits, including: foam, condoms, and spermicidal jelly
Prescription medications	Covered in compliance with the Medicaid agency's generic drug policy (see section 1309.11.01.01)

RIte Care Health Plans – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
Non-prescription drugs	When prescribed by a health plan physician, limited to non-prescription drugs identified as covered by the Medicaid agency
Laboratory, radiology and diagnostic services	When ordered by a health plan physician
Behavioral health services	Includes drug screens, substance abuse services necessary, and sexual abuse counseling
Outpatient behavioral health	Includes day treatment and inpatient substance abuse services and partial hospitalization
Residential treatment	Residential substance abuse treatment for adolescents thirteen (13) to seventeen (17) years of age or residential treatment ordered by the Department of Children, Youth, and Families are out-of-plan benefits
Methadone maintenance and methadone detox	As ordered by an outpatient services health plan physician
EPSDT	Services provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, follow-up vision, hearing, and dental visits. Includes interperiodic screens as medically indicated. Includes multidisciplinary evaluation and treatment for children with significant developmental disabilities or developmental delays. See section 1309.14 for out-of-plan benefits
Early Intervention services	Center-based health and education programs for children at risk for being developmentally delayed
Certified home health agency as ordered by a health plan, physician services (short-term acute)	As ordered by a health plan physician. Short-term acute includes all medically necessary home health services with the exception of home health care provided in lieu of care in a nursing facility
Post-stabilization care	As ordered by a physician in an urgent or emergency care setting
Emergency room services and transportation when provided outside of the State based on the prudent lay person standard	Services provided in accordance with the prudent layperson standard. See definition in section 1309.04. Must be provided in the United States
Nursing facility services	In an appropriately licensed nursing facility when ordered by a health plan physician
Private duty nursing licensed nurse midwives	As ordered by a health plan physician
Services of other health practitioners – includes practitioners, including any practitioners, certified and licensed by the State such as nurse practitioners, physician assistants, social workers, licensed dieticians, psychologists, and licensed nurse midwives	If referred by a health plan physician
School based health centers	If referred by primary care physician (PCP)
Podiatry services	As ordered by health plan physician
Optometry services	For adults 21 and older, benefit is limited to examinations that include refractions and eyeglass dispensing, once every two years, and any other medically necessary treatment visits for illness or injury to the eye. For children under 21 covered as medically necessary with no other limits
Durable medical equipment	As ordered by a health plan physician. Includes surgical appliances, prosthetic devices, orthotic devices, medical supplies, hearing aids, and molded shoes

RIte Care Health Plans – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
Hospice services	As ordered by a health plan physician
Nutrition services.	As referred to licensed dietitian by a health plan physician for certain medical conditions
Group education/programs,	On a self-referral basis including childbirth education classes, parenting classes, and smoking cessation programs
Non-emergency transportation	In accordance with section 1309.10.02
Interpreter services	For enrollees who speak a language other than English as their first language as described in section 1309.10.03
Organ transplant services	As described in Section 0300.20.05 and 0300.20.05.25, Organ Transplant Operations
Tracking, follow-up and outreach	In accordance with section 1309.10.04

Medicaid agency policy affects the access to and/or the scope and amount of several of these benefits as follows:

(01) Prescriptions: Generic Policy. For RIte Care enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

- Availability of suitable within-class generic substitutes or out-of-class alternatives.
- Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.
- Relative disruptions in care that may be brought on by changing treatment from one drug to another.
- Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.
- Relative clinical advantages and disadvantages of drugs within a therapeutic class.
- Cost differentials between brand and generic alternatives.
- Drugs that are required under federal and State regulations.
- Demonstrated medical necessity and lack of efficacy on a case by case basis.

(02) Non-emergency transportation policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, non-emergency transportation for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid-covered service from a Medicaid-participating provider. Includes bus passes, Rhody Ten Ride passes, RIPTIKS, other RIPTA fare products and also includes RIPTA paratransit vans and taxi services, if authorized by EOHHS or its agent.

(03) Interpretation services policy. EOHHS will notify the health plan when it knows of members who do not speak English as a first language who have either selected or been

assigned to the plan. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language.

(04) Tracking, Follow-up, Outreach. These services are provided by the health plan in association with an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.

02. Extended family planning services -- The extended family planning group benefit package includes:

- Gynecological Services. Limited to no more than four (4) office visits annually -- One (1) comprehensive gynecological annual exam and up to three (3) additional family planning method related office visits if indicated)

- Laboratory. Includes annual Pap smear; STD screening if indicated; anemia testing; dipstick urinalysis and urine culture if indicated; pregnancy testing.

- Procedures. Limited to the following office/clinic/outpatient procedures if indicated tubal ligation; treatment for genital warts; Norplant insertion and removal; IUD insertion and removal; incision and drainage of a Bartholin's gland cyst or abscess.

- For RIte Care enrolled members. Includes generic-first prescriptions and non-prescription family planning methods (Limited to twelve (12) 30-day supplies per year) when prescribed by a health plan physician.

- Contraceptives. Includes oral contraceptives, contraceptive patch, contraceptive vaginal, contraceptive implant, contraceptive IUD, contraceptive injection, cervical cap, diaphragm, and emergency contraceptive pills, when prescribed by a health care physician. Covered non-prescription methods include foam, condoms, spermicidal cream/jelly, and sponges.

- Referrals for other medically necessary services as appropriate/indicated, including: referral to State STD clinic for treatment if indicated.

- Referral to State confidential HIV testing and counseling sites, if indicated.

- Inpatient services are not a covered benefit, except as medically necessary follow-up treatment of a complication from provision of a covered procedure or service.

Categories of eligibility for this extending family planning benefit package are as follows:

(01) Women otherwise Medicaid ineligible. The package of services is available without the comprehensive benefit package. Women who have given birth and are not eligible for Medicaid under another coverage group, lose the full scope of covered services sixty (60) days postpartum or post-loss of pregnancy. Women in this category are eligible for RIte Care for a period of up to twenty-four (24) months for the full family planning benefit package. The benefit package includes interpreter services but does not include transportation benefits. Re-certification is required at twelve (12) months.

(02) Women who are otherwise eligible for Medicaid. Women enrolled in RIte Care are eligible for family planning services. Participation is voluntary. Members continue to be enrolled with the same health plan they selected or were assigned to for comprehensive health service delivery but for family planning services only for a twelve (12) month period. Upon re-certification at twelve (12) months, a participant may qualify for up to an additional twelve (12) months. Services are covered on an outpatient basis only. Non-prescription contraceptives are not covered for members in this category.

1309.11 In-plan Fee-For-Services Benefits

The health plan or its approved providers will bill the Medicaid agency for fee-for-service for Medicaid State Plan and Section 1115 waiver covered in-plan benefits that have not been included in the capitated rate.

1309.12 Out-of-Plan Benefits
REV: July 2016

Out-of-plan benefits are not included in the capitated rate and are not the responsibility of the health plan to provide or arrange. These services are provided by existing Medicaid-approved providers who are reimbursed directly by the Medicaid agency on a fee-for- service basis. Out-of-plan benefits are provided to all RIte Care enrollees with the following exceptions: Individuals eligible for Extended Family Planning only; State-funded pregnant and post-partum women with income above 253% of FPL; and anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid (Section 0348.35.10). The covered benefits are as follows:

01. Court-ordered services to out-of-network providers;

02. Residential substance abuse treatment services for adolescents (thirteen (13) to seventeen (17) years old);

03. Routine dental services (emergency dental services are in-plan);

04. Family planning services. RIte Care recipients may seek family planning services either in-plan or from an out-of-plan provider. When members seek these services in-plan, the plan must provide them as part of its capitated benefit package and may not bill the State fee-for-service. However, members are permitted to self-refer. For those individuals who elect to go out of network, the plan will reimburse the provider on a fee-for-service basis;

05. Non-medical case management for Head Start children;

06. Home visits for assessment and follow-up of Level I screenings (Family Outreach Program);

07. School-based health services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays;

08. Lead program home assessment/intervention and nonmedical case management provided by the Department of Health for children with lead poisoning;

09. Home-based treatment services for children;

10. CEDARR Services;

11. Seriously and Persistently Mentally Ill Adults & Seriously Emotionally Disturbed Children are provided Juvenile Drug Court Case Management Services (provided by Case Care Coordinators (CCP)).

12. Home stabilization services are available for beneficiaries eligible under MCAR 1301 who are homeless or at-risk for homelessness or transitioning from the community from institutional settings and *do not qualify for such services through any other federally-funded program administered by the state*. Home stabilization services encompass a broad range of time limited tenancy support services assisting with home find, tenancy and lease compliance, living and household management, entitlement assistance and financial counseling to health and wellness. To qualify for home stabilization services, the EOHHS or the agency's authorized representative must determine that the beneficiary meets criteria applicable to the basis of coverage as follows:

    (01) Medicaid eligible families with children, including parent/caretakers and pregnant women. To qualify, a beneficiary must be: (a) considered homeless or at-risk of homelessness according to the HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009; (b) in jeopardy of losing current housing due to non-payment of rent, unsafe living conditions or repeated episodes of conflict in the housing community as substantiated by a housing or health care provider; or (c) transitioning from an institution or residential treatment facility back into the community.

(02) Independent youth under age 19 (nineteen) or twenty-one (21) if eligible by virtue of SSI, and Chaffee eligible youth eligible under 1309.05.02(03). To qualify, a beneficiary must be: (a) considered homeless according to the criteria established in the U.S. McKinney-Vento Homeless Assistance Act of 1987; or (b) at-risk for or are transitioning from institutionally-based or residential treatment facilities, or congregate care back into the community.

1309.13 EPSDT Out-Of-Plan Services

For all Medicaid-eligible children and youth under age twenty-one (21), EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening, or at any occasion. Such medically necessary diagnosis and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-covered services as defined in the Title XIX or Title XXI of the Social Security Act or approved as part of the State's Section 1115 waiver.

The health plan must assure that all medically necessary, Medicaid-covered diagnosis and treatment services are provided, either directly or by referral. However, if the services are neither covered by the State Medicaid State Plan or the Section 1115 waiver nor included in the capitated benefit package, the health plan may bill the State fee-for-service. Such services include:

- Chiropractic
- Christian Science services
- Other services that are medically necessary (as determined and prior authorized by the state) to treat or ameliorate a condition that is discovered during an EPSDT screening.

1309.14 Communities of Care

The Medicaid agency has established a special service delivery system within both RIte Care and Rhody Health Partners managed care plans called the Communities of Care (CoC). The goal of the CoC is to improve access and promote member involvement in care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs. The target population or CoC are Medicaid members who utilize the ED four (4) or more times during the most recent twelve (12) month period. RIte Care members will be notified of the requirement to participate in CoC. Section 1314 of the MCAR sets forth the requirements of the CoC for MACC group eligible individuals and families, including those enrolled in RIte Care.

1309.15 Limits on Services

01. The following services are not covered under the RIte Care program:

- Experimental procedures, except as required by RI state law;
- Abortion services, except to preserve the life of the woman, or in cases of rape or incest;
- Private rooms in hospitals (unless medically necessary);
- Cosmetic surgery;
- Infertility treatment services; and
- Services of Institutions for Mental Diseases (IMD) for individuals age twenty-one (21) to sixty-five (65) except as available through a Medicaid managed care plan.

02. **Out-of-State Coverage**

Out-of-State Benefits — The Medicaid agency does not provide coverage for out-of-state services with two exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of the Medicaid agency.

1309.16 Scope of Provider Networks

The health plan must maintain provider networks in locations that are geographically accessible to the populations to be served, comprised of hospitals, physicians, mental health providers, substance abuse providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

1309.17 Mainstreaming / Selective Contracting

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of the Medicaid program. The health plan must ensure that all of its network providers accept RIte Care members for treatment. The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate RIte Care members in any way from other persons receiving services.

Health plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

1309.18 Primary Care Providers (PCPs)

The health plan has written policies and procedures allowing every member to select a primary care provider (PCP). The PCP serves as the member's initial and most important point of interaction with

the health plan network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

- Serving as the member's primary care provider;
- Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;
- Referring for specialty care and other medically necessary services both in- and out-of-plan;
- Maintaining a current medical record for the member; and
- Adhering to the EPSDT periodicity schedule for members under age twenty-one (21) or twenty-six (26), as appropriate.

In addition, the health plan retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

1309.19 Service Accessibility Standards

The service accessibility standards which the health plan must meet are:

- Twenty-four-hour coverage;
- Travel time;
- Days to appointment for non-emergency services.

In addition, health plans must staff both a member services and a provider services function and a Provider Services function.

01. Twenty-Four Hour Coverage--The health plan must provide coverage, either directly or through its PCPs, to members on a twenty-four (24) hours per day, seven (7) days a week basis. The health plan must also have available written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

02. Travel Time --The health plan must make available to every member a PCP whose office is located within twenty (20) minutes driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

03. Appointment for Non-Emergency Services --The health plan must make services available within twenty-four (24) hours for treatment of an urgent medical problem. The plan must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Non-emergent, non-

urgent mental health or substance abuse appointments for diagnosis and treatment must be made available within five (5) business days.

04. Member Services -- The health plan must staff a member services function operated at least during regular business hours and responsible for the following:

- Explaining the operation of the health plan and assisting members in the selection of a PCP;
- Assisting members to make appointments and obtain services;
- Arranging medically necessary transportation for members;
- Handling members' complaints; and
- Toll-free telephone number.

The health plan must maintain a toll-free Member Services telephone number. Although the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends.

05. Provider Services - The health plan must staff a provider Services function operated at least during regular business hours and responsible for the following:

- Assisting providers with questions concerning member eligibility status;
- Assisting providers with plan prior authorization and referral procedures;

- Assisting providers with claims payment procedures;
- Handling provider complaints.

1309.20 Mandatory Participation in Managed Care

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in section 1309.06, except as specified in MCAR section 1311.07. Medicaid members in these coverage groups with third-party medical coverage or insurance may be exempt from this mandate only as indicated in section 1309.06, at the discretion of the EOHHS.

1309.21 Exemptions from Managed Care – RIte Care only

Medicaid members are granted exemptions from mandatory enrollment in managed care in a narrow range of circumstances in accordance with the provisions set forth in section 1311.07. Among the unique RIte Care coverage groups identified in 1309.06, there is a special exemption for children and youth in, or aging out of, foster care who are up to age twenty-one (21). Children and young adults in this coverage group may be exempted from health plan enrollment at the discretion of the Department of Children, Youth and Families (DCYF) upon request to the Medicaid agency.

1309.22 Enrollment Procedures, Rights and Responsibilities

The enrollment process for MACC groups is set forth in MCAR section 1311.

1309.23 Information and Referral

REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1309.24 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

1309finaljuly2016
June 30, 2016

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1310:

Rhody Health Partners

For MACC Group Adults – 19 to 64

December 2013
March 2014 (T)
March 2016 (E)
July 2016

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1310:

Rhody Health Partners for MACC Group Adults – 19 to 64

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Introduction

These rules related to Access to Medicaid Coverage Under the Affordable Care Act, Section 1310 of the Medicaid Code of Administrative Rules entitled, "Rhody Health Partners for MACC Group Adults – 19 to 64" are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in Section 1310 of the Medicaid Code of Administrative Rules entitled, "Rhody Health Partners for MACC Group Adults – 19 to 64" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State.

1310 Rhody Health Program

1310.01 Overview

Rhody Health Partners (RHP) is a managed care delivery system for Medicaid eligible adults. Participants in Rhode Health Partners (RHP) are enrolled in a managed care organization (MCO), a type of health plan which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Medicaid agency contracts with MCOs to provide these health services to members at a capitated rate or fixed cost per enrollee per month.

Adults eligible under this rule who have access to a Medicaid approved employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program and are required to enroll in an employer plan approved by the Medicaid agency as a condition of retaining Medicaid eligibility.

1310.02 Scope and Purpose

Effective on January 1, 2014, Rhode Island is implementing a new eligibility system for individuals and families seeking affordable coverage funded in whole or in part by Medicaid, tax credits and/or other public subsidies. The new system uses a single standard – modified adjusted gross income (MAGI) – to determine income eligibility for affordable coverage across populations. To facilitate the transition to the MAGI, the RI Medicaid agency has reconfigured these populations into four distinct Medicaid affordable care coverage groups (MACC GROUPs): families, pregnant women, children and adults without dependent children. (See Medicaid Code of Administrative Rules (MCAR) Section 1301.03). Eligible members of the MACC group for adults without dependent children will be enrolled in a RHP health plan or, as applicable, RIte Share. The purpose of this rule is to describe the RHP delivery system for members of this MACC group and the respective roles and responsibilities of the Medicaid agency and the individuals receiving affordable coverage through RHP.

1310.03 Applicability

Effective January 1, 2014, the provisions governing RHP for persons who are eligible for Medicaid on the basis of being aged, blind, or with a disability are located in MCAR Section 0374.

1310.04 Definitions

"Communities of Care (CoC)" means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RIte Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

"Managed Care Organization (MCO)" means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 as follows:

(01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

"Medicaid Code of Administrative Rules (MCAR)" means the collection of administrative rules governing the Medicaid program in Rhode Island.

"Medically Needy" means a classification of persons eligible to receive Medicaid based upon similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"Member or enrollee" means a Medicaid-eligible person receiving benefits through a RIte Care managed care organization.

"New Applicant" means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date of this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Prudent Lay Person Standard" means the standard used to determine the need for an emergency room visit. An "emergency" is defined as a condition that a prudent lay person "who possesses an average knowledge of health and medicine" expects may result in: (1) placing a patient in serious jeopardy; (2) serious impairment of bodily function; or (3) serious dysfunction of any bodily organs.

"Rhody Health Partners" means the Medicaid managed care program that delivers affordable health coverage to eligible adults without dependent children, ages 19 to 64, under MCAR section 1311 and adults with disabilities eligible under section 0374.

"**RIte Care**" means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

"RIte Share" means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial coverage.

"Urgent Medical Problem" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

1310.05 MACC Group in Rhody Health Partners

The MACC group participating in RHP is adults, ages 19 to 64, who are not: pregnant, entitled to received Medicare Part A or B, or otherwise eligible for or enrolled in a Medicaid State Plan mandatory coverage group. (See MCAR Section 1301.05(05)).

1310.06 Overview of RHP

REV: July 2016

Individuals enrolled in RHP receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service

benefits may be furnished either by the managed care provider or by any participating provider. Rules of prior authorization apply to any service required by Medicaid agency. Each RHP member selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care physician orders treatment determined to be medically necessary in accordance with MCO policies.

01. Access to Benefits – Unless otherwise specified, MACC group adults coverage groups entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. In-plan services are paid for on a capitated basis. The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

02. Delivery of Benefits – The coverage provided through the RHP is categorized as follows:

- In-Plan Capitated Benefits, including: RHP Comprehensive Benefit Package including specialized services for persons who are Severely and Persistently Mentally Ill (SPMI)
- In-Plan Fee-for-Service Benefits
- Out-of-Plan Benefits

03. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health related condition including any such services are necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

1310.07 RHP In-Plan Capitated Benefits
REV: July 2016

The following are the benefits which the health plan provides or arranges within the capitated (fixed cost per enrollee per month) benefit. In-Plan benefits subject to the capitated rate are organized into the RHP comprehensive benefit package for persons qualifying for coverage as severely and persistently mentally ill (SPMI).

01. RHP comprehensive benefit package --The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

RHP – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
Inpatient hospital care	Up to 365 days
Outpatient hospital services	Includes physical therapy, occupational therapy, and speech, hearing and language services
Physician services	Includes surgical services including reconstructive surgery as medically necessary. Second surgical opinion to an in network or out-of-network physician, as ordered by a plan physician
Family planning services	Services include family planning counseling (available to eligible men and women) and services
Prescription medications	Covered in compliance with the Medicaid agency's generic drug policy (see section 1310.07.01.01)
Non-prescription drugs	When prescribed by a health plan physician, limited to non-prescription drugs identified as covered by the Medicaid agency
Laboratory, radiology and diagnostic services	When ordered by a health plan physician
Behavioral health services	Includes drug screens, substance abuse services necessary and sexual abuse counseling
Outpatient behavioral health	Includes day treatment and inpatient substance abuse services and partial hospitalization
Methadone maintenance and methadone detox	As ordered by an outpatient services health plan physician
Certified home health agency as ordered by a health plan services (short-term acute)	As ordered by a health plan physician. Short-term acute includes all medically necessary home health services with the exception of home health care provided in lieu of care in a nursing facility
Post-stabilization care	As ordered by a physician in an urgent or emergency care setting
Emergency room services and transportation when provided outside of the State based on the prudent lay person standard	Services provided in accordance with the prudent layperson standard. See definition in section 1309.04. Must be provided in the United States
Nursing facility services	In an appropriately licensed nursing facility when ordered by a health plan physician
Private duty nursing licensed nurse midwives	As ordered by a health plan physician
Services of other health practitioners – includes practitioners, including any practitioners, certified and licensed by the State such as nurse practitioners, physician assistants, social workers, licensed dieticians, psychologists, and licensed nurse midwives	If referred by a health plan physician
Podiatry services	As ordered by health plan physician
Optometry services	For adults 21 and older, benefit is limited to examinations that include refractions and eyeglass dispensing, once every two years, and any other medically necessary treatment visits for illness or injury to the eye
Durable medical equipment	As ordered by a health plan physician. Includes surgical appliances, prosthetic devices, orthotic devices, medical supplies, hearing aids and molded shoes
Hospice services	As ordered by a health plan physician. Services limited to those provided by Medicare
Nutrition services	As referred to licensed dietitian by a health plan physician for certain medical conditions
Group education/programs	On a self-referral basis including childbirth education classes,

RHP – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
	parenting classes, and smoking cessation programs
Non-emergency transportation	In accordance with section 1310.07.01.02
Interpreter services	For enrollees who speak a language other than English as their first language as described in section 1310.07.01.03
Organ transplant services	As described in Section 0300.20.05 and 0300.20.05.25, Organ Transplant Operations
Tracking, follow-up and outreach	In accordance with section 1310.07.01.04

Medicaid agency policy affects the access to and/or the scope and amount of several of these benefits as follows:

(01) Prescriptions: Generic Policy. For RHP enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

- Availability of suitable within-class generic substitutes or out-of-class alternatives.
- Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.
- Relative disruptions in care that may be brought on by changing treatment from one drug to another.
- Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.
- Relative clinical advantages and disadvantages of drugs within a therapeutic class.
- Cost differentials between brand and generic alternatives.
- Drugs that are required under federal and State regulations.
- Demonstrated medical necessity and lack of efficacy on a case by case basis.

(02) Non-emergency transportation policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, non-emergency transportation for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid covered service from a Medicaid participating provider. Includes bus passes, Rhody Ten Ride passes, RIPTIKS, other RIPTA fare products and also includes RIPTA paratransit vans and taxi services, if authorized by EOHHS or its agent.

(03) Interpretation services policy. EOHHS will notify the health plan when it knows of members who do not speak English as a first language who have either selected or been assigned to the plan. If the health plan has more than fifty members who speak a single language, it must make available general written materials, such as its member handbook, in that language.

(04) Tracking, Follow-up, Outreach. These services are provided by the health plan in association with an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.

02. SPMI modifications— SPMI adults have access to a comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the health plan when a beneficiary is enrolled in the Rhody Health Partners delivery system.

1310.08 In-plan Fee-For-Services Benefits

The health plan or its approved providers will bill the Medicaid agency for fee-for-service for Medicaid State Plan and Section 1115 waiver covered in-plan benefits that have not been included in the capitated rate.

1310.09 Out-of-Plan Benefits
REV: July 2016

Out-of-plan benefits are not included in the capitated rate and are not the responsibility of the health plan to provide or arrange. These services are provided by existing Medicaid-approved providers who are reimbursed directly by the Medicaid agency on a fee-for- service basis. Out-of-plan benefits are provided to all RHP enrollees with the following exceptions: anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

01. Court-ordered services to out-of-network providers;

02. Routine dental services (emergency dental services are in-plan);

03. Family planning services. RHP recipients may seek family planning services either in-plan or from an out-of-plan provider. When members seek these services in-plan, the plan must provide them as part of its capitated benefit package and may not bill the State fee-for-service. However, members are permitted to self-refer. For those individuals who elect to go out of network, the plan will reimburse the provider on a fee-for-service basis;

04. Seriously and Persistently Mentally Ill Adults & Seriously Emotionally Disturbed Children are provided Juvenile Drug Court Case Management Services (provided by Case Care Coordinators (CCP)).

05. Home stabilization services are available for adult beneficiaries, ages nineteen (19) to sixty-four (64), eligible under MCAR 1301 who are homeless or at-risk for homelessness or transitioning to the community from institutional settings and *do not qualify for such services through any other federally-funded program administered by the State*. Home stabilization services encompass a broad range of time limited tenancy support services assisting with home find, tenancy and lease compliance, living and household management, entitlement assistance and financial counseling to health and wellness. To qualify for home stabilization services, the EOHHS or the agency's authorized representative must determine that the beneficiary meets the following criteria:

(01) Beneficiary is considered homeless or at-risk of homelessness according to the HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009;

(02)Beneficiary has history of homelessness as defined by HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009; or

(03) Ability of the beneficiary to retain current housing situation is jeopardized because non-payment of rent, unsafe living conditions, or repeated episodes of conflict in the housing community as substantiated by housing or licensed health care professional health care medical provider; and

(04) Beneficiary is not receiving Medicaid-funded home stabilization services through a program administered by the state such as the Assertive Community Treatment (ACT) team operating under the auspices of the department of behavioral healthcare, developmental disabilities and hospitals.

1310.10 Communities of Care

The Medicaid agency has established a special service delivery system within both RIte Care and Rhody Health Partners managed care plans called the Communities of Care (CoC). The goal of the CoC is to improve access and promote member involvement in care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs. The target population or CoC are Medicaid members who utilize the ED four (4) or more times during the most recent twelve (12) month period. RIte Care members will be notified of the requirement to participate in CoC. Section 1314 of the MCAR sets forth the requirements of the CoC for MACC group eligible individuals and families, including those enrolled in RIte Care.

1310.11 Services that are Not Covered by Medicaid

01. Non-covered services --The following services are not covered under the Medicaid program:

- Experimental procedures, except as required by RI state law;

- Abortion services, except to preserve the life of the woman, or in cases of rape or incest;
- Private rooms in hospitals (unless medically necessary);
- Cosmetic surgery;
- Infertility treatment services; and
- Services of Institutions for Mental Diseases (IMD) for individuals age 21 – 65 in fee-for-services. RHP managed care enrollees may access IMDs.

02. Out-of-State Coverage --The Medicaid agency does not provide coverage for out-of-state services with two exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of the Medicaid agency.

1310.12 Scope of Provider Networks

The health plan must maintain provider networks in locations that are geographically accessible to the populations to be served, comprised of hospitals, physicians, mental health providers, substance abuse providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

1310.13 Mainstreaming / Selective Contracting

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of the Medicaid agency. The health plan must ensure that all of its network providers accept RHP members for treatment. The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate RHP members in any way from other persons receiving services.

Health plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

1310.14 Primary Care Providers (PCPs)

The health plan has written policies and procedures allowing every member to select a primary care provider (PCP). The PCP serves as the member's initial and most important point of interaction with the health plan network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

- Serving as the member's primary care provider;

- Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;

- Referring for specialty care and other medically necessary services both in- and out-of-plan;

- Maintaining a current medical record for the member; and

In addition, the health plan retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

1310.15 Service Accessibility Standards

The service accessibility standards which the health plan must meet are:

- Twenty-four-hour coverage;
- Travel time;
- Days to appointment for non-emergency services.

In addition, health plans must staff both a member services and provider services function and a Provider Services function.

01. Twenty-Four Hour Coverage--The health plan must provide coverage, either directly or through its PCPs, to members on a twenty-four hours per day, seven days a week basis. The health plan must also have available written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

02. Travel Time --The health plan must make available to every member a PCP whose office is located within twenty minutes driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

03. Appointment for Non-Emergency Services --The health plan must make services available within twenty-four hours for treatment of an urgent medical problem. The plan must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Non-emergent, non-urgent mental health or substance abuse appointments for diagnosis and treatment must be made available within five (5) business days.

04. Member Services -- The health plan must staff a member services function operated at least during regular business hours and responsible for the following:

- Explaining the operation of the health plan and assisting members in the selection of a PCP;

- Assisting members to make appointments and obtain services;
- Arranging medically necessary transportation for members;
- Handling members' complaints; and
- Toll-free telephone number.

The health plan must maintain a toll-free member services telephone number. Although the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends.

05. Provider Services - The health plan must staff a provider services function operated at least during regular business hours and responsible for the following:

- Assisting providers with questions concerning member eligibility status;
- Assisting providers with plan prior authorization and referral procedures;
- Assisting providers with claims payment procedures; and
- Handling provider complaints.

1310.16 Mandatory Participation in Managed Care

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in section 1309.06, except as specified in section 1311.07. Medicaid members in these coverage groups with third-party medical coverage or insurance may be exempt from this mandate only as indicated in section 1311.07, at the discretion of the EOHHS.

1310.17 Enrollment Procedures, Rights, and Responsibilities

The enrollment process for MACC groups using the RHP delivery system is set forth in MCAR section 1311.

1310.18 Information and Referral

REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

    - www.eohhs.ri.gov
    - www.dhs.ri.gov
    - www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1310.19 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

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June 30, 2016

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1311:

Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans

December 2013
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Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1311:

Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1311 of the Medicaid Code of Administrative Rules entitled, "Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in Section 1311 of the Medicaid Code of Administrative Rules entitled, "Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State as a technical amendment on March 6, 2014.

1311 Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans

1311.01 Overview

With the approval of the State's Title XIX, Section 1115 waiver in 2009, enrollment in a managed care organization became mandatory for all individuals and families covered in the Rhode Island Medicaid program who do not require long term services and supports. The State's goal in implementing this policy is to assure that all Rhode Islanders enrolled in Medicaid have access to an organized system of high quality services that provides a medical home focusing on primary care and prevention services.

1311.02 Scope and Purpose

The Medicaid eligible Medicaid Affordable Care Coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR) must enroll for coverage in a RIte Care (families, children and pregnant women) or Rhody Health Partners (adults 19-64 without children) managed care plan. There are other Medicaid coverage groups enrolled in both service delivery systems. This rule applies to all RIte Care coverage groups identified in section 1309 of the Medicaid Code of Administrative Rules (MCAR). It does not apply to adults eligible on the basis of age, blindness, or disability subject to the provisions for RIte Care and section 0374 of the MCAR for Rhody Health Partners for a description of these groups.

The Medicaid agency must ensure that enrollment in RIte Care and Rhody Health Partner (RHP) plans functions in a timely and efficient manner that respects the rights of Medicaid eligible individuals and families and the State's interest in assuring that they have ready access to an organized system of high quality health care. On January 1, 2014, the State will be implementing a new eligibility system for all new applicants for Medicaid in the MACC groups. The provisions of this rule identify the respective roles and responsibilities of the State – in this instance the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency – and the individuals and families eligible under all MACC, non-MAGI and non-Medicaid funded groups receiving coverage through RIte Care health plans, as identified in section 1309, and the MACC coverage group for adults eligible for the RHP plans, specified in section 1310.

The provisions of this rule also apply to any new applicants in these coverage groups who have access to employer-sponsored (ESI) health plans who may be qualified for the RIte Share premium assistance program on or after January 1, 2014, as specific in section 1312, until further notice from the Medicaid agency.

1311.03 Definitions

"**Employer sponsored insurance (ESI**)" means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSourceRI.

“Enrollee” means a Medicaid member (sometimes referred to as a Medicaid “beneficiary”) enrolled in a Medicaid managed care plan.

“Managed Care Organization (MCO)” means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

“**Medicaid Affordable Care Coverage (MACC) Group**” means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

“Medicaid Code of Administrative Rules (MCAR)” means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State’s Administrative Procedures Act (R.I.G.L. §42-35).

“**Medicaid member**” means a person who has been determined to be an eligible Medicaid beneficiary.

“Navigator” means a person working for a State-contracted organization with certified assisters who have expertise in Medicaid eligibility and enrollment.

“New Applicant” means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

“**Prospective Medicaid enrollee”** means an individual or family that has been determined eligible for Medicaid, but has not enrolled in a RIte Care or RHP plan.

“**Rhody Health Partners”** means the Medicaid managed care delivery system providing affordable health coverage to eligible adults without dependent children, ages 19 to 64, under section 1310 and adults with disabilities eligible under section 0374.

“**RIte Care**” means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

“RIte Share” means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial coverage.

1311.04 Initiating Enrollment: No Wrong Door

The enrollment process begins at the point in which an eligibility determination has been made and the applicant is notified. Once determined eligible, a Medicaid member must select a plan at the time a determination is made if applying on-line through the web-portal either alone or with assistance. Notice of eligibility provided by the Medicaid agency, whether electronically or on paper, must inform the Medicaid member of whether enrollment in a RIte Care versus Rhody Health Partners plan is required. The Medicaid coverage group that is the basis of eligibility for an individual or family determines the delivery system – RIte Care or RHP – in which a person must enroll (see MCAR section 1301).

01. Enrollment channels --Once determined eligible, a Medicaid eligible person may enroll in a RIte Care or Rhody Health Partners Plan, as appropriate:

    (01) Online through the eligibility portal independently or with a navigator's assistance;

    (02) Over the phone with a Contact Center representative; or

    (03) In-person at the Contact Center or a DHS office. (Contact information located in section 1311.25)

02. Information on enrollment options - The Medicaid agency and the RIte Care and RHP plans share responsibility for ensuring Medicaid applicants and prospective and current enrollees have access to accurate up-to-date information about their enrollment options. This information is available on-line if applying through the eligibility web portal, as well as through the Contact Center, the Medicaid agency, DHS and the participating plans. The information available must include:

    - Materials describing the Medicaid managed care delivery system.

    - A written explanation of enrollment options including information about the applicable service delivery system – RIte Care versus RHP – and choice of participating health plans health plans therein.

    - Upon requested, an indication of whether a prospective enrollee's existing physician is a participant in each of the respective plans.

    - Non-biased enrollment counseling through the Contact Center or a Navigator.

    - A chart comparing participating plans.

- Detailed instructions on how to enroll.

- Full disclosure of any time limits and consequences for failing to meet those time limits.

- Access to interpreter services.

- Notification in writing of the right to challenge auto-assignment for good cause through the Medicaid agency.

01. Non-biased enrollment counseling -- Non-biased enrollment counselors who are not affiliated with any participating plan help enrollees choose a managed care plan and a primary care provider (PCP) capable of meeting their needs. Factors that may considered when making this choice are whether an existing PCP participates in a particular plan as well as language preferences or limitation, geographic proximity, and so forth. Enrollment counselors are available by telephone or in-person at the Contact Center and DHS offices during regular hours of operation. They also are available in-person and by telephone at these locations to assist enrollees who would like to change health plans (e.g., during open enrollment or due to good cause).

02. Voluntary selection of health plan -- Prospective enrollees are given fourteen (14) calendar days from the completion of their eligibility determination to select a health plan. All members of a family must select the same health plan. If an individual or family does not select a health plan within the time allowed, the individual or family is automatically assigned to a health plan.

03. Automatic assignment into health plan -- The State employs a formula, or algorithm, to assign prospective enrollees who do not make a voluntary selection into a health plan. This algorithm considers quality and financial performance.

04. Requests for reassignment – Medicaid enrollees may who have selected a plan voluntarily or have been auto-assigned may request to be reassigned within certain limits. Such requests are categorized as follows:

(01) Requests made within ninety (90) days of enrollment. Medicaid members may be reassigned to the health plan of their choice if their written request for reassignment and their choice of an alternative plan is received by the Medicaid agency within ninety (90) days of the voluntary or auto-assigned enrollment and the plan selected is open to new members.

(02) Requests made ninety (90) days or more after enrollment. Medicaid enrollees who challenge an auto-assignment decision or seek to change plans more than ninety (90) days after enrollment in the health plan must submit a written request to the Medicaid agency

and show good cause, as provided in section 1311.07, for reassignment to another plan. A written decision must be rendered by the Medicaid agency within ten (10) days of receiving the written request and is subject to appeal.

05. Auto-assignment and resumption of eligibility – Medicaid members who are disenrolled from a health plan due to loss of eligibility are automatically re-enrolled, or assigned, into the same plan if they regain eligibility within sixty (60) calendar days. If more than sixty (60) days have elapsed, the Medicaid member is permitted to select a plan from those open for enrollment at that time.

06. Open-enrollment – To the extent feasible, the Medicaid agency must coordinate open enrollment periods with those established for affordable care more generally through the State's health insurance exchange – HealthSourceRI.

07. The Medicaid agency reserves the discretion to provide Medicaid wrap around coverage, as an alternative to coverage in a Medicaid managed care plan to any eligible individual who has comprehensive health insurance through a liable third party, including (but not limited to) absent parent coverage. Such wrap around coverage must be equivalent in scope, amount and duration to that provided to Medicaid eligible individuals enrolled in in a qualified health plan, including ESI, through the RIte Share program (MCAR section 1312).

1311.05 Enrollment of Newborns and Adopted Children

The enrollment of infants born to mothers who are Medicaid eligible varies depending on the mother's coverage group. Enrollment of adopted children who are eligible on their own or as part of a Medicaid eligible family also varies depending on the basis of Medicaid coverage.

01. Newborns – Infants born to mothers with income less than 253% of FPL who are enrolled in a health plan on the date of their baby's birth are automatically enrolled into a RIte Care health plan. If the newborn's mother is in enrolled in a RIte Care plan, the child is automatically enrolled in the mother's health plan. If the newborn's mother is enrolled in a RHP health plan, the baby and the mother will be enrolled in a RIte Care health plan, effective on the date of birth, once certification of the birth has been received. If the newborn's mother is enrolled in an ESI or other qualified health plan (QHP) with a Medicaid wrap, the baby is enrolled in RIte Care or RIte Share if the plan meets the cost-effectiveness test set forth MCAR section 1312. See MCAR section 1305 for newborn deeming provisions.

02. Adopted children -- Legally adopted children are enrolled as of the date the adoption becomes final. This date cannot be prior to the date Medicaid eligibility is established. The applicable provisions on eligibility and enrollment of child participating the State's adoption subsidy program are located in MCAR section 0342. A parent, caretaker or guardian must notify the Medicaid agency when a newborn deemed eligible is adopted.

03. Other Infants and Children -- All infants and children with income up to the 261% of the FPL level are Medicaid eligible under the MACC group for children and young adults, irrespective of the a eligibility of a parent, caretaker or pregnant mother as indicated in the provisions in MCAR section 1301. Any infants and children determined eligible on this basis are enrolled in a RIte Care or, as applicable, RIte Share-approved ESI health plan in accordance with the provisions of this rule applicable to all other Medicaid members.

1311.06 Medicaid Members Exempt from Enrollment Managed Care

Certain Medicaid members who would otherwise receive care through the RIte Care or RHP delivery systems may be granted exemptions from mandatory enrollment in a managed care health for good cause in narrow range of "extraordinary circumstances" upon approval of the Medicaid agency. An extraordinary circumstance, as defined for these purposes, is a situation, factor or set of factors that preclude a Medicaid member from obtaining the appropriate level of medically necessary care through the managed care delivery system -- RIte Care or RHP – designated for the Medicaid member's coverage group.

01. Types of extraordinary circumstances -- Such a situation, factor or set of factors may include the existence of a chronic, severe medical condition for which the member has a longstanding treatment relationship with a licensed health care practitioner – e.g., primary physician, specialist, etc -- who does not participate in any of the Medicaid health plans in the delivery system designated to provide care to the member.

02. Limits -- A Medicaid member's preference to continue a treatment relationship with a particular physician or other health care practitioner who does not participate with a heath plan in the member's designated delivery system does not constitute an "extraordinary circumstance" in and of itself.

03. Exemption requests – Requests for exemption to mandatory enrollment in managed care due to extraordinary circumstances must be made in writing, include appropriate documentation (letter from physician, medical records, or other as indicated), and signed. Exemption requests should be routed to the Medicaid agency.

04. Agency actions and duration of exemption --The Medicaid agency makes enrollment exemption determinations based on a consideration of the circumstances of each member's individual request. Once exempted, an individual can be exempt for as long as the extraordinary circumstance exists. Non-exempt Medicaid members in a household must follow the regular Medicaid health plan enrollment process.

1311.07 Health Plan Lock-In

Following initial enrollment into a plan, Medicaid members are restricted to that plan until the next open enrollment period. During this health plan lock-in, a Medicaid member may only be disenrolled under one of a set of specific allowed conditions.

01. Allowed conditions for disenrollment requests -- Members may request disenrollment for any of the following reasons:

    - Substandard care;
    - Inadequate access to necessary specialty services;
    - Insufficient transportation;
    - Discrimination;
    - Member relocation;
    - Good cause as defined in sections 1311.07 and 1311.19.03
    - Without cause during the ninety (90) days following the effective date of the Medicaid member's initial enrollment with the health plan.

02. Filing an appeal – Medicaid members seeking disenrollment during the lock-in period must first file a formal appeal in accordance with the grievance and appeal procedures of the health plan (see MCAR section 0110).

03. Agency review -- Disenrollment can only be ordered by the Medicaid agency after administrative review of the facts of the case. In the course of the review, the Medicaid agency must examine the evidence compiled by the health plan about the grounds that are the basis for the Medicaid member's request for disenrollment.

04. Notice of agency action – The Medicaid agency must provide the member with written notice of the action taken on the request for disenrollment. If the Medicaid agency determines that there is sufficient evidence to disenroll the Medicaid member, the notice must be sent to the member at least ten (10) days prior to the date the proposed disenrollment would be effective. The Medicaid member must meet with an enrollment counselor to select another health plan.

1311.08 Open Enrollment

During an open enrollment period, Medicaid members have an opportunity to change health plans. Open enrollment extends to all RHP enrollees and RIte Care enrollees with the exception of members in the Extended Family Planning coverage group.

1311.09 Membership Handbook

The Medicaid health plan must provide a Medicaid enrollee with a membership handbook and information on how to select a primary care physician member. This information must be sent by mail within ten (10) days of the date of plan enrollment for all members excluding foster children. The plan must send this same information to foster children within fifteen (15) days of the date of enrollment.

1311.10 Identification Cards

Medicaid members are issued two identification cards – permanent health plan cards and permanent Medicaid cards.

01. Health permanent cards -- Medicaid health plans must issue permanent identification cards to all Medicaid members within fifteen (15) days of enrollment. The card identifies the plan name and a twenty-four hour, toll-free telephone number for the Medicaid member to call in the event of an urgent or emergent health care problem. The card also includes the telephone number for the plan's membership services division and the name and telephone number of the recipient's primary care physician.

02. Medicaid cards -- A Medicaid identification card is also issued to Medicaid members who are eligible for out-of-plan benefits through the State's Medicaid Management Information System (MMIS).

1311.11 Interim Fee-for-Service Coverage

There is a seven (7) day period between Medicaid health plan assignment and plan enrollment in which services provided to a Medicaid member may be paid for on a fee-for-service basis. The services must be delivered to the Medicaid member by a health provider or practitioner certified to participate in the RI Medicaid program to qualify for the fee-for service payment. Services delivered prior to plan enrollment to a State-funded pregnant woman with income above 253% of the FPL are not covered.

1311.12 Verification of Eligibility/Enrollment

Medicaid health plans have the opportunity to contact the Medicaid agency or a DHS office or the automated eligibility verification system as necessary and appropriate to verify eligibility and plan enrollment if a Medicaid member requires immediate services.

1311.13 Responsibility of Medicaid Members to Report Change in Status

Medicaid members are responsible for reporting certain changes in status including any related to family size, residence, income, employment, third party coverage, and child support. A status change form must be filed with the Medicaid agency, the Contact Center or a DHS field office within ten (10) days of the date the change takes occurs. In addition, the Medicaid agency conducts periodic reviews to determine whether any changes in status have occurred that affect eligibility or health plan enrollment. Medicaid health plans must also report to the Medicaid agency any changes in the status of Medicaid members once they become known.

1311.14 Renewals of Continuing Eligibility

Repealed June 2014

1311.15 Transitioning Members between Health Plans and Delivery Systems

It may be necessary to transition a Medicaid member between health plans or from one delivery system -- RHP to RIte Care or vice versa -- for a variety of reasons:

01. Change in plans within a delivery system – The transition between Medicaid health plans may occur as a result of change in health plan during open enrollment or a change that is ordered as part of a grievance resolution. The health plans have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another plan. The health plan must transfer this information at no cost to the member.

02. Change in delivery systems – Medicaid members may be transitioned from one managed care delivery system into another as a result of changes in eligibility status. Adults enrolled in RIte Care who are between the ages of 19 and 64 may be eligible under the MACC group for adults when their dependent children age out of MACC group for children and young adults. Once a RHP member has given birth, both newborn and/or parents may be transitioned to RIte Care if income is within the eligibility thresholds set forth in 1301. Enrollment in health plans during such transitions will strive to preserve the continuity of care to the full extent feasible. Accordingly, Medicaid members enrolled in a particular plan subject to a delivery system transition will be enrolled in the same health plan, if participating, in the new delivery system.

1311.16 Grievance and Appeals

The State provides a grievance and appeals process that health plan providers and Medicaid enrollees must use when seeking redress against health plans. This is the same process that the health plans must use when seeking to disenroll members who are habitually non-compliant or who pose a threat to plan employees or other members. This process has multiple components that extend from complaint resolution to the filing of formal appeals.

01. Internal complaint resolution --The health plans resolve member and provider complaints through internal mechanisms whenever possible. The health plans therefore must maintain written policies and procedures for resolving member complaints and for processing grievances either upon request or when the time allotted for complaint resolution expires. This information must be included in the member handbook distributed to enrollees by the Medicaid health plans and provided to the public upon request.

02. Timeliness -- The health plan may take up to fifteen (15) days to seek resolution of a medical care related complaint and up to thirty (30) days to seek resolution of a non-medical care related complaint. If a complaint is not resolved to the satisfaction of the member or provider within the allotted time, the health plan must agree to automatically register the complaint as a formal grievance, unless requested otherwise by the member or provider. The health plan also must agree to register a complaint as a formal grievance if requested to do so at any time by the member or provider, even if the fifteen (15) or thirty (30) day limit has not been reached. In addition, the health plan must comply with the initial and second level appeals process as described in Rhode Island's *Rules and Regulations for the Utilization Review of Health Care Services.*

1311.17 Member/Provider Initiated Formal Grievances

The health plans maintain internal policies and procedures to conform to State reporting policies and provide a process for logging formal grievances. RIte Care and RHP members must exhaust the internal health plan appeals process before requesting an EOHHS Administrative Fair Hearing. Appeals filed with a health plan fall into three (3) areas:

01. Medical Emergency - A health plan must decide an appeal of a policy within two (2) business days when a treating provider, such as a doctor who takes care of the member, determines the need for care to be an emergency and all necessary information has been received by the health plan.

02. Other Medical Care - There are two (2) levels of a non-emergency medical care appeal.

(01) Initial level of appeal. The Medicaid health plan must decide an appeal within fifteen (15) days of the date that all necessary information has been received by the plan. If the initial decision is against the member, then the health plan must offer the second level of appeal.

(02) Second level of appeal. The health plan must decide on the grievance within fifteen (15) days of the date that all necessary information has been received by the plan.

RIte Care and RHP members may also choose to initiate a third (3rd) level or external appeal, per the Department of Health *Rules and Regulations for the Utilization Review of Health Care Services* (R23-17.12-UR). A member does not have to exhaust the third level appeal before accessing the EOHHS administrative fair hearing process.

3. Non-Medical Care - If the grievance involves a problem other than medical care, the health plan must decide the grievance within thirty (30) days of the date that all necessary information has been received by the health plan. Medicaid members must exhaust the internal health plan appeals process in these cases before requesting an EOHHS Fair Hearing. Regulations governing the appeals process are found in section 0110 of the MCAR.

1311.18 Health Plan Initiated Disenrollment

The health plan may seek disenrollment of a member who is habitually non-compliant or poses a threat to health plan employees or other members. A health plan initiated disenrollment, is subject to an administrative review process by the Medicaid agency and must follow the following requirements:

01. Health plan disenrollment requests -- For a plan to disenroll a Medicaid member, the plan must send a request, along with accompanying documentation, to the Medicaid agency. When the request is received, the Medicaid agency sends a notice to the Medicaid member informing him or her that the plan is seeking to take a disenrollment action and explaining the reason given by the plan for taking such an action. The notice also informs the member that of the right to submit within ten (10) days any evidence establishing a good cause appeal rejecting the disenrollment action.

02. Medicaid agency action -- The Medicaid agency must investigate and render a decision within ten (10) days of receipt of evidence from both parties. The Medicaid agency's decision is subject to appeal. If, based upon the evidence submitted by the health plan, the Medicaid agency determines that the Medicaid member should be disenrolled from the health plan, a notice is sent to the Medicaid member by the Medicaid agency stating the decision and the basis thereof at least ten (10) days prior to the date the proposed disenrollment would be effective.

03. Good Cause appeal -- A Medicaid member subject to a health plan request for disenrollment has the right to present evidence establishing good cause. Good cause must be filed prior to the

end of the ten (10) day advance notice period. The filing of good cause is submitted in writing to the Medicaid agency. Good cause includes circumstances beyond the Medicaid member's control sufficiently serious to prevent compliance; an unanticipated household emergency; a court-required appearance; incarceration; breakdown in transportation arrangements; or inclement weather which prevented the Medicaid member and other persons similarly situated from traveling to, or participating in, the required appointment. A member's preference to remain in fee-for-service does not constitute good cause for an appeal of the request for disenrollment.

1311.19 Medicaid Agency Authority

EOHHS has sole authority as the Medicaid Single State Agency for disenrolling Medicaid members from a health plan. Requests for disenrollment, either as the result of a formal grievance filed by the Medicaid member against the health plan, or by the health plan against the Medicaid member, is subject to an administrative review process by the Medicaid agency.

1311.20 Reasons for Disenrollment

EOHHS may disenroll Medicaid eligible health plan members for a variety of reasons including, but not limited to, any of the following:

- Death;
- Loss of eligibility;
- Selection of another health plan during open enrollment;
- Change of residence outside of the plan's service area;
- Non-payment of premium share;
- Incarceration;
- Permanent placement in Eleanor Slater Hospital;
- Long-term placement in a nursing facility for more than thirty (30) days;
- Disenrollment as the result of a formal grievance filed by the member against the health plan; or
- Disenrollment as the result of a formal grievance filed by the health plan against the member.

1311.21 Disenrollment Effective Dates

Member disenrollments outside of the open enrollment process become effective on the date specified by the State, but not fewer than six (6) days after the health plan has been notified, unless the health plan waives this condition. The health plans have written policies and procedures for complying with State disenrollment orders.

1311.22 Right to Appeal

All notifications of disenrollment must include information regarding the Medicaid member's right to appeal the decision and the procedures for requesting an EOHHS administrative fair hearing.

1311.23 EOHHS Hearings

See MCAR section 0110.

1311.24 Medicaid Member Rights and Protections

All Medicaid members are guaranteed access to quality health care delivered in a timely and respectful manner. To ensure this goal is met, the following rights and protections must be clearly stipulated by both the Medicaid agency and the health plan.

01. Enrollment -- The Medicaid agency will make every effort to provide the following:

- Multilingual services to all people who do not speak English;
- Written enrollment information will be provided in a clear and easy-to-understand format;
- Enrollment information provided by the plan must include detailed information on how to obtain transportation services, second opinions, interpreter services, referrals, emergency services and out of state services unavailable in Rhode Island. Information must also be provided regarding switching primary care providers, disenrollment for good cause, the in-plan grievance process and the EOHHS appeals process;
- The State will conduct a special enrollment outreach effort for beneficiaries who are homeless or who live in transitional housing;
- Once a Medicaid member is enrolled, the health plan will conduct a special enrollment outreach effort for any enrollees who are homeless or who live in transitional housing;

- The health plan is prohibited from engaging in any door-to-door or telemarketing or any other similar unfair marketing practices;

- Enrollees will be provided with counseling assistance in the selection process for their primary care providers;

- Medicaid members who receive on-going care from a primary care provider or specialist will be advised by the non-biased enrollment counselor which providers are participating in each health plan option so as to promote continuity of care;

- If a Medicaid member is auto-assigned to a health plan, the member may dispute that assignment through the right to rebuttal. A decision by the Medicaid agency must be rendered within ten (10) days of the filing of the rebuttal and is subject to appeal.

02. Second Opinions and Switching Doctors – Every Medicaid member must be informed of the following:

- Health plans must provide, at their expense, a second opinion within the health plan upon an enrollee's request. A decision on the request for a second opinion will be made in a timely manner and approval shall not be unreasonably withheld;

- Health plans must provide a second opinion by a qualified, non-participating provider when the plan determines that an enrollee's chemical dependency or mental health problem does not require treatment;

- A Medicaid member is entitled to a second surgical opinion by a plan physician, or if the referral is made by a plan physician, to a second surgical opinion by a non-participating physician;

- Medicaid members have the right to switch providers within the plan, upon request. Reasons for switching providers include the following: substandard care; problems with language or communication; discrimination; rude treatment or personality conflicts with providers or provider staff; moving or good cause;

- Members who are denied a second opinion or denied the right to switch providers will have the right to appeal under the grievance procedures as listed below.

03. Grievance Procedures – Medicaid members must also be informed of their rights including the following:

- The right to appeal the following decisions: assignments to providers; referrals; denial of services; and determinations of non-emergency care;

- The right to a timely in-plan grievance procedure;

- The right to a timely fair hearing from the Executive Office of Health and Human Services. (See section 0110 of the MCAR);

- Grievances filed with health plan that relate to medical treatment must be decided within fifteen days.

04. Disenrollment – The following apply to requests for disrenrollment, as indicated:

- Medicaid members may request to disenroll from any health plan for the remainder of an enrollment period for any of the reasons established in section 1311.18;

- A rapid disenrollment process must be provided for individuals and families who are dislocated and move to another area due to homelessness, domestic abuse, or other similar crises, if they cannot access in-plan services within a reasonable distance from their new location;

- Medicaid members who are disenrolled have a right to appeal that decision through the EOHHS administrative appeals process as outlined in section 0110 of the MCAR general provisions.

05. Interpreter Services --Plans are encouraged to provide availability to twenty-four (24) hour interpreter services for every language group enrolled by the health plan for all points of contact, especially telephone contact. In addition, reasonable attempts must be made by the plans to have written materials, such as forms and membership manuals, translated into other languages. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language. Interpreter services are provided if a plan has more than one hundred (100) members or ten percent (10%) of its Medicaid membership, whichever is less, who speak a single language other than English as a first language.

06. Exceptions Based on Safety Needs -- Providers, health plans and the State must consider the personal safety of a client in instances of domestic violence in all of the following matters:

    - Enrollment policies;

    - Disenrollment policies;

    - Second opinions;

    - Switching primary care physicians/practitioners; and

- Grievance procedures.

07. Referral to Rhode Island Legal Services -- Notices to Medicaid members must include the information indicated that they may represent themselves or be represented by someone else such as a lawyer, relative, or another person in the hearing and appeal process. Notices must also information regarding free legal help being available by calling Rhode Island Legal Services.

1311.25 Information
REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1311.26 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Section 1312:

RIte Share Premium Assistance Program

December 2013
March 2014 (T)

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Rules and Regulations Section 1312:

RIte Share Premium Assistance Program

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1312 of the Medicaid Code of Administrative Rules entitled, "RIte Share Premium Assistance Program"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

1312 RIte Share Premium Assistance Program

1312.01 Overview

Under the terms of Section 1906 of Title XIX of the U.S. Social Security Act, states are permitted to pay an eligible individual's share of the costs for enrolling in employer sponsored health insurance coverage if it is cost effective to do so. R.I.G.L. 40-8.4-12 authorized the Medicaid agency to establish the RIte Share Premium Assistance Program to subsidize the costs of enrolling Medicaid eligible individuals and families in employer sponsored health insurance (ESI) plans that have been approved as meeting certain cost and coverage requirements. The Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, uses cost-effective criteria to determine whether ESI plans meet these requirements.

1312.02 Scope and Purpose

This section applies to individuals and families determined to be Medicaid eligible under section 1301 (Medicaid Affordable Care Coverage "MACC" groups). It also applies to specified individuals determined to be Medicaid eligible under section 1309 (non-MAGI or non-Medicaid funded). If these individuals or families have access to insurance provided through an employer (ESI), the Medicaid agency must conduct a review of the coverage to determine if the benefits are comparable to Medicaid benefits and if the cost of the ESI is less expensive than full Medicaid coverage. When ESI is found to be cost-effective, the State will pay the employee's premium.

The purpose of this rule is to set forth the provisions governing participation in the RIte Share program, the buy-in requirement and the process for determining whether an ESI plan meets the cost-effectiveness criteria established by the EOHHS, the Medicaid agency. The rule also identifies the respective roles and responsibilities of Medicaid eligible individuals and families and the Medicaid agency.

1312.03 Definitions

For the purposes of this section, the following definitions apply:

"**Cost-effective**" means that the portion of the ESI that the State would subsidize, as well as wrap-around costs, would, on average, cost less to the State than enrolling that same individual/family in a managed care delivery system.

"**Cost sharing**" means any co-payments, deductibles or co-insurance associated with ESI.

"Employee Premium" means the monthly premium share an individual or family is required to pay to the employer to obtain and maintain ESI coverage.

"**Employer-Sponsored Insurance or ESI"** means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSourceRI.

"Group health plan" means an employee welfare benefits plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 as qualified in R.I.G.L. 27-50-3(T)(1) and 27-18.6-2(15).

"Health insurance coverage or health benefit plan" means a policy, contract, certificate or agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services as defined and qualified in R.I.G.L. 27-18.5-2(7), 27-18.6-2(14) and 27-50-3(U)(1).

"Medicaid member" means a person who has been determined to be an eligible Medicaid beneficiary.

"Modified Adjusted Gross Income or (MAGI)" means income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income. The MAGI is the standard for determining income eligibility for all Medicaid affordable care coverage groups (MCAR section 1301).

"New Applicant" means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"Policy holder" means the employee with access to ESI.

"RIte Share-approved employer-sponsored insurance (ESI)" means an employer-sponsored health insurance plan that meets the coverage and cost-effectiveness criteria for RIte Share.

"RIte Share buy-in" means the monthly amount a parent or caretaker of a Medicaid-eligible child or young adult must pay toward RIte Share-approved ESI that covers the parent or caretaker with access to the ESI and his/her Medicaid-eligible children. Only applies in instances when household income based on the MAGI is above 150% the FPL.

"RIte Share premium assistance program" means the Rhode Island Medicaid premium assistance program in which the State pays the eligible Medicaid member's share of the cost of enrolling in a RIte Share-approved ESI plan. This allows the State to share the cost of the health insurance coverage with the employer.

"RIte Share Unit" means the entity within EOHHS responsible for assessing the cost-effectiveness of ESI, contacting employers about ESI as appropriate, initiating the RIte Share enrollment and disenrollment process, handling member communications, and managing the overall operations of the RIte Share program.

"RIWorks" means the State's Temporary Assistance for Needy Families (TANF) program that provides assistance to low income needy families on the path to full employment and financial independence. The program is administered by the Rhode Island Department of Human Services, one

of the four State agencies under the Executive Office of Health and Human Services (EOHHS) agenda.

"Third Party Liability (TPL)" means other health insurance coverage. This insurance is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always payer of last resort, the TPL is always the primary coverage.

"Wrap-around services or coverage" means any health care services not included in the ESI plan that would have been covered had the Medicaid member been enrolled in a RIte Care (MCAR 1309) or Rhody Health Partners (MCAR section 1310) plan. Coverage of deductibles and co-insurance is included in the wrap. Co-payments to providers are not covered.

1312.04 RIte Share Populations

The income of Medicaid members affects whether and in what manner they must participate in RIte Share as follows:

01. Income at or below 150% of FPL -- Individuals and families determined to have household income at or below 150% of the Federal Poverty Level (FPL) based on the modified adjusted gross income (MAGI) standard -- in accordance with MCAR section 1307 – are required to participate in RIte Share if a Medicaid-eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RIte Share is a condition of maintaining Medicaid eligibility. The buy-in requirement described in section 1312.08 does not apply, however.

02. Income above 150% FPL and policy holder is not Medicaid-eligible -- Premium assistance is available when the household includes Medicaid-eligible members, but the ESI policy holder, typically a parent or caretaker, is not eligible for Medicaid. Premium assistance for parents/caretakers and other household members who are not Medicaid eligible is provided when:

    (01) Enrollment of the Medicaid-eligible family members in the approved ESI plan is contingent upon enrollment of the ineligible policy holder; and

    (02) It is cost-effective to provide a subsidy to family coverage compared to the cost of enrolling Medicaid eligible family members in a Medicaid managed care plan, using methodology described in section 1312.08.

03. Medicaid-eligible children and young adults. Eligible children and young adults remain eligible for Medicaid if the person with access to RIte Share-approved ESI does not enroll as required.

1312.05 RIte Share Enrollment as a Condition of Eligibility

For Medicaid members over the age of nineteen (19), enrollment in RIte Share is a condition of eligibility. This requirement also applies to any individuals who have or previously had the option to waive ESI coverage to receive financial compensation, including but not limited to, an increase in hourly wage, an increase in weekly salary, and/or a lump sum payment. (An increase in wages for waiving coverage is also known as "pay in lieu of benefits.")

01. Exemptions – In certain circumstances, Medicaid members with access to ESI are exempt from enrolling as condition of maintaining eligibility:

(01) Non-Citizen policy holder. RIte Share enrollment is not required if the employed parent/caretaker in the household with ESI is a non-citizen ineligible for Medicaid due to immigration status.

(02) Under age 19. Medicaid-eligible children and young adults up to age nineteen (19) are not required to enroll in a parent/caretaker relative's ESI as a condition of maintaining Medicaid eligibility.

(03) RIWorks. There is a limited six (6) month exemption from the mandatory enrollment requirement for RIWorks program participants. See section 1312.05 below.

02. Mandatory ESI Enrollment -- Once it has been determined by the Medicaid agency that the ESI offered by a particular employer is RIte Share-approved, all Medicaid members with access to that employer's plan are required participate in RIte Share. If the policy holder (i.e., employee) in the household is a Medicaid-eligible parent/caretaker age nineteen (19) or older, the policy holder is responsible for enrolling any Medicaid-eligible family members (i.e., spouse, caretaker, and children) in the RIte Share–approved ESI plan.

03. Non-compliance – Failure to meet the mandatory enrollment requirement results in the termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen (19) or older in the household that could be covered under the ESI until the policy holder complies with the RIte Share participation and enrollment procedures established by the Medicaid agency in this rule. (See section 1312.20).

04. Reinstatement – The period of ineligibility may be shortened and Medicaid eligibility reinstated if participation in RIte Share by the policy holder is no longer required either due to a change in the status of the ESI (e.g., the employer's plan is no longer RIte Share-approved) or access to the employer's plan (e.g., the policy holder changes jobs or is no longer qualified for ESI as a result of a decrease in work hours).

1312.06 Rhode Island Works Participants

RIWorks participants who are Medicaid-eligible are not required to enroll in a RIte Share-approved ESI plan for the first six (6) months of employment. This six month exemption also applies to families losing eligibility for RIWorks due to employment. Specifically, to be subject to enrollment in a RIte Share approved ESI plan, the RIWorks participant must be:

- Age nineteen (19) or older; and
- Employed for a period of six (6) consecutive months or more by the same employer.

RIWorks participants who do not meet both of these criteria at the time Medicaid eligibility is renewed in accordance with section 1312.16.01 are exempt from participating in RIte Share.

1312.07 RIte Share Premium Assistance

Under the RIte Share Premium Assistance Program, the State pays the policy holder's premium. In some cases, the State will also pay for cost-sharing requirements. Medicaid members also receive wrap-around services.

01. Premium payments – The Medicaid agency pays for ESI premiums as follows:

- The Medicaid agency pays the premium the policy holder must to pay to the employer for ESI for his or her own individual coverage (e.g., parent/caretaker who is pregnant women).

- The Medicaid agency pays the premium the policy holder must pay to the employer for ESI for family/dependent coverage. See section 1312.17.

02. Cost-sharing --Medicaid members enrolled in ESI are not obligated to pay any cost-sharing that is not otherwise applicable to Medicaid. The Medicaid agency pays for any ESI co-insurance and deductibles in such instances. Co-pays are not covered by the Medicaid agency, but RIte Share enrollees are not required to pay co-payments to Medicaid certified providers. The health care provider may not bill the RIte Share member for any cost-sharing required by the ESI, including co-payments.

03. Wrap-around Coverage --Services and benefits that are covered by Medicaid, but are not offered through the ESI plan, are made available through the Medicaid program. Wrap-around services/coverage ensures that RIte Share enrollees receive health coverage comparable in scope, amount and duration to Medicaid members enrolled in RIte Care or Rhody Health Partners. Medicaid covers these services for Medicaid members participating in RIte Share enrollees when using Medicaid providers.

04. Repayment and recoupment -- EOHHS has the authority to recover Medicaid benefit overpayment claims and cost share arrearages through offset of the individual State income tax refund in accordance with Section 44-30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 of the Rhode Island General Laws in Chapter 44-30.1 entitled 'Setoff of Refund of Personal Income Tax.' An example of a benefit overpayment is a premium payment made to a policy holder for ESI that was not active during the month(s) for which the payment was made.

1312.08 RIte Share Buy-in Requirement

In certain instances, Medicaid members participating in RIte Share are subject to a buy-in requirement. This requirement applies only when a Medicaid-eligible child is residing in a household with MAGI-based income above 150% of the FPL must enroll in the RIte Share-approved ESI plan of a parent/caretaker – "the policy holder" – who is not eligible for Medicaid.

01. Buy-in amount -- The parent/caretaker is required to pay a monthly buy-in amount that varies with income as follows:

Monthly Family Income	*Monthly Buy-In Amount*
Over 150% and not greater than 185% FPL	$ 61.00
Over 185% and not greater than 200% FPL	$ 77.00
Over 200% and not greater than 250% FPL	$ 92.00

02. Notice – The Medicaid agency must provide the adult in the family subject to the buy-in requirement with timely notice. This may be done separately or in conjunction with the notice of RIte Share participation. The notice must include the amount of the buy-in, the process for making payments, the consequences for non-payment and a statement of the right to appeal and request a hearing.

03. Payment -- Buy-in amounts are not prorated. Therefore, a full monthly buy-in amount is due if RIte Share enrollment is effective for any portion of a coverage month.

04. Method of payment -- The parent/caretaker pays the monthly RIte Share buy-in amount to the Medicaid agency. Further information about the payment method is provided in the notice of the buy-in requirement sent to the parent/caretaker.

04. Non-compliance – If the parent/caretaker fails to pay the buy-in amount as required, eligibility may be terminated for failing to cooperate in accordance with section 1312.22. Children and young adults in the family who are eligible for Medicaid will be enrolled in a RIte Care plan. Only individuals over age nineteen (19) are subject to the disenrollment sanction.

1312.09 Basis for Approving of ESI Plans

Only ESI or group health plans that meet the cost-effectiveness and benefits criteria specified in this section are approved for the RIte Share premium assistance program.

01. Sources of information for determining cost-effectiveness -- Determinations of ESI cost effectiveness on information gathered from the following sources:

(01) Application materials. When applying for Medicaid, applicants must indicate: current health insurance coverage status; relationship to policy holder; plan name; policy number; eligibility for and type of coverage (e.g., individual, family, individual and single dependent); employee costs for coverage (e.g., employee's share for individual versus family/dependent coverage); and individuals covered by plan. MCAR section 1303 explains the process for applying for Medicaid through the State's affordable care eligibility system and the manner in which this information is collected and maintained.

(02) The RIte Share Unit. This Unit of the Medicaid agency collects data about ESI plans of the employers of Medicaid- eligible individuals/households. Information from employers includes data necessary to determine whether the employer's ESI offerings meet the Medicaid agency's cost-effectiveness and benefits criteria.

02. EOHHS reserves the right to request additional information about the ESI plan from the Medicaid member, the policy holder, even if not an eligible Medicaid member and, where appropriate and necessary, the employer or insurance carrier.

1312.10 Methodology for Determining Cost-Effectiveness

The RIte Share Unit uses the information about the ESI plan to compare the enrollment cost (i.e., payment of the employee's share) for the Medicaid members in the family, and any ineligible policy holder, in a Medicaid managed care plan versus RIte Share. An ESI plan is determined to be cost effective when on the aggregate, the total cost of Medical coverage through RIte Share is less than the average cost to cover them through a Medicaid managed care plan. RIte Share participants receive coverage comparable in scope, amount and duration to coverage provided in a Medicaid managed care plan.

01. Cost-effectiveness test -- To be cost-effective, the policy holder's monthly ESI premium share, deductibles, co-insurance plus any Medicaid covered services not covered by the ESI plan (e.g., services covered under the RIte Care Health Plan contract but not under the ESI plan) must be less than the average capitation payment for an average individual/family enrolled in a Medicaid managed care plan. These average costs must be actuarially determined at such intervals as deemed appropriate by EOHHS.

02. There are three cost effectiveness determinations for each employer plan:

    (01) Family coverage where all family members are Medicaid-eligible with income less than or equal to 133% of the FPL based on the MAGI standard;

    (02) Family coverage where only children and pregnant women in the family are Medicaid eligible with income greater than 133% of the FPL and less than or equal to 250% of the FPL based on the MAGI standard; and

    (03) Individual coverage where only the employee is Medicaid-eligible (e.g., pregnant women).

The figures used as the basis for assessing cost effectiveness shall be made available, upon request, by EOHHS.

1312.11 Scope and Consequence of Approving an ESI Plan

RIte Share-approved ESI plans are reevaluated on an annual basis to ensure that all Medicaid members who are enrolled receive coverage comparable in scope, amount and duration to that provided in a Medicaid managed care plan. From the date an ESI plan is approved until the date it is reevaluated, any Medicaid members who work for that employer and their Medicaid-eligible dependents must enroll in the ESI through RIte Share. Parents/caretakers of a Medicaid-eligible child who have access to a RIte Share-approved ESI plan must enroll the child in the employer plan irrespective of their own Medicaid eligibility. In either case, failure of the parent/caretaker to enroll in the RIte Share-approved plan does not affect the eligibility of the child.

1312.12 Enrollment Process

Medicaid members who are required to participate in RIte Share must enroll in the ESI plan as directed by the Medicaid agency. Enrollment into RIte Share may occur upon initial determination at the time of annual renewal, or as deemed appropriate by the EOHHS.

01. Eligibility determination and RIte Share referral – The referral for RIte Share participation is based on information provided by the Medicaid member in conjunction with an application or annual renewal; and documented in the RIte Share database as to whether an employer offers RIte Share-approved coverage.

02. Notice RIte Share participation required – The notice that participation in RIte Share is a condition of retaining Medicaid eligibility must be sent by EOHHS as follows:

    (01) Fourteen days notice. Upon determining that a Medicaid member is qualified for coverage through RIte Share, EOHHS provides a written Notification of Eligibility for Enrollment stating the employee must select a RIte Share-approved ESI plan through their employer's personnel or human resources office within fourteen (14) calendar days.

    (02) Thirty days notice. Written notice will be sent to the Medicaid recipient approximately thirty (30) days prior to the date that enrollment in RIte Share is required, but only in instances when approval of the ESI plan is the impetus for the requirement to enroll rather than a determination/renewal of Medicaid eligibility; and the employer is not participating in RIte Share.

03. Prior agreement – In certain circumstances, EOHHS may have a prior agreement with the employer which permits the RIte Share Unit to enroll an eligible individual/family in the ESI plan upon receipt of an acknowledgment or written consent from the policy holder. The notification of enrollment sent from the RIte Share Unit to the Medicaid ineligible policy holder as well as to any Medicaid recipients in such cases shall explain any such prior arrangements and any additional appeal and hearing rights that follow therefrom.

1312.13 Access to ESI

All Medicaid applicants and members are required to provide information about access to ESI. For the purposes of RIte Share, “access” to ESI is as follows:

- A Medicaid-eligible individual, age nineteen (19) or older who is, or has the option to be, enrolled in an employer-sponsored health insurance or group health benefit plan;

- A Medicaid-eligible individual who is, or has the option to be, enrolled in an employer-sponsored health insurance or group health benefit plan as the spouse, dependent or family member of a Medicaid-ineligible policy holder.

Failure to provide this information as required may lead to the denial or termination of Medicaid eligibility, unless there is good cause for non-compliance as specified in section 1312.23.

1312.14 Non-custodial Parents with TPL

Medicaid is always the payer of last resort. Accordingly, the Medicaid agency considers all other health insurance or coverage provided to a Medicaid-eligible individual as third-party liability (TPL) coverage. EOHHS reserves the right to require Medicaid members to transition to the TPL coverage in instances it meets the cost and coverage effectiveness criteria for RIte Share. Special rules for handling this transition when a parent who does not have custody of the Medicaid-eligible child has access to ESI or other TPL are as follows:

01. TPL Coverage through the non-custodial parent -- Children who are enrolled in both RIte Care and ESI through a non-custodial parent (NCP), will be transitioned into RIte Share unless the custodial parent shows good cause for not making the transition. Once enrolled in TPL coverage, the child must retain access to all applicable Medicaid covered services the entire time that they are in RIte Share. Should the NCP lose their ESI, the RIte Share Unit must be notified at least ten (10) days prior to the child's disenrollment to meet established reporting requirements and assure the child is transitioned back into RIte Care without coverage gaps.

02. Custodial parent non-compliance -- If the custodial parent refuses to allow the child to be enrolled in the NCP's ESI or TPL coverage more generally, then the custodial parent's Medicaid eligibility is terminated until the parent complies with the RIte Share participation requirement. Good cause exemptions to RIte Share are permitted under section 1312.23.

03. Notice and enrollment – Medicaid members who are potential candidates for RIte Share must be provided with notice from the Medicaid agency letter explaining their rights and responsibilities including:

    (01) RIte Share participation. The requirement to participate in RIte Share is a condition of Medicaid eligibility for adults in the household. The Medicaid member with TPL must receive the notice fourteen (14) or thirty (30) days, as appropriate (see section 1312.11.02), prior to the required transition from a Medicaid managed care plan.

    (02) Grace period. Parents/caretakers are given a fourteen (14) day grace period to report any changes in the NCP's coverage and/or report any difficulties with using the NCP's coverage.

    (03) Failure to respond. If the parent/caretaker does not respond, the Medicaid members who are covered under the NCP's policy will be transitioned from RIte Care to RIte Share, and sent appropriate documentation. Those who are not covered under the NCP's coverage (e.g., custodial mom, children not related to the NCP) will remain on RIte Care.

(04) Cost-sharing. The notification must indicate clearly that the Medicaid agency will not make payment for coinsurance, cost sharing obligations, or wrap-around coverage to or for the NCP policy holder or any other Medicaid-ineligible family member/dependent enrolled in the approved ESI plan.

(05) Buy-in. If income is above 150% of the FPL, the notice must state the basis for the buy-in and the amount that must be paid per month in accordance with section 1312.07 and the consequences for non-compliance in section 1312.22.

1312.15 Continuing Eligibility – Renewals

For Medicaid members renewing eligibility, the Medicaid agency must assess as part of the redetermination process whether anyone in the household is a RIte Share participant and if there has been any change in access to ESI.

01. Notice of renewal – Medicaid members must be provided with a notice at the time of renewal specifying the terms for continuing eligibility. The terms for continuing coverage vary as follows:

(01) Medicaid managed care enrollees without access to ESI continue enrollment in the Medicaid managed care plan that provided coverage in the previous period of eligibility in accordance with MCAR section 1311.

(02) Medicaid managed care enrollees who have gained access to a RIte Share-approved ESI plan continue to be enrolled in the Medicaid managed care plan that provided coverage in the previous period of eligibility pending review by the RIte Share Unit. In such cases, EOHHS sends a notice stating that eligibility is continued and that coverage in a Medicaid managed care plan continues pending action on the ESI plan by the RIte Share Unit. A referral to the RIte Share Unit is made accordingly.

(03) RIte Share participants who retain access to the RIte Share-approved ESI plan that provided coverage during the during the previous period of eligibility, continue to be enrolled in the ESI plan pending review by the RIte Share Unit of any changes that might result in withdrawal of approval of the ESI plan, disenrollment, and subsequent enrollment in a Medicaid managed care plan.

02. Loss of ESI -- RIte Share participants who involuntarily lose access to an approved ESI plan that provided coverage during the previous period of eligibility for any of the reasons stated in 1312.21.02 receive coverage as follows:

(01) If the ESI plan is a Medicaid managed care plan, and the involuntary disenrollment occurred in the ninety (90) day period prior to and inclusive of the renewal date, the

Medicaid-eligible family members must be enrolled in a Medicaid managed care plan according to the enrollment procedures set forth in MCAR section 1311.

(02) If the ESI plan is not a Medicaid managed care plan, any Medicaid-eligible individuals in the family receive coverage through fee-for-service pending either enrollment in a Medicaid managed care plan, or if the Medicaid members have gained access to another ESI plan, approval of that plan by the RIte Share Unit.

03. Notice of renewal -- In all such cases, the notice of renewal for continuing eligibility sent by EOHHS to the Medicaid members shall include a statement of the applicable terms for continuing eligibility including any buy-in requirement, the reason(s) for establishing the terms, and the right to appeal and request a hearing with respect to either (See MCAR section 0110), as well as all other information required in this section. The enrollment referral transmitted to the RIte Share Unit shall also indicate which terms apply and shall be sent at the time the redetermination is made.

1312.16 Renewal of RIWorks Participants

At the time eligibility renewals are completed, EOHHS is responsible for assessing whether RIWorks participants are subject to enroll in a RIte Share-approved plan as a condition of Medicaid eligibility.

01. Employed under 6 months -- Only those RIWorks participants, age nineteen (19) and over, who have access to ESI and have been steadily employed for a period of six (6) consecutive months or more, shall be subject to enrollment in RIte Share. All other RIWorks participants continue enrollment in the RIte Care plan which provided coverage until the next scheduled redetermination of eligibility.

02. Employed 6 months or over -- If the RIWorks participant has been employed for over six (6) months, the notice of renewal sent by the Medicaid agency must state that enrollment in the RIte Care plan that provided coverage during the previous period of eligibility is continued, pending review of the ESI plan by the RIte Share Unit. The Medicaid members shall receive notice from the RIte Share Unit at least fourteen (14) days prior to enrollment in an ESI plan if enrollment in an approved ESI plan is a condition of retaining continuing eligibility.

1312.17 RIte Share Premium Assistance Payment

It is the responsibility of EOHHS to establish the appropriate mechanism for transferring payment for the RIte Share-approved ESI plan premiums.

01. The payment options include:

(01) Enrollment costs are paid directly by the employer without any wage withholding from the policy holder. The RIte Share Unit or its agent either mails a check or electronically

transfers payment to the employer's bank or account, on a monthly basis, to cover the enrollment costs for any individuals/families on the ESI as a result of RIte Share enrollment. These are called "participating" employers.

(02) Enrollment costs are paid by the employer after wage withholding from the policy holder. The RIte Share Unit or its agent mails a check or electronically transfers payment to the policy holder, on a monthly basis, to cover the enrollment costs for any individuals/families on ESI as a result of RIte Share enrollment.

(03) Enrollment costs (both the employer's premium share and the employee's premium share or employee's premium share only) are paid directly to the insurance carrier on a monthly basis by the RIte Share Unit or its agent. (If both the employer and employee enrollment costs are paid, EOHHS then bills the employer for the employee's enrollment costs).

02. Notice of payment method --The notification of RIte Share participation sent to the recipient(s) shall clearly specify the method for paying enrollment costs.

1312.18 Role of RIte Share Unit

The RIte Share Unit is responsible for overseeing the operations of the program as follows:

- Eliciting information from RI employers about the health plans they offer to workers on an ongoing basis.
- Evaluating health plans for RIte Share approval.
- Maintaining a database of RIte Share-approved ESI plans; and
- Contacting employers to make RIte Share enrollment decisions.

Upon receipt of member referral information, the RIte Share Unit verifies employment and access to a RIte Share-approved ESI plan. Based on this review, the RIte Share Unit determines:

- Whether the Medicaid is approved for RIte Share; and
- The date that individual or family must enroll in the ESI in order to maintain Medicaid eligibility.

The specific procedures for making such determinations vary depending on the enrollment status of the Medicaid members and the employer's customary enrollment process.

1312.19 ESI Enrollment Verification

Verification of enrollment in a RIte Share-approved ESI plan is required.

01. Participating employer -- For Medicaid members working for a RIte Share "participating" employer, the employer is required to submit verification to the RIte Share Unit that initial enrollment in the ESI has been made in the manner prescribed by EOHHS.

02. Approved plan -- For individuals working for a RIte Share-approved employer, the individual must provide verification of enrollment by completing the appropriate form, which requires the signature of a representative of the employer or submitting a copy of the official ESI enrollment receipt. Once this verification has been received, EOHHS will initiate premium payment.

1312.20 Failure to Enroll

Failure to enroll in the ESI plan is grounds for termination of Medicaid eligibility for the parent(s) or caretaker over the age of nineteen (19) in the household. If a Medicaid-eligible policy holder does not enroll as required, a referral is then made by the RIte Share Unit to the appropriate DHS field representative.

01. Discontinuation – The Medicaid agency sends a Notice of Discontinuation, stating that Medicaid eligibility has been terminated for adults in the household due to the failure to enroll in the RIte Share-approved plan. Anyone in the household subject to the notice may reapply (for inactive cases) or request reinstatement (for active Medicaid cases) if they choose to comply with RIte Share, if an exemption from participation is granted, or if the individual no longer has access to the ESI.

02. Disqualification -- Procedures for handling cases in which the policy holder is not eligible for Medicaid are the same as for an eligible policy holder, with one exception: The Medicaid agency sends a Notice of Disqualification to the policy holder indicating that ESI costs will not be paid by EOHHS.

Both the Notice of Discontinuation and the Notice of Disqualification shall include a statement indicating that any affected Medicaid-eligible individuals in the household have the right to appeal and to request a hearing to contest the change in eligibility and the enrollment decision.

1312.21 Disenrollment from RIte Share-Approved Plan

RIte Share participants who are voluntarily or involuntarily disenrolled from an approved ESI plan must report the change in enrollment status to the Medicaid agency in no more than ten (10) days from the date the disenrollment action occurs. The type of disenrollment determines the Medicaid agency's response as follows:

01. Voluntary disenrollment -- Medicaid-eligible RIte Share participants age nineteen (19) and over who voluntarily disenroll from an approved ESI will be terminated for coverage based on the failure to meet the non-financial cooperation requirements set forth in this section. Voluntary disenrollment includes, but is not limited to, instances in which a RIte Share participant:

(01) Requests that the employer drop coverage or cease enrollment for the entire family or a Medicaid eligible individual in the family;

(02) Fails to meet the requirements established by the employer to maintain enrollment in the approved plan -- e.g., submit required documentation or forms, etc.

(03) Engages in unlawful or fraudulent acts, such as submitting false claims that violate the terms for continuing enrollment in the ESI plan.

02. Involuntary disenrollment – Involuntary disenrollment includes the loss of access to ESI as a result of change in employment, termination of coverage by the employer for an entire class of workers, death, separation, divorce, or disability of the policy holder, or any other factors that could be reasonably construed as involuntary disenrollment as defined in this section.

03. RIte Share Unit responsibilities. Upon receiving a report from the employer, the ESI plan insurance provider, or Medicaid member indicating that disenrollment has occurred, the RIte Share Unit verifies the accuracy of the report and assesses whether it is voluntary or involuntary in nature.

(01) Voluntary disenrollment – Notice of Discontinuation. Once the report has been verified and it is determined to be voluntary disenrollment, EOHHS sends a Notice of Discontinuance noting termination of the Medicaid eligibility of the policy holder, parent(s) or caretaker relative in the applicant household until the individual demonstrates compliance with enrollment procedures established by EOHHS. The Notice of Discontinuance must also include any remedies for shortening the period of ineligibility as well as the right to request a hearing and appeal the decision:

- Medicaid-ineligible individuals are provided with a notice from the Medicaid agency stating they are disqualified for RIte Share.

- All Medicaid-eligible pregnant women and children must be automatically enrolled in a RIte Care plan.

- This period of Medicaid ineligibility may be shortened and Medicaid eligibility established if such individual becomes exempt from RIte Share enrollment or no longer has access to ESI for reasons such as a change in employment. (See sections 1312.21.02).

(02) Involuntary disenrollment. There is no adverse action taken against Medicaid members required to participate in RIte Share if disenrollment from an approved ESI plan is involuntary.

1312.22 Cooperation Requirements

All Medicaid applicants and members must cooperate with the non-financial requirements for eligibility as follows:

01. Information --All individuals and families are required to provide information about other health coverage (TPL) and/or access to ESI when applying for initial or continuing eligibility. The required information relating specifically to access to ESI includes, but is not limited to:

- The names of any family members in the household currently covered by, or with access to, ESI;
- The name of the policy holder and the employer offering the ESI; and
- Verification of monthly enrollment costs via a paycheck stub if the policy holder is currently enrolled or, if available, enrollment information provided by the employer indicating the policy holder's monthly premium for the appropriate family composition.

02. RIte Share participation -- Medicaid members required to enroll in the ESI must cooperate as follows:

(01) Enroll in the ESI in the manner, and within the timelines, established by EOHHS. Failure to do so will result in the termination of Medicaid for any eligible parents/caretaker age nineteen (19) and older in the family. The eligibility of any other Medicaid members in a family must not be terminated as the result of the refusal of an otherwise ineligible policy holder to enroll in the ESI. See section 1312.20.

(02) Submit verification of enrollment in accordance with section 1312.19 when the employer does not participate in RIte Share.

(03) Provide reports to the Medicaid agency indicating any changes in enrollment status of Medicaid eligible family members, enrollment costs, household composition, employment, income, residence, and access to ESI within ten (10) days from the date the change occurs.

(04) Pay Buy-in Amounts – Medicaid members subject to the buy-in requirements must cooperate in making monthly buy-in amounts in accordance with section 1312.07 to remain eligible for Medicaid. Failure to make a required premium payment, without

good cause, as specified in section 1312.23, results in disenrollment from the RIte Share Premium Assistance Program and loss of Medicaid eligibility.

1312.23 Good Cause

EOHHS is responsible for determining whether good cause exists for an exception to the non-financial cooperation requirements for Medicaid eligibility contained in section MCAR 1305 and, more specifically, for participation in RIte Share, except as noted below:

01. Extraordinary circumstances -- EOHHS must exempt a Medicaid member from RIte Share participation only when there are extraordinary circumstances which preclude the individual from receiving medically necessary care through the RIte Share-approved plan. For purposes of this exemption, "extraordinary circumstances" may include:

    (01) The existence of an unusual and life-threatening medical condition which requires medical treatment that cannot be provided or arranged by the RIte Share plan whether it is provided through the custodial or non-custodial parent;

    (02) The existence of a chronic, severe medical condition for which the Medicaid member has a long standing treatment relationship for that condition with a provider who does not participate in the RIte Share plan; or

    (03) Enrollment in the health plan of the non-custodial parent could result in reasonably anticipated physical and/or emotional harm to the child, custodial parent, or other relative with whom the child is living. Claims of physical and/or emotional harm must be determined by the Medicaid agency to be of a genuine and serious nature. The emotional harm to the custodial parent or other relative with whom the child lives must be of such a serious nature that the capacity to care for the child adequately would be reduced.

02. Corroborative evidence – Such evidence supporting a determination of good cause must be supplied to the Medicaid agency. Corroborative evidence may include: court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the non-custodial parent might inflict physical and or emotional harm on the child, custodial parent, or other relative with whom the child lives.

03. Other programs -- If good cause has been granted for any other benefit program administered by EOHHS or DHS, the good cause exemption will be honored by the RIte Share Program.

04. Nature of request -- Enrollment exemptions requested due to extraordinary circumstances must be in writing, with appropriate documentation (letter from physician, medical records, restraining orders, or others as indicated), and signed by the Medicaid member, parent/caretaker or person designated to make the request on their behalf.

05. Basis of the determination -- EOHHS makes RIte Share participation exemption determinations on a case by case basis after considering all required documentation and any other relevant information pertaining to the request. An exemption may be granted for any length of time during the period in which the extraordinary circumstances exist. When an exemption is granted, Medicaid members are enrolled in the appropriate a Medicaid managed care plan in accordance with MCAR section 1311.

06. Limits -- An individual's preference to continue a treatment relationship with a doctor or other health care provider who does not participate in the RIte Share plan does not in and of itself constitute an "extraordinary circumstance."

1312.24 Notice and Appeal Rights

Medicaid applicants and recipients shall receive timely notification of eligibility and enrollment determinations and the right to appeal. EOHHS shall also provide timely notification, including appeal rights, of any adverse decisions that reduce or terminate benefits. See MCAR section 0110 for full statement of these rights.

1312.25 Information
REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1312.26 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Section 1314:

Communities of Care

December 2013

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Rules and Regulations Section 1314:

Communities of Care

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1314 of the Medicaid Code of Administrative Rules entitled, "Communities of Care"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

1314 Communities of Care

1314.01 Overview

The goal of the Medicaid program is to ensure that all eligible individuals and families have access to high quality, cost effective care that promotes health, safety and independence. Toward this end, the Medicaid agency has established a special service delivery system within both RIte Care and Rhody Health Partners (RHP) managed care plans called the Communities of Care (CoC). The goal of the CoC is to improve access and promote member involvement in care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs.

Note: Members of Connect Care Choice, eligible under MCAR sections 0374 and 0375, are also subject to CoC enrollment.

1314.02 Scope and Purpose

Eligible members of the Medicaid Affordable Care Coverage Groups, as specified in section 1301 of the Medicaid Code of Administrative Rules (MCAR), and non-MAGI coverage groups enrolled in RIte Care (section 1309) and RHP (0374) must participate in the CoC if directed to do so by the Medicaid agency. The purpose of this rule is to identify the target populations for the CoC within these service delivery systems, describe the central components of the CoC, and to define the respective roles and responsibilities of Medicaid enrollees and the State, as represented by the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency.

1314.03 Definitions

"Communities of Care (CoC)" means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RIte Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

"Enrollee" means a Medicaid member or beneficiary who is enrolled in a Medicaid managed care plan.

"Health Services Utilization Profile" means the health plans will continuously identify Communities of Care enrollees through several mechanisms: (1) utilization analysis of the health plans claims system, (2) identification from hospital ED reports, (3) provider referrals, and (4) other appropriate methods selected by the Contractor.

"Individualized Incentive Plans" means CoC Members will be eligible to receive incentives and rewards to promote personal responsibility, accountability and good health care practices.

"Managed Care Organization (MCO)" means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"Medicaid Code of Administrative Rules (MCAR)" means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State's Administrative Procedures Act (R.I.G.L. §42-35).

"Medicaid member" means a person who has been determined to be an eligible Medicaid beneficiary.

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Peer Navigator" means paraprofessionals with specialized training who are community resource specialists employed and supervised by peer advocacy organizations.

"Restricted Provider Network" means a limited network of health providers, selected by the CoC member, that must provide all of the member's primary care, narcotic prescription care, pharmacy and behavioral health care while participating in the CoC.

1314.04 Target Population and Notice of Participation

The target population for the CoC is Medicaid members who utilize the ED four (4) or more times during the most recent twelve (12) month period. RIte Care and RHP members must be notified of the requirement to participate in CoC in writing. The notice must include an overview of the CoC, a statement of plan and member responsibilities, all applicable appeal rights and duration of services. The EOHHS reserves the right to make exceptions to CoC participation when clinically appropriate.

1314.05 Health Profiles

The Medicaid agency is responsible for developing a Health Service Utilization Profile. The EOHHS or its contracted MCO will create a health services utilization profile for each CoC member based on the services used and determine whether the member is eligible for the Restricted Provider Network or the Select Provider Referral as specified below.

Health plans will complete a utilization profile for every member identified for enrollment in Communities of Care. The profile will be completed for all Communities of Care enrollees within fifteen (15) days of identification for enrollment. The primary purpose of this profile is to review the member's complete utilization/claims history and determine if there is a care management component in place via the health plan or in association with the member's primary care medical home and whether the member is a candidate for the restricted provider network (Lock-In).

1314.06 Restricted Provider Network (RPN)

CoC members who have certain patterns of utilization are enrolled in a restricted provider network in which they must select and use a specific set of health care providers. CoC members are locked-in to this network – that is, cannot choose other providers – for the duration of their participation in the CoC.

01. Utilization Patterns – Any Medicaid enrollee demonstrating one or more of the following utilization patterns/practices within a consecutive 180-day period will be enrolled in the RPN of CoC:

- ED visits with three (3) or more different Emergency Departments in a consecutive 180-day period;
- Utilization of four (4) or more different primary care providers (PCPs)s in a consecutive 180-day period;
- Utilization of four (4) or more different behavioral health providers in a consecutive 180-day period;
- Prescriptions at six (6) or more different pharmacies in a consecutive 180-day period;
- Received controlled substances from four (4) or more different providers in a consecutive 180-day period;
- A medical billing history during past 180 days that suggests a possible pattern of inappropriate use of medical resources (e.g., conflicting health care services, drugs, or supplies suggesting a pattern of risk); and
- Other relevant patterns that emerge during the utilization profile.

02. Assignment to Restricted Provider Network -- CoC members identified to enroll in the RPN (lock-in) must select the following providers:

- One PCP
- One pharmacy
- One narcotic prescriber and/or psychiatric medication prescriber (as appropriate based on health utilization profile and case review)
- One or more mental health and/or substance abuse providers, as appropriate.

03. Lock-in – Once the RPN providers have been selected, CoC members must obtain their care from the selected providers.

04. Exemptions -- A member may be exempt from assignment to the RNP when deemed clinically appropriate by the Medicaid agency or the recommendation of the Medical Director of a Medicaid MCO subsequent to further review of the member's health service utilization profile.

05. Member Rights – CoC members must be notified by the Medicaid agency of their right to appeal assignment to the restricted provider network CoC option.

1314.07 Member Outreach and Engagement

The Medicaid agency, or its contracted MCO, must conduct outreach to eligible CoC members to identify the causes for utilization of the ED for non-emergent conditions, and to discuss strategies for reducing reliance on ED utilization in the future. This includes providing information on how to improve connections with care providers, to avoid acute episodes, to improve management of chronic conditions. During outreach, the Medicaid agency, or its contracted MCO, must review the CoC program and the member's rights and responsibilities. This includes explanation of the RPN and SPN and associated appeal rights.

1314.08 Care Management / Peer Navigator

CoC enrollees must be assigned a care manager to assist them in developing an individualized care plan. CoC members may be referred to a peer navigator as well. The role of the peer navigator is to assist the CoC member in reducing barriers to care, to access medical and non-medical resources, and to guide the CoC member throughout the care coordination and treatment process.

The peer navigator will assist the member in reducing barriers to care, accessing medical and community resources and assist the member throughout the care coordination and treatment process. This includes but is not limited to:

(1) assistance with making appointments for health care services;

(2) canceling scheduled appointments if necessary;

(3) assisting members with transportation needs;

(4) following up with members and providers to assure that appointments are kept;

(5) rescheduling missed appointments;

(6) linking members to alternatives to ED use for non-emergency care, when needed;

(7) assisting members to access both formal and informal community-based support services such as child care, housing, employment, and social services;

(8) assisting clients to deal with non-medical emergencies and crises;

(9) assisting clients in meeting care plan goals, objectives and activities;

(10) providing emotional support to members, when needed; and

(11) serving as a role model and guiding the member to practice responsible health behavior.

1314.09 Development and Implementation of Personal Rewards

Individualized incentive plans will be developed for each CoC member, based on the member's care plan, which reward specific behaviors and achievements consistent with CoC goals. The incentive plans are developed by the member's care manager and/or peer navigator, in conjunction with the member. Members shall be able to select their incentives and rewards, based on a prescribed menu of options, to assure they are meaningful. Examples of possible incentives or rewards include gift cards, digital thermometers or recognition events.

An individualized incentive plan, consistent with the member's care plan, will be developed for each enrollee. The incentive plan will reward achievement of care plan goals, objectives and/or activities. Members will be able to select their incentives and rewards, based on a prescribed menu of options to assure Member meaningfulness to the reward program.

1314.10 Completion of CoC Program Enrollment

Completion of participation in CoC will occur under the following circumstances:

- The CoC member's care plan objectives are achieved.
- Medicaid eligibility is discontinued for any reason.
- At the discretion of the Medicaid agency, after a minimum of 12-months enrolled in the program.

The Medicaid agency or the contracted MCO must provide appropriate notice to the CoC member in each of the circumstances.

1314.11 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Section 1315:

Rhode Island Affordable Health Care Coverage Assistance Program

December 2013

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Rules and Regulations Section 1315:

Rhode Island Affordable Health Care Coverage Assistance Program

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1315 of the Medicaid Code of Administrative Rules entitled, "Rhode Island Affordable Health Care Coverage Assistance Program"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

1315 Rhode Island Affordable Health Care Coverage Assistance Program

1315.01 Overview

RIGL §40-8.12-3 (as contained in Public Law 13-144) mandated the Executive Office of Health and Human Services (EOHHS) to establish a fund to ensure insurance coverage through HealthSource RI is affordable for parents and caretakers of Medicaid-eligible children in households with incomes below 175% of the federal poverty level (FPL). The fund is available to assist parents/caretakers who are not otherwise eligible for Medicaid through the newly established RI Affordable Health Care Coverage Assistance Program (AHCCA).

1315.02 Scope and Purpose

Effective January 1, 2014, parents/caretakers of Medicaid-eligible children in households with incomes below 175% FPL who are not Medicaid eligible themselves can apply for financial assistance paying for health insurance coverage accessed through HealthSource RI. The purpose of this rule is to set forth the provisions governing this financial assistance. The rule describes the scope of the Affordable Health Care Coverage Assistance (AHCCA) program, the basis for determining eligibility, and the respective responsibilities of the State and the individuals seeking assistance through the program.

1315.03 Definitions

For the purposes of this rule, the following definitions apply:

"Affordable Care Act (ACA)" means the federal Patient Protection and Affordable Care Act of 2010. The law is also sometimes referred to as "Obamacare" and federal health reform.

"APTC/CSR eligibility" APTC/CRS eligibility means the application of the IRS-based measure of income known as "Modified Adjusted Gross Income" for determining eligibility for affordable health care through health insurance exchanges/marketplaces established under the ACA. Also, APTC means advanced premium tax credits and CSR means cost sharing reductions.

"HealthSourceRI" means the state-based health insurance marketplace (also referred to as a "benefit exchange") established in conjunction with implementation of the federal Affordable Care Act of 2010.

"Parent or Caretaker or Caretaker relative" means any adult over age nineteen (19) living with a Medicaid-eligible dependent child that has assumed primary responsibility for that child as defined in MCAR section 1305.13.

"Qualified Health Plan" means a health plan certified by HealthSourceRI that provides essential benefits and meets all other related ACA requirements to be offered through the State's health benefits exchange.

"Silver Plan" means a qualified health plan offered through HealthSourceRI that covers about 70% of an enrollee's medical costs. There are federal subsidies for certain Silver plan enrollees to help cover co-payments and other out-of-pocket expenses.

1315.04 Eligibility Requirements

Parents/caretaker relatives must meet certain requirements related to income, health coverage, and relationship to be eligible to participate in the Affordable Health Care Coverage Assistance program. Coverage through HealthSourceRI is also a condition of eligibility.

01. Eligibility -- The requirements are as follows:

    (01) Income. Household income at or under 175% of the FPL.

    (02) Health Coverage. Parents/Caretakers must not be otherwise eligible for Medicaid.

    (03) Relationship. Parents/Caretakers need to have primary responsibility for a Medicaid-eligible child.

02. Plan enrollment – AHCCA financial assistance will be available only if the applicant has enrolled in a Silver Plan through HealthSoureRI.

1315.05 Application Process

Parents/caretakers must make application for the AHCCA through the EOHHS.

01. Applicant's Responsibilities – To obtain assistance, applicants must submit a request to EOHHS. Application forms will be available at the HealthSourceRI Contact Center located at: 70 Royal Little Drive Providence, RI 02904 or at www.eohhs.ri.gov or www.healthsourceri.com. Applicants must also provide demographic information and information regarding enrollment in a Qualified Health Plan through HealthSource RI.

02. State's Responsibilities -- The Medicaid agency must review and determine eligibility for financial assistance within sixty (60) days. If additional information is needed by the Medicaid agency, a new review period will begin once the additional information has been received.

1315.06 Eligibility Approval – Premium Amount

If a parent/caretaker is approved, the Medicaid agency calculates the amount of AHCCA financial assistance in accordance with the following chart:

Rhode Island Affordable Health Care Coverage Assistance Program Assistance after January 2014

Total Family Size	138% FPL to 150% FPL	151% FPL to 175% FPL
2	$39	$28
3	$49	$43
4	$59	$58
5	$69	$73
6	$79	$88

1315.07 Notice

The EOHHS must send a notice to the parent/caregiver relative with an eligibility determination for AHCCA. If eligibility exists, the notification must include the amount of the subsidy. Notice of denial must state the reasons for the disapproval of the application. All notices must include a statement of the rights of the parent/caregiver applicant.

1315.08 Payment of Subsidies

The payment options for the AHCCA subsidy include the following:

- Option 1 -- The parent/caretaker pays the premium due to the insurer. EOHHS or its agent either mails a check or electronically transfers payment to the bank or account of parent/caretaker relative on a monthly basis.

- Option 2 – The AHCCA payment is made to the insurer and is deducted from the amount the parent/caretaker is required to pay to the insurer.

1315.09 Duration and Continuing Eligibility

01. Period of eligibility -- Eligibility for the AHCCA subsidy is for a twelve (12) month period. The subsidy may be curtailed sooner if there is a change in any eligibility factor that affects household or enrollment in the Qualified Health Plan selected by the parent/caretaker. Continuation of the subsidy must be reconsidered if such a change occurs, if eligibility under section 1315.04 still applies, AHCCA financial assistance continues.

02. Notice – The EOHHS must provide notice to the eligible parent/caretaker sixty (60) days prior to termination. The notice must include guidance on how to apply for continued financial assistance as well as the right to appeal EOHHS actions as indicated in 1315.10.

1315.10 Termination or Denial of Participation

Eligibility for the AHCCA must be denied or terminated, as appropriate, upon determining that an applicant has provided false information on an application for assistance or has not provided timely notification of changes that would affect the eligibility factors set forth in section 1315.04.

1315.11 Hearing and the Right to Appeal

The EOHHS must provide applicants and recipients of AHCCA subsidies with notice of the right to appeal and request a hearing with regard to the following agency actions:

- A determination that an applicant disapproved for AHCCA participation and the basis for the decision of ineligibility;
- The amount of assistance determined;
- Termination of eligibility to participate in the AHCCA.

1315.12 For Further Information or to Obtain Assistance

See the following websites:

- www.eohhs.ri.gov
- www.HealthSourceRI.com

For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1315.13. Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1318:

Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals

January 2014 (E)
May 2014

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1318:

Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1318 of the Medicaid Code of Administrative Rules entitled, "Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals**" are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-152); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR 435 §§ 1102 and 1103.

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid presumptive eligibility determinations made by Rhode Island hospitals as contained in MCAR section 1305.15, "Access to Medicaid Coverage Under the Affordable Care Act: Eligibility for Medicaid Affordable Care Coverage Groups" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State on December 11, 2013.

1318 Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals

1318.01 Overview and Statutory Authority

The goal of the federal Affordable Care Act (ACA) of 2010 is to improve access to high quality health insurance coverage for people of all ages and income levels. In keeping with this purpose, the ACA established a presumptive eligibility program for certain individuals and families in the newly reconfigured Medicaid Affordable Care Coverage (MACC) groups. The MACC groups in Rhode Island are described in the Rhode Island Medicaid Code of Administrative Rules (MCAR), Section 1301.

Federal regulations governing the program at 42 Code of Federal Regulations (CFR) §435.1110 authorize the states to provide Medicaid for a limited period of time to individuals who are determined by a "qualified hospital", on the basis of preliminary information, to be presumptively eligible for Medicaid. This initial determination is made by the hospital on the basis of the characteristics for MACC group eligibility. The states have the discretion under these provisions to tailor presumptive eligibility requirements program within certain parameters to meet their own unique needs.

1318.02 Scope and Purpose of Hospital Presumptive Eligibility Program for Medicaid

The State of Rhode Island had determined that presumptive eligibility will be available to individuals in the MACC groups who qualify for Medicaid-funded affordable coverage. For all other individuals with MACC-like characteristics, presumptive eligibility must be determined by a qualified hospital, licensed in Rhode Island, and is only available in certain circumstances contingent upon preliminary information supplied by the individual. Further, presumptive eligibility is only available on a temporary basis – until the last day of the month following the initial determination of presumptive eligibility or the date full eligibility is determined, whichever comes first.

(01) Exclusions: Individuals in the MACC groups who are eligible for affordable coverage funded through the Children's Health Insurance Program (CHIP) under Title XXI of the U.S. Social Security Act are excluded from presumptive eligibility. CHIP-funded beneficiaries excluded from HPE are as follows:

- All lawfully present non-citizen children while subject to the federal five (5) year ban;
- Children up to age 19 with income from 133% to 261% of the FPL;
- All non-qualified non-citizen pregnant women with income up to 253% of the FPL; and
- Pregnant women with income from 185% to 253% of the FPL.

01. **Implementation** – Effective January 27, 2014, the State will be making presumptive eligibility available to individuals who have been determined by a qualified hospital to meet the characteristics of one of the MACC groups identified in MCAR section 1301 (and as below)

eligible for Medicaid-funded affordable coverage under Title XIX, with the exception of the exclusions noted above.

02. **Governing Provisions** – The purpose of these rules is to set forth the provisions governing hospital presumptive eligibility determinations including, but are not limited to the:

- Qualifications of applicants for Medicaid presumptive eligibility;
- Criteria that a qualified hospital must use when making a determination of presumptive eligibility;
- Application timelines and procedures for individuals who qualify for Medicaid coverage during the presumptive eligibility period.

1318.03 Definitions

"Children's Health Insurance Program (CHIP)" means the program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

"Executive Office of Health and Human Services (EOHHS)" means the designated "single state agency", authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*), to be legally responsible for the programmatic oversight, fiscal management, and administration of the Medicaid program.

"Hospital Presumptive Eligibility (HPE)" means Medicaid eligibility granted on a temporary basis to a person who meets certain criteria during a defined period.

"Medicaid Affordable Care Coverage (MACC) Groups" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"Medicaid Code of Administrative Rules (MCAR)" means the compilation of rules governing the Rhode Island Medicaid Program, promulgated in accordance with the State's Administrative Procedures Act (RIGL §42-35).

"Qualified Hospital" means any licensed Rhode Island hospital participating in the Medicaid program that executes a Notice of Intent to Participate in the HPE Program and a Memorandum of Understanding with EOHHS to conduct presumptive eligibility determinations, participates in training and certification sponsored by EOHHS, and remains in good standing with EOHHS protocols.

"Self-Attestation" means the act of a person affirming through an electronic or written signature that the statements the person made when applying for Medicaid eligibility are truthful and correct.

1375.04 Populations Eligible for HPE

01. Qualified hospitals participating in the HPE Program may complete presumptive eligibility assessments for individuals who have the characteristics of members of the MACC groups funded through Title XIX. HPE excludes individuals eligible for coverage funded through CHIP and any individuals eligible for Medicaid on the basis of age, blindness or disability and/or in need of Medicaid-funded long-term services and supports.

02. Qualified hospitals are authorized to make presumptive eligibility determinations for individuals who demonstrate potential Medicaid eligibility in one of the following MACC groups, but only as specified:

    a) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children with income up to 133% of the FPL under the age of 18, or 19 if enrolled in school full-time.

    b) Pregnant women with income up to 185% who are United States citizens or qualified non-citizens. Members of this coverage group can be of any age. Pregnant women are limited to one (1) HPE determination per pregnancy.

    c) Children and Young Adults up to the age of 19 with income up to 133% of the FPL (CHIP exclusions apply).

    d) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group.

1318.05 Scope of Coverage

01. **Eligibility Period.** The hospital presumptive eligibility period begins, and includes, the date the hospital makes the HPE determination. The hospital presumptive eligibility period ends on the date that the Medicaid agency renders a determination for full Medicaid eligibility; or the last day of the month following the month in which the hospital made the HPE determination, whichever comes first.

02. **Covered Services.** Individuals determined eligible for HPE, receive the same scope of State Plan and Section 1115 waiver services as members of a MACC group, except as follows:

- All HPE beneficiaries -- No transportation services.

- Pregnant women -- Maternity services are limited to prenatal ambulatory care only. (Birthing expenses are not covered.)

03. **Service Delivery.** Individuals determined to be presumptively eligible for Medicaid are enrolled in a fee-for-service plan. When full Medicaid eligibility is determined, participants will be enrolled at EOHHS' discretion in a managed care organization (MCO), as indicated in MCAR Section 1311.

1318.06 Requirements for Hospitals

A hospital must meet certain requirements to be deemed qualified to participate in the HPE.

01. **Participation.** A qualified hospital must be licensed in RI and a participating Medicaid provider under the Rhode Island Medicaid State Plan or Section 1115 waiver. The hospital must notify EOHHS of its election to make presumptive eligibility determinations, and agree to HPE determinations in compliance with State policies/procedures and these rules.

02. **Application Process:** The qualified hospital must:

(a) Assist individuals in completing and submitting the full application for health insurance affordability programs in Rhode Island. This assistance includes assuring that the individual understands any documentation requirements.

(b) NOT require individuals assessed for HPE to verify information related to any HPE eligibility criteria/characteristic, including pregnancy.

(c) Accept self-attestation of income, citizenship, and residency, as applicable, when determining eligibility.

(d) Provide individuals with written notice after the HPE determination is made that includes, but is not limited to:

- HPE determination (i.e., approved or denied);
- If approved, the beginning and ending dates;
- If denied, the reason(s) for the denial, options for submitting a regular Medicaid application and information on how to make application.

e) The qualified hospital must utilize EOHHS-approved materials and methods in determining HPE and completing full Medicaid applications, including the EOHHS and HSRI websites and the State's single streamlined application.

03. **Confidentiality.** The qualified hospital must comply with all applicable State and federal laws and regulations regarding patient privacy and the confidentiality of health care communications and information.

04. **Records Retention.** In accordance with the provisions of the state agency's record retention policy, the qualified hospital shall maintain organized records of all HPE applications for ten (10) years from the date the last Medicaid billing was submitted to EOHHS.

05. **Medicaid Agency Notification**. The qualified hospital shall notify the state agency of HPE approvals, and the applicable date ranges, within five (5) business days.

06. **Hospital Staff.** The qualified hospital must only use employees of the hospital to assist with HPE applications. The hospital is prohibited from subcontracting HPE work to a non-hospital based company or independent contractor. In addition:

(a) Each qualified hospital shall have a minimum of one (1) staff member trained and certified to perform HPE duties on each shift.

(b) The hospital must affirm that all HPE personnel meet the minimum qualifications specified herein and comply with EOHHS policies and procedures for participation in the Medicaid hospital presumptive eligibility program and participate in all trainings, knowledge-based tests, and keep up-to-date on notifications with regard to HPE. The hospital must assign one accountable individual to be the liaison with the State Medicaid Agency and its designees.

(c) The qualified hospital HPE staff must assist Medicaid applicants with the completion and submission of a Medicaid application. Additionally, qualified hospital staff must provide the information specified in this subsection pertaining to the HPE decision, eligibility period, and requirement to complete a full application.

(d) HPE staff must complete the requisite EOHHS training and maintain knowledge of any program changes. HPE staff training must include: in-person training; computer-based training; and proficiency testing and certification. Training and testing shall be completed at specific intervals as directed by EOHHS, but no less than annually.

- Assignment of Qualified Hospital Staff Online Application Credentials. Prior to assignment of online HPE administrator credentials, qualified hospital staff must complete EOHHS-approved training and provide documentation of completion of training in the format required. Proof of training also must be made available upon request by applicants.

- Proficiency standards. Hospital HPE staff must achieve the minimum certification testing score set forth in contractual standards established with EOHHS.

1318.07 Reporting

The qualified hospital must submit monthly reports in a standardized format as defined by EOHHS. These reports must be submitted electronically by the fifth business day of the month following HPE determinations. The reports must reflect accurate measurement of the performance requirements described in section 1318.08 below. In addition, the qualified hospital must prepare and submit any ad-hoc reports to EOHHS upon request.

1318.08 Performance Requirements

The EOHHS requires that a qualified hospital meet certain performance standard to continue participation in the HPE. First, the qualified hospital must submit full Medicaid applications for ninety-five percent (95%) of the individuals granted HPE within five (5) calendar days from the date of the initial determination of presumptive eligibility. Second the percentage of these Medicaid applications that must be deemed fully complete by the EOHHS -- that is, contain no errors or otherwise require the State's intervention in processing -- is set forth in contractual standards between

the hospital and the EOHHS. Last, the number of individuals qualifying for HPE who must be determined to be eligible for full Medicaid, as determined by the EOHHS, is also set forth in the Notice of Intent to Participate in the HPE Program and a Memorandum of Understanding with EOHHS for the qualified hospital established by EOHHS. In the event a qualified hospital does not meet acceptable performance standards, participation in the HPE may be suspended or terminated at the discretion of the EOHHS.

1318.09 Office of Program Integrity Agency Authority

The EOHHS may undertake an array of actions to assess whether qualified hospitals are meeting the performance standards for the program. The EOHHS Office of Program Integrity (OPI) has been assigned responsibility for performing routine audits and intensive reviews of the HPE program, as appropriate. The OPI is also responsible for overseeing the development and submission of any hospital Corrective Action Plans deemed warranted. The OPI initial audits will commence within the first six (6) months of the program's start-up date and then be performed annually thereafter or as needed.

1318.10 Corrective Action

In the event a qualified hospital does not achieve proficiency on the performance requirements outlined in subsection 1318.08, the EOHHS may require the development of Corrective Action Plan (CAP) indicating interventions the hospital proposed to take to achieve compliance with these and/or other contractual standards. The OPI is responsible for reviewing and monitoring compliance with the CAP. HPE determinations may be suspended while the CAP is being prepared or implemented, as appropriate.
EOHHS reserves the right to request modifications to the CAP if the CAP is deemed ineffective to achieve compliance;

- The qualified hospital must submit weekly CAP reports to EOHHS measuring the outcome of the corrective actions the hospital has instituted;

- HPE suspensions remain in full force and effect until such time as the hospital demonstrates to EOHHS that it has instituted corrective measures to bring the hospital into full compliance with State and federal requirements.

1318.11 For Further Information or to Obtain Assistance

For further information or to obtain assistance, please contact:

Deborah Florio, Administrator
Executive Office of Health and Human Services
Deb.Florio@ohhs.ri.gov

1318.12 Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Section 1360:

Transportation Services

December 2013
April 2016

Rhode Island Executive Office of Health and Human Services

Rules and Regulations Section 1360

Transportation Services

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Introduction

These rules related to Transportation Services**, Section 1360 of the Medicaid Code of Administrative Rules,** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), as amended, and Title XIX of the Social Security Act.

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

Unless otherwise noted, the provisions contained herein pertain to transportation services for Medicaid beneficiaries, clients of the Non-Medicaid Elderly Transportation Program, and Temporary Assistance to Needy Families (TANF) recipients.

These regulations shall supersede all previous regulations related to transportation services promulgated by EOHHS and filed with the Rhode Island Secretary of State.

1360 Transportation Services for Medicaid Beneficiaries

REV: April 2016

The Executive Office of Health and Humans Services recognizes that Medicaid beneficiaries need available and appropriate transportation in order to access medical care, and assure the provision of such transportation when required to obtain medically necessary services covered by the Medicaid program. Transportation can be provided by any of the following modes, as appropriate to the needs of the individual. Public transit (bus) is the preferred mode of non-emergency medical transportation (NEMT) when both the beneficiary and the provider are within one-half (½) mile of an established bus route.

- Public transit (bus)
- Private Car
- Public Motor Vehicles
- Multi-Passenger Van
- Ambulance
- Wheelchair Van.

1360.01 Covered Services

REV: April 2016

Covered Services - The Medicaid Program covers emergency and non-emergency medical transportation (NEMT). Ground transportation is covered and provided for when the individual has Medicaid and is receiving a Medicaid-covered service from a Medicaid- participating provider.

A) Non-Emergency Medical Transportation (NEMT)

Non-emergency medical transportation (NEMT) is covered when the recipient has no other means of transportation, no other community resource exists (i.e., family, friends) and transportation by any other means would endanger the individual's health or safety. NEMT may be provided by ambulance if this mode is medically necessary. Physician/clinician documentation or attestation will be required.

To be eligible for NEMT services, Medicaid participants must be unable to find alternative transportation and require transportation services for medical/health visits that are part of a total patient plan of care supervised and ordered by a health care professional.

- If medically justified and communicated during the reservation to the State's transportation broker, an additional person can be permitted to accompany a beneficiary.
- More than one beneficiary may be transported by the same vehicle on the same trip, provided there are adequate seating and safety restraints for all passengers and at no time the health and safety of any of the other passengers are compromised.
- Passengers must not have their trip lengthened by more than 30 minutes due to increasing the number of passengers in the same vehicle.

- Transportation to communities that closely border Rhode Island may be provided for Medicaid-covered services and as pre-authorized by the transportation broker subject to review and approval of the State, as needed. See Addendum "1" or a list of border communities.

B) Emergency Transportation

"Emergency Transportation" means transportation to a medical treatment when required to obtain emergency health care services for unforeseen circumstances which demand immediate attention at a hospital to prevent serious impairment or loss of life. Medically necessary emergency transportation is provided by ambulance.

When medical services are obtained at a hospital participating in the Medicaid program, it is the responsibility of the hospital or emergency department staff to provide and pay for appropriate transportation home if needed.

For Medicaid Managed Care beneficiaries, emergency transportation is provided by the Managed Care Organization. Billing for this service is through the Managed Care Organization.

For Medicaid Fee-For-Service beneficiaries, emergency transportation is provided by the Medicaid Fee-For-Service program. Billing for this service is through the Medicaid Fee-For-Service program.

C) Out-of-State Non-Emergency Medical Transportation

With the exception of transportation to communities that closely border Rhode Island, NEMT for out-of-state trips will only be considered for payment when the service is medically necessary and the Medicaid-covered service is either not available in Rhode Island or there are other extenuating medical circumstances.

All out-of-state NEMT, with the exception of NEMT to border communities, requires prior authorization from the State's transportation broker.

D) Nursing Facility Residents

An individual residing in a Nursing Facility whose condition precludes transportation by the facility vehicle to and from a physician's office, medical laboratory, hospitals, etc., may be transported for non-emergency medical services when:

- Patient cannot be transported by any other means through the facility;
- Required medical service cannot be provided within the facility (i.e., portable x-ray services provided in a facility setting);
- Facility has exhausted all other alternative means (including transportation by family or friends) whenever possible.

Emergency medical transportation services can only be provided when a patient is severely ill or injured and transportation by any other means would endanger the individual's health or safety.

1360.02 Transportation Requests
REV: April 2016

All NEMT requests must be scheduled through the State's transportation broker. Some requests may require a physician or clinician's attestation and/or documentation. Information on how to contact the State's transportation broker is available at: www.eohhs.ri.gov.

A) ***Door-to-Door***

"Door-to-door transportation" is defined as transportation of the client from the outside door of his/her residence to the outside door of his/her destination, including the return trip. "Door-to-door" is further defined herein to mean the transport of the client from the ground level door of his/her residence to the ground level door of his/her destination, including the return trip. The dwelling should be accessible by means of an ADA-approved (Americans with Disabilities Act) ramp or client-provided assistance.

When necessary, service shall include passenger assistance from the client's door to the vehicle and from the vehicle to the door of the destination and include the return trip. Each client case must be assessed on an individual basis as to need. Beneficiaries must request this service at the time of reservation to the State's transportation broker. Transportation providers are not permitted to enter the client's residence or the provider's office. Beneficiaries who will require additional assistance in leaving their destination or upon arrival at their medical appointment may bring an escort with them. Beneficiaries must inform the transportation broker when they reserve transportation that an escort will accompany them.

B) ***Passenger Cancellations***

Passengers must make every effort to keep their scheduled trip appointments. If unable to keep an appointment, notification must be provided to the State's transportation broker at least twenty-four (24) hours prior to the scheduled trip.

C) ***Passenger No-Shows***

Passengers who frequently (more than three (3) instances per month) do not cancel their regularly scheduled trip appointment at least twenty-four (24) hours in advance may be required to schedule each trip separately at least two (2) days in advance (i.e., will no longer be eligible for "standing order" pick-ups). Clients who frequently (more than three (3) instances per month) do not cancel other scheduled trips (e.g., scheduled physician visits) at least twenty-four (24) hours in advance may also be required to confirm scheduled trips the morning of or twenty-four (24) hours in advance.

D) ***Physician's/Clinician's Attestation and/or Documentation***

All NEMT transportation requests that require an attestation and/or documentation statement by the recommending physician/clinician must include the specific reason/rationale why NEMT is required based upon a client's functional ability and not only upon diagnosis.

1360.03 Transportation Provider Participation Guidelines
REV: April 2016

Ambulance providers:

- Must have a license issued through the Rhode Island Department of Health (DOH);
- License is renewed annually;

Taxi and Public Motor Vehicles:

- Must have a license issued through the Rhode Island Division of Public Utilities and Carriers (PUC) validating proof of authority to engage granted by the PUC RIGL Title 39 chapter 14 Taxi Cab Statute and Title 39 chapter 14.1 Public Motor Vehicles.
- Providers are required to maintain and ensure drivers have a valid Hackney License (Blue Card).
- A license is renewed annually through the Division of Public Utilities and Carriers.

PUC License Types:
A) Taxi – Public Certificate for Convenience and Necessity

B) Public Motor Vehicles – Certificate of Operating Authority

NEMT

To participate in the NEMT Program, a transportation provider must enter into a signed agreement with the State's transportation broker. Providers must be in compliance with all applicable state and federal statutes and regulations. All providers will be recruited and retained by the State's transportation broker. All required provider documents must be submitted to the State's transportation broker. All providers must meet the requirements set forth by the State's transportation broker.

1360.04 Recertification Process
REV: April 2016

Ambulance providers shall be recertified annually by the Rhode Island Department of Health.

Taxi Public Motor Vehicle Carriers and Providers shall be required to forward a copy of their license or recertification to the State's transportation broker within thirty (30) days of renewal to also avoid interruption of program enrollment.

1360.05 Claims Billing Guidelines
REV: April 2016

The State's transportation broker is responsible for claims and billing for NEMT.

Providers will bill the health plans for emergency transportation provided to Medicaid managed care beneficiaries. Providers will bill the Medicaid Fee-for-Service Program for emergency transportation provided to Medicaid beneficiaries enrolled in the State's Fee-for-Service delivery system.

2) Medicare/Medicaid Crossover Claims

A. **Emergency Transportation**

Medicare is the primary payer for emergency transportation. The Medicaid FFS Program will not make any additional payment on claims where the Medicare payment is equal to or more than the Medicaid allowable amount.

Payment of cross-over claims for Medicaid managed care recipients is handled and directed by the managed care plans.

B. **Non-Emergency Transportation**

Certain forms of non-emergency transportation may be covered by Medicare. This may include basic life support and advanced life support (both of which are provided by ambulance) as well as transportation provided to/from hospitals and dialysis centers. The transportation broker may be responsible for payment of Medicaid-covered NEMT services that were denied by Medicare, subject to prior approval and verification by the broker.

3) Patient Liability

The NEMT payment is considered payment in full. The transportation provider is not permitted to seek further payment from the beneficiary in excess of any payment received from the State's transportation broker.

Transportation providers are not permitted to seek further payment from the participant in excess of any payment received for emergency transportation from either the health plan or the Medicaid FFS Program.

1360.06. Non-Medicaid Elderly Transportation Program
REV: April 2016

The Non-Medicaid Elderly Transportation Program is for individuals age 60 years and older who are not Medicaid eligible and who are not getting transportation from the RIPTA Ride Program or from

the Americans with Disabilities Act (ADA) Program. The Elderly Transportation Program provides transportation to and from medical appointments, adult day care, meal sites, dialysis/cancer treatment and the "Insight Program." The program requires a two dollar ($2.00) co-payment for each trip segment. The $2 co-payment is collected and retained by the transportation driver. Medicaid and "Costs Not Otherwise Matchable" ("CNOM")-eligible co-pay individuals are exempt from this co-pay for transportation in Priorities #1 - #4 in section 1360.07 (below).

The Non-Medicaid Elderly Transportation Program provides safe, quality transportation services to qualified elderly individuals. Emphasis is placed on priority categories of transportation services in relation to existing state funding, vehicle and passenger safety and sensitivity to the needs and concerns of elderly clients. Transportation funds available for this program are specifically allocated for services to be provided for Rhode Island residents sixty (60) years of age and older.

Eligible participants must be legal residents of the State of Rhode Island. As a condition of eligibility for transportation services, participants must provide the information noted below to the transportation broker. This may include, but is not limited to:

1. Date of birth;
2. Proof of residency (e.g., valid Rhode Island driver's license and/or Rhode Island state identification card issued by the Rhode Island Division of Motor Vehicles; voter identification card; current utility bill for a residence within Rhode Island in the name of the individual requesting transportation services);
3. Social Security number;
4. Medical documentation as requested by the State's transportation broker.

1360.07 Non-Medicaid Elderly Transportation Program – Specific Services
REV: April 2016

The following transportation services may be provided to Rhode Island elders by the State's transportation broker based on the following prioritization. Service provision is contingent upon available state funding.

Special Medical Care (Priority 1)
Special medical transportation includes transportation for the purpose of kidney dialysis or cancer treatments. Names of clients to be transported are to be provided to the State's transportation broker by the medical treatment facility, family, friends, or the client themselves. The State reserves the right to limit special medical transportation based on funding constraints or other programmatic requirements.

Adult Day Care (Priority 2)
This category includes transport to and from Adult Day Care Centers that are licensed by the Department of Health (DOH). Residences of clients shall be verified by the Adult Day Care Center

and provided to the State's transportation broker. The State reserves the right to limit transportation to Adult Day Care centers based on funding constraints or other programmatic requirements.

General Medical Care (Priority 3)

This category includes transportation for any medical/health services that are part of a total patient plan of care supervised by a health care professional. Trips eligible under this service category include visits to physicians' offices and dental offices as well as all trips for tests and/or treatments ordered by a health care professional as part of a treatment plan. The State reserves the right to limit General Medical transportation based on funding constraints or other programmatic requirements.

INSIGHT (Priority 4)

This category includes transport to and from INSIGHT, at their INSIGHT service location(s). Riders must be sixty-five (65) years of age or over, have a sight impaired condition and/or presently registered with the INSIGHT agency.

Transportation shall be at the discretion of the State and available during the same days and hours as General Medical trips. Trip requests must be forwarded to the State's transportation broker at least forty-eight (48) hours in advance. The State reserves the right to limit transportation to INSIGHT based on funding constraints or other programmatic requirements.

Senior Nutrition Transportation (Priority 5)

This category includes transport to and from congregate meal sites for the elderly. The Senior Nutrition Project shall be responsible for securing names and addresses of individuals to be transported. This information shall be forwarded to the State's transportation broker for scheduling. The Nutrition Site shall verify residence of all individuals in the geographic area. The State reserves the right to limit transportation to specific meal sites based on funding constraints or other programmatic requirements.

1360.08 Non-Medicaid Elderly Transportation Program Service Provision Guidelines

REV: April 2016

Limitation on Transportation

The State reserves the right to limit or restrict the availability of transportation due to funding constraints, service availability, weather, etc. (This provision applies to clients of the Non-Medicaid Elderly Transportation Program only).

Door-to-Door

"Door-to-door transportation" is defined as transportation of the client from the outside door of his/her residence to the outside door of his/her destination, including the return trip. "Door-to-door" is further defined herein to mean the transport of the client from the ground level door of his/her residence to the ground level door of his/her destination, including the return trip. The dwelling should be accessible by means of an ADA-approved (Americans with Disabilities Act) ramp or client-provided assistance.

When necessary, service shall include passenger assistance from the client's exterior door to the vehicle and from the vehicle to the exterior door of the destination and include the return trip. Each case must be assessed on an individual basis as to need. Participants must request this service at the time of reservation to the State's transportation broker. Transportation providers are not permitted to enter the client's residence or the provider's office. Participants who will require additional assistance in leaving their destination or upon arrival at their medical appointment may bring an escort with them. Participants must inform the transportation broker when they reserve transportation that an escort will accompany them.

Transport to Nearest Sites

Transportation to meal sites, kidney dialysis, and cancer treatments shall be to the facility closest to the client's home, whenever possible. If not possible, the participant shall receive approval from his/her physician or primary care provider to receive such services at another site based on medical necessity.

Transportation to adult day care facilities shall be to the facility closest to the client's home unless transportation to another center is more appropriate. This is also subject to the availability of transportation services to that center. General medical trips shall be to the nearest health care professional whenever possible unless the participant has received approval from his/her physician or primary care provider to receive such services at another site based on medical necessity.

Days and Hours of Service

Service days shall typically include Monday-Friday. Trips may also be scheduled on weekends and holidays when medically necessary. Trips for Senior Nutrition Transportation (Priority 5) must occur between 10:00 a.m. – 2:00 p.m.

Passenger Cancellations

Passengers must make every effort to keep their scheduled trip appointments. If unable to keep an appointment, notification must be provided to the State's transportation broker at least twenty-four (24) hours prior to the scheduled trip.

Passenger No-Shows

Passengers who frequently (more than three (3) instances per month) do not cancel their regularly scheduled trip appointments at least twenty-four (24) hours in advance may be required to schedule each trip separately at least two (2) days in advance (i.e., will no longer be eligible for "standing order" pick-ups). Passengers who frequently (more than three (3) instances per month) do not cancel other scheduled trips (e.g., separate physician visits) at least twenty-four (24) hours in advance will also be required to confirm scheduled trips the morning of or twenty-four (24) hours in advance.

After a sixty (60) day period, passengers may request reinstatement of eligibility for standing order and scheduled ride pick-ups without being required to confirm such trips in advance. Requests will be subject to EOHHS approval.

Passengers with a frequent pattern of no-shows will receive written notice from the State's transportation broker that they will be subject to a change in their transportation benefit. (See section 1360.10 herein, "Complaint Process for Medicaid Beneficiaries and Persons Using the Non-Medicaid Elderly Transportation Program and TANF recipients").

1360.09. Transportation for Recipients of Temporary Assistance to Needy Families (TANF)
EFF: April 2016

Recipients of the State's Temporary Assistance to Needy Families (TANF) Program are eligible to receive a monthly bus pass. To obtain a monthly bus pass, TANF recipients must call the State's transportation broker to request a pass.

Bus passes will be mailed to the recipient following the request.

1360.10 Complaint Process for Medicaid Beneficiaries and Persons Using the Non-Medicaid Elderly Transportation Program and TANF Recipients
REV: April 2016

Individuals may file a complaint as follows:

- Passengers or their family members may submit a formal written or verbal complaint to the State's transportation broker at: 1-855-330-9131 or 1-866-288-3133 (for hearing impaired).
- The State's transportation broker will attempt to resolve the complaint with the individual or his/her family.
- In the event transportation benefits are terminated or substantially altered, after due notice, and the complainant wishes to pursue his/her concerns further, the written complaint shall be forwarded to the State for a fair hearing. State fair hearings shall be conducted in accordance with the provisions of the Medicaid Code of Administrative Rules, Section #0110 "Complaints and Hearings" promulgated by EOHHS and available on the Secretary of State's website: www.sos.ri.gov/rules.
- In the event transportation benefits are terminated or substantially altered due to a lack of Program funding, formal appeal rights to a Medicaid fair hearing shall not be available.
- Individuals who fail to show up at their scheduled pick up time will receive written notice from the transportation broker that they will be subject to a change in their transportation benefit if they fail to show up for four (4) or more rides. Individuals will receive a warning letter for each of three (3) failures to show up, followed by a fourth letter notifying them they are being moved to mass transit or gas mileage payment because they failed to show up for a scheduled ride four (4) or more times. Individuals will receive written notice on how to appeal this determination in accordance with the provisions of this section.

1360.11 Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

April 21, 2016
1360transfinalfinalapril2016

Addendum 1
Border Communities

Border Communities include cities and town that border Rhode Island and are considered for the purpose of the Rhode Island Medical Assistance Program, in-state providers. Out-of-state service restrictions and prior authorization requirements are not imposed on providers in the following communities:

Connecticut	***Massachusetts***
Danielson	Attleboro
Groton	Bellingham
Moosup	Blackstone
Mystic	Dartmouth
New London	Fall River
North Stonington	Foxboro
Pawcatcuk	Milford
Putnam	New Bedford
Stonington	North Attleboro
Thompson	North Dartmouth
Waterford	Rehoboth
	Seekonk
	Somerset
	South Attleboro
	Swansea
	Taunton
	Uxbridge
	Webster
	Westport
	Whitinsville

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Section 1373:
The Sherlock Plan
Medicaid for Working People with Disabilities Program

December 2013

May 2014 (T)

Rhode Island Executive Office of Health and Human Services

Rules and Regulations Section 1373:

The Sherlock Plan – Medicaid for Working People with Disabilities Program

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Introduction

These rules**, Section 1373 of the Medicaid Code of Administrative Rules entitled, "The Sherlock Plan – Medicaid for Working People with Disabilities Program"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Chapter 40-8.7 (Health Care Assistance for Working People with Disabilities); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These rules shall supersede all previous regulations related to the Sherlock Plan and the Medicaid for Working People with Disabilities Program promulgated by the Executive Office of Health and Human Services and filed with the Rhode Island Secretary of State.

1373. The Sherlock Plan – Medicaid for Working People with Disabilities Program

1373.01 Overview

Program Description

The Sherlock Plan – Medicaid for Working People with Disabilities Program is an SSI-related categorical eligibility group comprised of working adults with disabilities pursuant to the Balanced Budget Act of 1997 (42 USC section 1396a(a)(10)(ii)(XIII)). People eligible under this category are entitled to the full scope of Medicaid benefits, home and community-based services, and services needed to facilitate and/or maintain employment. Participants may be required to pay a premium in order to remain active on the program.

1373.02 Program Eligibility

To be found eligible for the program of Working People with Disabilities, a person must:

- Be at least eighteen (18) years of age; and
- Currently meet the Medicaid requirements for eligibility based on a disability. Individuals meeting this disability requirement are not required to meet the provision that a person be unable to engage in substantial, gainful employment; and
- Have proof of active, paid employment such as a pay stub or current quarterly U.S. Internal Revenue Service (IRS) tax statement (for those who are self-employed).
- Have countable earned net income no greater than 250% of the FPL. Countable income is defined as the total earned income remaining after all SSI-related disregards are applied; and
- Have countable assets no greater than $10,000 (individual) or $20,000 (couple). Medical savings accounts or retirement accounts are not counted as a resource; approved items that are necessary for an individual to remain employed are also not counted as a resource (i.e., wheelchair accessible van).

1373.03 Income Limits

Financial eligibility is defined as countable net income equal to or less than two hundred fifty percent (250%) of the Federal Poverty Level (FPL). Countable income for purposes of establishing program eligibility excludes any unearned income and is defined as the total earned income remaining after all SSI-related disregards are applied.

The SSI-related disregards listed in EOHHS Code of Administrative Rules, Section 0364 are applied, including a $20 per month General Income Exclusion, and including impairment related work

expenses as defined in the Code of Federal Regulations, 20 CFR, Section 416.976. Participants in this program will be defined as a family size of one (1) for financial eligibility purposes. Therefore, only the income of the individual seeking to participate in the Program will be reviewed and counted in income calculations.

1373.04 Resources Limits

The following resource limits apply to applicants for and participants in the Working People with Disabilities Program:

Resource Limits	
Individual	$10,000
Couple	$20,000

When calculating available resource amounts for a married couple, the resources of both the individual accepted into the program and his/her spouse must be determined available and applied to the resource limit of $20,000.

The following resources are not countable for this program:

1. IRS recognized medical savings accounts or retirement accounts.

2. Items necessary for an individual to remain employed and/or independent (such as a specially adapted vehicle).

1373.05 Retroactive Coverage

As an SSI-related coverage group, participants in the Working People with Disabilities Program are eligible for retroactive coverage. Eligibility for retroactive coverage will be determined in accordance with the rules established in EOHHS MCAR 0310 with the following special requirement that is unique to this coverage group:

- Premiums must be paid in full before retroactive eligibility can be instituted.

Participants may deduct premium amounts from the total amount of any unpaid medical bills in the retroactive eligibility period.

1373.06 Access to Employer-Based Health Insurance

Participants in the Program who have access to employer-based health insurance are required to enroll in the plan as a condition of participation in the Medicaid buy-in program, provided that enrollment in the employer-based health insurance plan is cost-effective and its benefits are comparable to the benefits provided by the Medicaid program. If coverage meets Medicaid

requirements, Medicaid will pay the employee's share of the monthly premium. Enrollment of the individual in the employer-based health insurance plan is without regard to any enrollment season restrictions.

1373.07 Premium Rate Setting
REV: May 2014

Premium Calculation

01. Once a person has been found eligible to participate in the Program as a working person with a disability, a premium is calculated using the buy-in payment rates in EOHHS Medicaid Rules, Section 1312.08[1] pertaining to the RIte Share Premium Assistance Program. For the purposes of premium calculation, the individual's and spouse's earned income will be counted. The total earned income will be income remaining after all SSI-related disregards are applied.

02. The balance of the countable earned income, together with any unearned income, will be assigned premiums in amounts specified in EOHHS Medicaid Rules, Section 1312.08.

1373.08 Premium Collection Methods

01. Electronic Funds Transfer (EFT)
The participant requests that his/her bank allow the State to withdraw the monthly premium directly from the family's savings or checking account by an electronic transfer to Medicaid. The participant is given an EFT form to complete. The funds will be withdrawn by the State on the third (3rd) day of the month prior to the month of coverage. The person will be notified by letter if the EFT premium payment was not successful.

02. Wage withholding
The participant may request that their employer withhold the monthly premium. The employer will then pay the monthly premium to Medicaid through an EFT. The participant is given a special form requesting wage withholding and deposit or transfer to take to his/her employer to be completed and mailed.

03. Direct Pay
The participant pays the premium to Medicaid by check or money order every month. A premium payment coupon and pre-addressed envelope will be provided to the family before the premium is due. The check or money order and the premium payment coupon are mailed or delivered to the Medicaid fiscal agent.

[1] Note that Section 1312 supersedes section 0348 of the Medicaid Code of Administrative Rules.

1373.09 Non-Payment of Premiums

Non-payment of premiums is treated in the same manner as for RIte Share participants as detailed in the EOHHS MCAR section 1312.22.

1373.10 Loss of Employment or Eligibility

A participant in the Program who loses employment may retain eligibility, under this group, for up to four (4) months by continuing to pay the previously determined premium. If the person is still unemployed at the end of the four (4) month period, he/she will no longer qualify to participate in the Program as a working adult with a disability.

A person no longer eligible to participate in the Program may retain approved medical savings accounts and retirement account assets in the amount held on the last full day of eligibility. These medical savings account and/or retirement account assets will be considered non-countable assets for purposes of Medicaid eligibility under any other coverage group. The individual is responsible for providing verification of these account balances as of the last date of eligibility as a working adult with a disability if it is to be disregarded for other forms of Medicaid coverage.

1373.11 Available Services

Services include the full scope of Categorical Medical Assistance benefits, Home and Community Based services, including personal care services provided through an agency or through a self-directed program, and services needed to facilitate and/or maintain employment. The applicant/beneficiaries services are coordinated through the Medicaid Office and the Office of Rehabilitation Services (ORS). Long-term care services and supports are listed in EOHHS Code of Rules, Section 0399.

Services to maintain and support employment shall be determined and approved through an assessment of need utilizing a state approved assessment instrument. Authorized personal care services may be provided in the home, workplace or other necessary setting (i.e., physician office).

1373.12 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

State of Rhode Island & Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1475:

Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries

July 2016

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Title IX of the Social Security Act

Rules and Regulations Section 1475:

Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries

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Introduction

These rules, Section 1475 of the Medicaid Code of Administrative Rules entitled, "Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries," are newly adopted and promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 and 40-8.13 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication, or overlap was identified, and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede the Medicaid Code of Administrative Rules, Sections 0374 and 0375: "Community Supported Living Arrangements and Integrated Care Program," last promulgated by EOHHS and filed with the Rhode Island Secretary of State in May 2014 and MCAR Section 0399.21, in those areas related to the Program for All-Inclusive Care for the Elderly (PACE) plan enrollment, last amended in July 2009.

Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries

Section 1475.00 Managed Care Service Delivery Arrangements

A. Overview of this Rule

The purpose of this rule is describe the managed care service delivery options for Elders and Adults with Disabilities and long-term care beneficiaries. The purpose is also to set forth in clear language the respective roles and responsibilities of the Executive Office of Health and Human Services (EOHHS), beneficiaries, health plans, and other contractual entities related to managed care enrollment and service delivery for Elders and Adults with Disabilities and long-term care beneficiaries.

Overview of Managed Care Programs for Adults with Disabilities and Elders					
Program	**Rhody Health Partners**	**Rhody Health Options**		**Medicare-Medicaid Plan**	**PACE**
Population	Elders and Adults with Disabilities who do not have Medicare or other third-party coverage and are not eligible for LTSS	Elderly and non-elderly adult Medicaid beneficiaries who do not have Medicare and are eligible for LTSS (May have other third-party coverage)	Elderly and non-elderly adults who have full Medicare (Parts A, B, and D) coverage and Medicaid Health Coverage	Elderly and non-elderly adults who have full Medicare (Parts A, B, and D) coverage and Medicaid Health Coverage	Medicaid beneficiaries age 55 and older who qualify for a nursing home level of care
Mandatory/ Voluntary Enrollment	Mandatory	Voluntary	Voluntary	Voluntary	Voluntary
Covered Services	Medicaid	Medicaid	Medicaid	Medicaid and Medicare Parts A, B, and D	Medicaid and Medicare Parts A, B, and D (if eligible)
Participation Criteria	• Age 21 and older; and • Eligible for Medicaid Health Coverage on the basis of the SSI income standard (IHCC group)	• Age 21 and older; • Eligible for Medicaid Health Coverage on the basis of the SSI income standard (IHCC group) or the MAGI income standard (MACC group); and • Receive LTSS	• Age 21 and older; • Eligible for Medicaid Health Coverage on the basis of the SSI income standard (IHCC group) or the MAGI income standard (MACC group); and • Enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D	• Age 21 and older; • Eligible for Medicaid Health Coverage on the basis of the SSI income standard (IHCC group) or the MAGI income standard (MACC group); and • Enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D	• Age 55 years and older; • Meet criteria for high or highest need for a nursing facility level of care; and • Meet all other requirements for LTSS
Populations Not Enrolled	• Enrolled in Medicare Parts A and/or B; • Have other third-party coverage; or • Receive LTSS for more than 30 days	• Reside in Tavares, Eleanor Slater, or out-of-state hospitals; or • In hospice on the enrollment date	• Determined eligible for Medicaid as medically needy and not receiving LTSS; • Reside in Tavares, Eleanor Slater, or an out-of-state hospital; or • In hospice on the enrollment date	• Determined eligible for Medicaid as medically needy and not receiving LTSS • Reside in Tavares, Eleanor Slater, or an out-of-state hospital; • In hospice on the enrollment date; • Reside out-of-state for 6 consecutive months or longer; or • Eligible for the Sherlock Plan	

B. Definitions

For the purpose of this rule, the following terms are defined as follows:

"Appeal" means a request to review an "adverse benefit determination" based on medical necessity, appropriateness, health care setting, and effectiveness.

"Categorical Eligibility" means an applicant/beneficiary included in an IHCC group who is eligible for Medicaid health coverage on the basis of income, resources, a characteristic, and/or a level of need in a mandatory or optional coverage group under the Medicaid State Plan, or who is treated as such, under the State's Section 1115 demonstration waiver, in accordance with Title XIX. Excludes persons who must spenddown to become eligible for Medicaid health coverage as medically needy.

"Communities of Care (CoC)" means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RIte Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

"Community Health Team-Rhode Island (CHT-RI)" means the primary care case management program for adults who have fee-for-service Medicaid coverage and otherwise do not have access to such services.

"Elders and Adults with Disabilities (EAD)" means the Medicaid IHCC group established by R.I.G.L. 40-8.5 for adults with an SSI characteristic related to age (elders 65 years of age or older) or disability.

"Executive Office of Health and Human Services (EOHHS)" means the state agency that is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

"**Full Dual Eligible**" means a beneficiary who is enrolled in Medicare Parts A and B and is eligible for Medicaid Health Coverage through an IHCC or MACC group for elders and adults with disabilities on the basis of income, resources and, when applicable, a characteristic or need for LTSS.

"**Grievance"** means an expression of dissatisfaction about any matter other than an action associated with an adverse benefit determination and includes complaints about the quality of care or services provided, and aspects of interpersonal relations such as rudeness of a provider or an employee or a failure to respect an enrollee's rights.

"**Integrated Health Care Coverage (IHCC) Group"** means any Medicaid coverage group consisting of adults who are eligible on the basis of receipt of Supplemental Security Income (SSI), SSI protected status, the SSI income methodology and a related characteristic (age or disability), or as a result of participation in another federal or State program (e.g., Breast and Cervical Cancer). Includes beneficiaries eligible for community Medicaid (non-long-term care), Medicaid-funded LTSS, and the Medicare Premium Payment Program.

"**Integrated Care Initiative (ICI)"** means a Medicaid initiative that delivers integrated and coordinated services to certain MME and MNM beneficiaries through a managed care arrangement. Includes services from across the care continuum including primary, subacute, and long-term care. Rhody Health Options (RHO) and the Medicare-Medicaid Plan (MMP) were established through ICI.

"Long-Term Services and Supports (LTSS)" means a spectrum of services covered by the Rhode Island Medicaid program that are required by individuals with functional impairments and/or chronic illness, and includes skilled or custodial nursing facility care, as well as various home and community-based services.

"**Managed Care Arrangement (MCA)"** means a system that uses capitated financing to deliver high quality services and promote and optimize health outcomes through a medical home. Such an arrangement also includes services and supports that optimize the health and independence of beneficiaries who are determined to need or be at risk for Medicaid funded LTSS. Includes any arrangement under which an MCO is granted some or all of the responsibility for providing and/or paying for long-term care services and supports through a contractual agreement with the Medicaid program.

"Managed Care Organization (MCO)" means an entity that provides health plan(s) that integrate an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and emphasizes preventive and primary care.

"Medicaid Affordable Care Coverage (MACC) Groups" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility as outlined in MCAR Section 1301.

"**Medicaid and Medicare Enrolled (MME)"** means full dual eligible or partial dual eligible plus beneficiaries who are receiving Medicaid Health Coverage, are enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D.

"Medicaid Code of Administrative Rules (MCAR)" means the collection of administrative rules governing the Medicaid program in Rhode Island.

"**Medicaid Health Coverage"** means the full scope of health care services and supports authorized under the State's Medicaid State Plan and/or Section 1115 demonstration waiver provided through an authorized Medicaid delivery system. The term encompasses the scope of health coverage available to categorically and medically needy eligible beneficiaries as well as those who are treated as such under the State's Section 1115 demonstration waiver. However, the term does not apply to partial dual eligible persons who, under the provisions of this section, qualify only for financial assistance through the MPPP to help pay Medicare cost-sharing.

"Medicaid No Medicare (MNM)" means Medicaid beneficiaries without Medicare who meet the financial and clinical criteria for LTSS and, as such, qualify for enrollment in RHO.

"Medically Necessary Service" means a medical, surgical, or other service required for the prevention, diagnosis, cure, or treatment of a health related condition including any such services that are necessary to prevent or slow a decremental change in either medical or mental health status.

"Medically Needy" means an IHCC group for elders and persons with disabilities who have high medical expenses and income that exceeds the maximum eligibility threshold for Medicaid. For non-LTSS beneficiaries in this coverage group, Medicaid eligibility and coverage occur when the amount they spend on medical expenses meets the medically needy income limit established by the State. For LTSS beneficiaries, excess income must be contributed toward the cost of care. Non-LTSS medically needy beneficiaries are covered on a fee-for-service basis.

"Medicare-Medicaid Plan (MMP)" is an integrated managed care plan under contract with the federal Centers for Medicare and Medicaid Services (CMS) and EOHHS to provide fully integrated Medicare and Medicaid benefits to eligible MME beneficiaries.

"Member or Enrollee" means a Medicaid-eligible person receiving benefits through Rhody Health Partners, Rhody Health Options, a Medicare-Medicaid Plan, or the Program for All-Inclusive Care for the Elderly.

"**Partial Dual Eligible"** means a Medicare beneficiary who does not meet the requirements for Medicaid Health Coverage, but who is eligible for the State's Medicare Premium Payment Program (MPPP).

"**Partial Dual Eligible Plus"** means a Medicare beneficiary who is eligible for Medicaid Health Coverage as medically needy and the MPPP.

"Person-centered Planning" is an individualized approach to planning that supports an individual to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. Person-centered planning places the individual at the center of decision-making. It is designed to enable people to direct their own services and supports to live a meaningful life that maximizes independence and community participation. Person-centered planning is a process that is directed by the individual, with impartial assistance and supported decision-making when helpful. Person-centered planning teams may include people who are close to the individual, as well as people who can help to bring about needed change for the person and access to appropriate services. However, at all times, the individual is empowered to decide who is part of the planning team. Person-centered planning must meet the requirements of 42 CFR 441.301(c)(1) including, but not limited to, ensuring that a person has sufficient and necessary information in a form he or she can understand to make informed choices, enabling the person to direct the process to the maximum extent possible, and conducting planning meetings at times and in locations that are convenient to the individual.

"**Primary Care"** means an array of primary, acute, and specialty services provided by licensed health professionals that includes, but is not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings (e.g., office, inpatient, care, home care, day care).

"Program of All Inclusive Care for the Elderly (PACE)" means a risk-based managed care service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet the financial and clinical criteria for a nursing facility level of long-term services and supports. Beneficiaries must be 55 years or older to participate in this option.

"Rhody Health Options" means the capitated managed care delivery system operating under contract with EOHHS to manage and coordinate Medicaid covered services and supports, including LTSS, for eligible MNM and MME beneficiaries and to coordinate Medicaid covered services with Medicare covered services for eligible MME beneficiaries.

"Rhody Health Partners (RHP)" means the Medicaid managed care service delivery option for adults in the IHCC groups that provides primary/acute and specialty care through a medical home that focuses on prevention and promoting healthy outcomes. The rule for RHP for adults age 19-64 in the MACC groups is located in MCAR Sections 1310 and 1311.

"SSI Income Standard" means the basis for determining Medicaid eligibility that uses the definitions and calculations for evaluating income and resources established by the U.S. Social Security Agency for the Supplemental Security Income program.

"SSI Protected Status" means the class of beneficiaries who retain categorical eligibility for Medicaid even though they are no longer eligible for SSI due to certain changes in income or resources.

1475.01 Rhody Health Partners (RHP)

A. Authority and Scope

In 2005, R.I.G.L. §40-8.5-1.1 authorized the Medicaid agency to establish mandatory managed care delivery systems for adults nineteen (19) years of age or older who are eligible on the basis of participation in the Supplemental Security Income (SSI) program (see MCAR Section 0356 to 0370) or an SSI-related characteristic associated with age or a disability and income. In Rhode Island, persons with SSI-related characteristics are eligible under the Medicaid State Plan option for low-income elders and adults living with disabilities (EAD) in accordance with R.I.G.L. §40-8.5 (MCAR Section 0372). The requirements for adults in associated special eligibility groups that have unique financial (e.g., SSI Protected Status) or clinical criteria (e.g., breast and cervical cancer coverage group) or limited benefits (e.g., partial dual eligible group and the Medicare Premium Payment Program) are also located in MCAR Section 0372.

Beneficiaries eligible in these coverage groups who do not require LTSS are sometimes referred to as "Community Medicaid" and are members of the State's Integrated Health Care Coverage (IHCC) groups. The provisions governing eligibility set forth in MCAR Sections 0356 to 0372 and enrollment as established herein will remain in effect unless or until replaced.

IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in a Rhody Health Partners (RHP) Medicaid managed care plan. Eligible beneficiaries have the choice of two-RHP participating health plans.

B. EOHHS Responsibilities

EOHHS or its designee is responsible for determining the eligibility of members of the IHCC groups in accordance with requirements established in the applicable sections of federal and State laws, rules and regulations unless deemed eligible by virtue of receipt of SSI. In general, persons will be informed of their enrollment options at the time a determination of eligibility is made.

IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in an RHP Medicaid managed care plan. EOHHS enters into contractual arrangements with the MCOs offering RHP plans that assure access to high quality Medicaid covered services and supports. EOHHS is also responsible for informing beneficiaries of their service delivery options and initiating enrollment in a participating RHP plan.

C. RHP Enrollees

Enrollment in an RHP plan typically occurs no more than thirty (30) days from the date of the determination of eligibility unless excluded.

Excluded from RHP enrollment. Beneficiaries in the following categories are excluded from enrollment in an RHP plan and may be enrolled in an alternative Medicaid managed care arrangement:

(1) **Third-Party Coverage** – SSI and EAD eligible beneficiaries who are enrolled in Medicare Parts A and/or B or have other third-party coverage are not subject to mandatory enrollment in an RHP plan.

(2) **Receiving Medicaid-funded LTSS** – Medicaid and MME beneficiaries who require LTSS for more than thirty (30) days are voluntarily enrolled in an RHO plan. This includes newly eligible members of the IHCC groups and RHP enrollees subsequent to receipt of thirty (30) continuous days of LTSS in-plan. MME beneficiaries requiring LTSS can also enroll in the MMP if eligible.

(3) **Exempt Due to Age** – SSI and EAD beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from mandatory enrollment in RHP and receive all Medicaid health coverage on a fee-for-service basis.

(4) **Medically Needy Eligible, Non-LTSS** – Beneficiaries who are determined eligible as medically needy due to excess income and resources are also exempt from enrollment in managed care. Medicaid health coverage for beneficiaries in this category is provided in accordance with the provisions of MCAR Section 0368.

The exempted and excluded populations receive all Medicaid covered services on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system. In addition, during the period while awaiting plan enrollment, beneficiaries eligible for RHP receive health coverage on a fee-for-service basis.

D. RHP Enrollment Process

RHP-eligible beneficiaries have the choice of two participating plans. EOHHS employs a formula, or algorithm, to assign prospective enrollees to a health plan. Eligible beneficiaries are sent a letter from EOHHS at least forty-five (45) days prior to the enrollment effective date notifying them of their health plan assignment and the enrollment effective date. The letter also includes information on their health plan choices. Beneficiaries are given at least thirty (30) days to review the health plan enrollment assignment and request a change. At the end of this timeframe, EOHHS enrolls the beneficiary, effective the first day of the following month, as follows:

(1) **Beneficiary Action –** If the beneficiary makes a choice to change health plan assignment, EOHHS initiates enrollment, as appropriate, into the selected RHP plan.

(2) **No Beneficiary Action –** If a beneficiary does not respond within the allotted timeframe, the beneficiary is enrolled in the assigned RHP plan.

(3) **Delivery System Changes** –Enrollment into RHP is always prospective in nature. Medicaid beneficiaries are required to remain enrolled in this service delivery option, but they can request reassignment to another plan within the first ninety (90) days of enrollment. They are also authorized to transfer from one MCO to another once a year during an open enrollment period. Medicaid enrollees who challenge an auto-assignment decision or seek to change plans more than ninety (90) days after enrollment in the health plan must submit a written request to the Medicaid agency and show good cause, as provided in section 1311.07, for reassignment to another plan. A written decision must be rendered by the Medicaid agency within ten (10) days of receiving the written request and is subject to appeal, as described MCAR Section 0110. If a beneficiary becomes

eligible for LTSS or Medicare, EOHHS initiates RHP disenrollment and, if eligible, offers the alternative option of enrolling in Medicaid LTSS managed care arrangements such as Rhody Health Options, the Program for All-Inclusive Care for the Elderly (PACE), a Medicare-Medicaid Plan, or a fee-for-service (FFS) alternative.

(4) **Auto Re-Assignment after Resumption of Eligibility** – Medicaid beneficiaries who are disenrolled from RHP due to a loss of eligibility are automatically re-enrolled, or assigned, back into the managed care service delivery option they were in previously if they regain eligibility within sixty (60) calendar days. If more than sixty (60) calendar days have elapsed, the enrollment process will follow the process established in this section.

E. RHP Member Disenrollment

Disenrollment from an RHP plan may be initiated by EOHHS or the plan in a limited number of circumstances as follows:

(1) **EOHHS Initiated Disenrollment –** Reasons for EOHHS initiated disenrollment from an RHP plan include but are not limited to:

- Death;
- No longer Medicaid eligible;
- Eligibility error;
- Enrolled in Medicare or other third-party coverage;
- Placement in a long-term care institution – e.g., nursing facility – for more than thirty (30) consecutive days;
- Placement in Eleanor Slater, Tavares, or an out-of-state hospital;
- Incarceration; and
- Eligibility for Medicaid LTSS in the community or in a facility.

(2) **Member Disenrollment Requested by RHP plan** – An RHP plan may request in writing the disenrollment of a member whose continued enrollment seriously impairs the plan's ability to furnish services to either the particular member or other members. An RHP plan is not permitted to request disenrollment of a member due to:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

All plan-initiated disenrollments are subject to approval by EOHHS, after an administrative review of the facts of the case has taken place. Beneficiaries have the right to appeal EOHHS' disenrollment decision (see MCAR Section 0110). EOHHS will determine the disenrollment date as appropriate, based on the results of this review.

F. Grievances, Appeals and Hearings

Federal law requires that Medicaid MCOs have a system in place for enrollees that includes a grievance process, an appeal process, and access to an administrative fair hearing through the State Administrative

Fair Hearing Process. For in-plan services, RHP members must exhaust the internal MCO Level I and Level II appeals process before requesting an EOHHS hearing. Regulations governing the appeals process for out-of-plan services are found in MCAR Section 0110.

(1) **Types of Internal Appeals –** The plan must maintain internal policies and procedures to conform to state reporting policies, and implement a process for logging appeals. Appeals filed with a managed care plan fall into three (3) categories:

(a) **Medical Emergency**. An MCO must decide the appeal within seventy-two (72) hours when a treating provider, such as a doctor who takes care of the member, determines the care to be an emergency and all necessary information has been received by the MCO.

(b) **Non-Emergency Medical Care**. The two levels of a non-emergency medical care appeal are as follows:

- For the initial level of appeal, the MCO must decide the appeal within fifteen (15) days from the date that all necessary information is dated as received by the MCO. If the initial decision is adverse to the member, then the MCO must offer the second level of appeal.

- For the second level of appeal, the MCO must make a decision within fifteen (15) days of the date that all necessary information is dated as received by the MCO.

(c) **Non-Medical Care.** If the appeal involves a problem other than medical care, the MCO must resolve the appeal within thirty (30) days of the date that all necessary information is dated as received by the MCO.

(2) **External Appeal**. RHP members who exhaust the health plan's internal appeal processes may choose to initiate an "external appeal," in accordance with the Rhode Island Department of Health's *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.1-UR).* A member does not have to exhaust the third level appeal before accessing an EOHHS hearing.

Regulations governing the appeals process are found in MCAR Section 0110.

1475.02 RHP Benefit Package

The IHCC groups participating in RHP under this section receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider.

(1) **Access to Benefits** – Each RHP member selects a primary care provider (PCP) who performs necessary medical care and coordinates referrals to specialty care. The PCP orders treatment determined to be medically necessary in accordance with the health plan's policies. Prior authorization rules may apply, as required by the Medicaid agency.

(2) **Delivery of Benefits** – In-plan services are paid for on a capitated basis.

(3) **Medical Necessity** – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be

provided solely for the convenience of the member or service provider.

(4) **Medicaid Benefits** – The coverage provided through RHP is categorized as follows:

RHP Benefits			
(a) In-Plan		***(b) Out-of-Plan***	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Court-ordered Mental Health and Substance Abuse Services Ordered to a Non-network Facility or Provider
(03)	Physician Services	(03)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)
(04)	Family Planning Services	(04)	Nursing home Services in Excess of 30 Consecutive Days
(05)	Prescription Drugs	(05)	Residential Services for Beneficiaries with Intellectual and Developmental Disabilities
(06)	Non-Prescription Drugs	(06)	Home stabilization services
(07)	Laboratory Services		
(08)	Radiology Services		
(09)	Diagnostic Services		
(10)	Outpatient & Inpatient Mental Health and Substance Use Services		
(11)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court		
(12)	Court-ordered Mental Health and Substance Abuse Treatment – Civil Court		
(13)	Home Health Services		
(14)	Emergency Room Service and Emergency Transportation Services		
(15)	Nursing Home Care and Skilled Nursing Facility Care		
(16)	Services of Other Practitioners		
(17)	Podiatry Services		
(18)	Optometry Services		
(19)	Oral Health		
(20)	Hospice Services		
(21)	Durable Medical Equipment		
(22)	Group/Education Programs		
(23)	Interpreter Services		
(24)	Transplant Services		
(25)	Adult Day Services		
(26)	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those at High Risk for Acquiring HIV		

RHP Benefits			
(a) In-Plan		*(b) Out-of-Plan*	
(27)	AIDS Medical Case Management		
(28)	Opioid Treatment Provider Health Home		
(29)	Preventive services, including: • Homemaker • Minor Environmental Modifications • Physical Therapy Evaluation and Services		

(5) Communities of Care – The primary goal of Communities of Care (CoC) is to improve access to care and promote member involvement in their care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs. The target population for CoC is Medicaid beneficiaries who utilize the ED four (4) or more times during the most recent twelve (12) month period. RHP beneficiaries who are eligible for CoC are required to participate. A full description of the CoC is located in MCAR Section 1314.

1475.03 to 1475.24 Reserved

1475.25 Integrated Care Initiative (ICI)

A. Authority and Overview

In accordance with R.I.G.L. 40-8.13, the State's Section Waiver 1115 Demonstration, and other federal waivers and authorities, EOHHS has developed and implemented the ICI to expand access to comprehensive care management and services through two managed care delivery system options:

(1) **Rhody Health Options (RHO) –** A voluntary program that integrates Medicaid covered services across the care continuum for beneficiaries who need LTSS and do not have Medicare (MNM), and manages and coordinates the care of certain beneficiaries who are dual eligible for Medicaid and Medicare (MME).

(2) **Medicare-Medicaid Plan (MMP)** – Under the authority of a special federal demonstration program, the MMP integrates and coordinates Medicare and Medicaid covered services through a managed care arrangement for MME beneficiaries. Enrollment is voluntary for eligible beneficiaries. The operations of the MMP are bound by a three-way agreement between EOHHS, the federal Centers for Medicare and Medicaid Services (CMS), and the participating MCO.

B. EOHHS Responsibilities

As the single State agency for Medicaid, EOHHS oversees administration of the program and is responsible for ensuring that eligibility determinations and enrollment procedures are conducted in accordance with applicable federal and State laws and regulations. There are both MACC group (MAGI standard) and IHCC group (SSI standard) eligibility pathways that may result in enrollment in RHO for beneficiaries. To enroll in the MMP, applicants must qualify as an MME in accordance with the applicable provisions set forth herein. Enrollment in PACE is a standing option for eligible beneficiaries. Applicants are processed as

summarized below:

(1) **Eligibility Determinations** – EOHHS or its designee is responsible for determining the eligibility of applicants for Medicaid and Medicaid-funded LTSS, including those who have third party coverage through Medicare. All LTSS applicants must meet financial and clinical criteria related to the need for an institutional level of care set forth in MCAR Sections 0376 and 1500, respectively. The eligibility duties of EOHHS also include**:**

(a) **Level of Need.** EOHHS applies clinical criteria to determine whether and to what extent the needs of an applicant/beneficiary require the level of care provided in an institutional setting – nursing facility, hospital, intermediate care facility for intellectual disabilities. EOHHS is also responsible for identifying beneficiaries for whom there is unlikely to be an improvement in functional/medical status.

(b) **Beneficiary Liability**. EOHHS determines the amount LTSS beneficiaries must pay toward the cost of the care – beneficiary liability – through a process referred to as the post-eligibility treatment of income (PETI). All beneficiaries of Medicaid-funded LTSS are required under the Medicaid State Plan and the State's Section 1115 waiver to contribute to the cost of the services they receive to the full extent their income and resources allow, irrespective of care setting or service delivery option. Failure to make such payments may result in termination of eligibility for non-cooperation (See MCAR Section 1500.01 (F)).

(c) **Person Centered Planning and Service Arrangements**. In addition to determining eligibility and beneficiary liability for Medicaid LTSS, EOHHS is responsible for engaging beneficiaries in person-centered care planning in which the beneficiary leads an assessment and discussion of his or her needs and goals and information about various care options. This process includes the development of a service plan that corresponds to the beneficiary's needs and goals and assists beneficiaries and their families in selecting the appropriate service delivery option and making care arrangements.

(2) **Service Delivery Options and Enrollment** – EOHHS assures that every beneficiary has access to health coverage through the service delivery options provided for in federal and State law that most appropriately meet his or her needs. Once a determination of eligibility has been made, beneficiaries are evaluated for enrollment in managed care versus fee-for service.

C. Service Delivery Options

EOHHS provides the following delivery options to Medicaid beneficiaries who meet program participation criteria:

(1) **Rhody Health Options (RHO) –** RHO is a managed care service delivery system that integrates and manages Medicaid covered services across the care continuum. The State contracts with an MCO – Neighborhood Health Plan of RI – to manage and coordinate all Medicaid State Plan and waiver services for RHO enrollees. For MNM beneficiaries, RHO integrates the full range of Medicaid services. For MME beneficiaries, RHO manages and coordinates the Medicaid wraparound services to which they are entitled, but otherwise has no impact on enrollment in Medicare Parts A and B, Medicare Advantage Plans, or Medicare Part D prescription drug coverage. Neighborhood Health Plan of RI is currently the only MCO offering an RHO plan. See MCAR Section 1475.26 for more information on RHO.

(2) **Medicare-Medicaid Plan (MMP)** – The MMP is a managed care service delivery system designed to manage and coordinate the full spectrum of both Medicaid and Medicare services for Medicare and Medicaid (MME) adults. Neighborhood Health Plan of RI is currently the only MCO offering an MMP in Rhode Island. See MCAR Section 1475.40 for more information on the MMP.

(3) **PACE –** PACE is a service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet a "high" or "highest" level of need for LTSS in accordance with MCAR Section 1500. Beneficiaries must be 55 years old or older to participate in this option. See MCAR Section 1475.70 for more information on PACE.

(4) **Fee-for-service –** Beneficiaries participating in RHO or the MMP receive at least some of their Medicaid health coverage on a fee-for-service basis. Beneficiaries eligible for RHO, the MMP, and PACE also have the option to obtain all of their Medicaid covered services on a fee-for-service basis.

Community Health Teams provide care coordination and assistance to beneficiaries in Medicaid fee-for-service who are not eligible for enrollment in managed care. The Community Health Team-Rhode Island (CHT-RI) is a Primary Care Case Management (PCCM) program for adults who have Medicaid coverage. Currently, these Medicaid members do not receive care management and are not enrolled in a health plan. The CHT-RI program is administered by CareLink and provides beneficiaries assistance with:

- Navigating the health care system
- Care management, client advocacy, and health education
- Working with a person's primary care provider
- Links to community resources

Participation in CHT-RI is voluntary. A person can disenroll at any time on a monthly basis. The State auto-enrolls eligible beneficiaries, but provides them with the opportunity to opt out in person, by mail, or by telephone.

1475.26 Rhody Health Options (RHO)

A. RHO Participation Criteria

Medicaid beneficiaries are eligible for participation in RHO if they are twenty-one (21) years of age or older as follows:

(1) **RHO-eligible Enrollees: Medicaid No Medicare (MNM)** – This group consists of Medicaid beneficiaries without Medicare who meet the financial and clinical criteria for LTSS. Includes Medicaid beneficiaries who have other forms of third party commercial coverage (e.g., employer, union, TRICARE). MNM beneficiaries in this group are enrolled in a plan offered by an MCO under contract with EOHHS that provides integrated, coordinated health services and supports across the care continuum, including LTSS. Beneficiaries who meet these criteria are eligible to receive Medicaid primary care – acute and subacute services – as well as long-term care through an RHO plan providing they are twenty-one (21) years of age or older and meet the applicable eligibility criteria for LTSS and a specific IHCC group or the MACC group for parents/caretakers.

(2) **RHO-eligible Enrollees: Medicare-Medicaid Eligible (MME)** – This group consists of

Medicare-Medicaid (MME) beneficiaries who are receiving Medicaid Health Coverage, enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D. Includes MME and other Community Medicaid IHCC group beneficiaries who do not need LTSS but are excluded from enrollment in RHP under MCAR Section 1475.01. MME beneficiaries have access to RHO, but only for Medicaid services that are not covered by Medicare. For MME beneficiaries, participation in RHO does not affect the scope, amount, or duration of their Medicare coverage. EOHHS began RHO enrollment in November 2013. RHO-eligible MME beneficiaries are as follows:

- Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;
- MAGI-eligible adults in the MACC group for parents/caretakers; and
- LTSS recipients residing in institutional or home and community-based settings including those qualifying for the level of care provided in a nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID) – e.g., nursing facility, assisted living and I/DD group home residents as well as those residing in their own homes.

MME beneficiaries are entitled to Medicaid State Plan and Section 1115 waiver services that are not covered by Medicare. These Medicaid so-called "wraparound" services for MME beneficiaries are managed and coordinated through RHO.

Excluded Beneficiaries – Certain Medicaid beneficiaries are excluded from participating in RHO as indicated below:

Beneficiaries Excluded from RHO
(a) Medicare beneficiaries who are not receiving Medicaid Health Coverage, including partial dual eligible beneficiaries who participate in the Medicaid Premium Payment Program as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs)
(b) Dual Eligible beneficiaries who are not enrolled in all segments of Medicare
(c) Medicaid beneficiaries residing in Tavares, Eleanor Slater, or out-of-state hospitals
(d) Beneficiaries who are in hospice on the effective enrollment date. Enrollees who elect hospice care after they are enrolled in RHO can remain in RHO
(e) Medicaid and dual eligible beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from mandatory enrollment in managed care and receive all Medicaid health coverage on a fee-for-service basis
(f) Beneficiaries who are determined eligible as medically needy for Community Medicaid due to excess income and resources are also exempt from enrollment in managed care

Excluded beneficiaries receive all Medicaid covered services – including LTSS – on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system.

B. RHO Service Delivery Option

RHO is a managed care service delivery system that integrates and manages Medicaid covered services across the care continuum. EOHHS contracts with an MCO – Neighborhood Health Plan of RI – to manage and coordinate all Medicaid State Plan and waiver services. For MNM beneficiaries, RHO integrates the

full range of Medicaid services. For MME beneficiaries, RHO manages and coordinates the Medicaid wraparound services to which they are entitled, but otherwise has no impact on enrollment in Medicare Parts A and B, Medicare Advantage Plans, or Medicare Part D prescription drug coverage. Neighborhood Health Plan of RI is currently the only MCO offering an RHO plan.

C. RHO Enrollment

MNM and MME beneficiaries are not required to receive their Medicaid benefits through managed care and have the opportunity to opt-out of managed care prior to enrollment or after being enrolled. All enrollments into RHO are prospective in nature. Accordingly, there is no retroactive enrollment into this service delivery option. EOHHS is responsible for ensuring beneficiaries have access to the information they need to make reasoned decisions about whether to obtain their Medicaid health coverage through RHO. The enrollment process proceeds as follows:

(1) **Auto-assignment and Opt-Out.** EOHHS sends a letter to eligible Medicaid beneficiaries explaining ICI and providing an auto-assignment into RHO. This communication also provides instruction on how to opt-out to FFS.

(2) **Decision Timeframe.** Beneficiaries are given a reasonable timeframe of a minimum of thirty (30) days from the date the enrollment letter is sent to consider these options and make an enrollment decision.

- **Beneficiary Action.** If the beneficiary makes an enrollment choice within the specified timeframe, EOHHS initiates enrollment accordingly.

- **No Action by Beneficiary.** If a beneficiary does not respond within the specified timeframe, enrollment proceeds in accordance with the auto-assignment into RHO, as indicated in the written communication from EOHHS.

(3) **Opportunity to Change Option.** Once enrolled, beneficiaries may change Medicaid delivery systems on a monthly basis. Any such changes requested are processed and take effect in accordance with the applicable EOHHS enrollment schedule. Beneficiaries who voluntarily disenroll from an RHO plan can re-enroll in the plan on a monthly basis.

(4) **Auto Re-Assignment after Resumption of Eligibility.** Medicaid beneficiaries who are disenrolled from RHO due to a loss of eligibility are automatically re-enrolled into RHO if they regain eligibility within sixty (60) calendar days. If eligibility is regained more than sixty (60) calendar days after enrollment has elapsed, the process proceeds in accordance with the subpart (3) above.

D. RHO Disenrollment

(1) **EOHHS Initiated Disenrollment EOHHS –** Reasons for EOHHS disenrollment from an RHO plan include but are not be limited to:

- Death;
- Loss of Medicaid eligibility;
- Loss of Medicare eligibility (if previously fully dually eligible for Medicare and Medicaid and not receiving LTSS);

- MNM beneficiary loss of LTSS eligibility;
- Eligibility error;
- Placement in Eleanor Slater Hospital, Tavares, or an out-of-state residential hospital;
- Incarceration;
- Change of state residence;
- Enrollment in PACE;
- Enrollment in the Medicare-Medicaid Plan; and
- Opt-out to FFS.

(2) **Managed Care Entity Member Disenrollment Request** – The RHO plan may request in writing that a member be disenrolled. Such a request must be made on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members. EOHHS does not permit disenrollment requests based on:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

(3) **Disenrollment Review –** All disenrollments are subject to approval by EOHHS. EOHHS determines the disenrollment date, as appropriate. Beneficiaries have the right to appeal EOHHS' disenrollment decision (see MCAR Section 0110). Beneficiaries who are disenrolled receive their Medicaid benefits on a fee-for-service basis.

E. Grievances, Appeals and Hearings

RHO offers multiple opportunities for Medicaid beneficiaries to contest decisions affecting their health coverage. Regulations governing fee-for-service appeals and appeals for out-of-plan services are located in MCAR Section 0110.

(1) **Level I and Level II Plan Appeals –** For in-plan services, RHO Members must exhaust the internal managed care entity's Level I and Level II appeals process before requesting an EOHHS administrative fair hearing. The RHO plan must maintain internal policies and procedures to conform to state reporting policies, and implement a process for logging grievances and appeals. Appeals must be resolved by the RHO managed care entity within specified timeframes depending on the level of the appeals process. These timeframes are related to the date the RHO plan receives the information from all interested parties required to review and resolve the issue in dispute. Internal RHO plan appeals fall into three (3) categories:

(a) **Expedited.** The RHO plan must render a decision within seventy-two (72) hours of the date all necessary information has been received by the managed care entity when the RHO plan or a treating provider, such as a licensed physician who takes care of the member, determines that standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The plan can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary's best interest.

(b) **Other Medical Care.** There are two levels of non-emergency medical care appeals:

- For the initial level of appeal, the managed care entity must decide the appeal within fifteen (15) days of the date all necessary information is received by the managed care entity. If the initial decision is adverse to the member, then the RHO plan must offer the second level of appeal.

- For the second level of appeal, the RHO plan must make a decision within fifteen (15) days of the date that all necessary information has been received by the managed care entity.

(c) **Non-Medical Care**. If the grievance involves a problem other than medical care, the RHO plan must make a decision within thirty (30) days of the date all necessary information has been received by the plan.

(2) **Level III – External Appeal** – RHO members may also choose to initiate a third level or "external appeal," in accordance with the Rhode Island Department of Health's *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.1-UR).* A member is not required to exhaust the third level appeal before accessing an EOHHS hearing.

1475.27 RHO Benefit Package

RHO provides a comprehensive benefit package. For MME members, Medicare-funded or other third-party benefits, including prescription drug coverage, is continued for MME members while participating in the RHO plan. In such instances, Medicaid is the payer of last resort. The RHO plan is responsible for coordinating all Medicaid-covered services with Medicare-covered services.

(1) **Access to Benefits** – Each MNM member selects a primary care provider (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The PCP orders treatment determined to be medically necessary in accordance with the health plan's policies. Prior authorization rules may apply, as required by the Medicaid agency.

(2) **Delivery of Benefits** – In-plan services are paid for on a capitated basis. Certain Medicaid-covered services are considered "out-of-plan" and are provided on a fee-for service basis. The RHO plan is not responsible for delivering or reimbursing out-of-plan services, but the RHO plan is expected to coordinate in-plan services with out-of-plan services. Out-of-plan services are provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a fee-for-service basis.

(3) **Medical Necessity.** The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

(4) **RHO Benefits** – The coverage provided through RHO is categorized as follows:

RHO Benefits			
(a) In-Plan		***(b) Out-of-Plan***	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)

RHO Benefits			
(a) In-Plan		***(b) Out-of-Plan***	
(03)	Physical Therapy Evaluation and Services	(03)	Residential Services for Clients with Intellectual and Developmental Disabilities
(04)	Physician Services	(04)	Home Stabilization Services
(05)	Care Management Services		
(06)	Family Planning Services		
(07)	Prescription Drugs		
(08)	Non-Prescription Drugs		
(09)	Laboratory Services		
(10)	Radiology Services		
(11)	Diagnostic Services		
(12)	Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient		
(13)	Home Health Services		
(14)	Home Care Services		
(15)	Emergency Room Service and Emergency Transportation Services		
(16)	Nursing Home Care and Skilled Nursing Facility Care		
(17)	Services of Other Practitioners		
(18)	Podiatry Services		
(19)	Optometry Services		
(20)	Oral Health		
(21)	Hospice Services		
(22)	Crossover Claims		
(23)	Durable Medical Equipment		
(24)	Adult Day Health		
(25)	Nutrition Services		
(26)	Group/Individual Education Programs		
(27)	Interpreter Services		
(28)	Transplant Services		
(29)	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those that are at High Risk for Acquiring HIV		
(30)	AIDS Medical Case Management		
(31)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court		
(32)	Court-Ordered Mental Health and Substance Abuse Treatment – Civil Court		
(33)	Preventive Services, including: • Homemaker • Minor Environmental Modifications • Physical Therapy Evaluation and Services • Respite		
(34)	Long Term Services and Supports, including:		

RHO Benefits			
(a) In-Plan		*(b) Out-of-Plan*	
	• Homemaker • Environmental Modifications (Home Accessibility Adaptations) • Special Medical Equipment (Minor Assistive Devices) • Meals on Wheels (Home Delivered Meals) • Personal Emergency Response (PERS) • Skilled Nursing Services (LPN Services) • Community Transition Services • Residential Supports • Day Supports • Supported Employment • RIte @ Home (Supported Living Arrangements-Shared Living)* • Private Duty Nursing • Supports for Consumer Direction (Supports Facilitation) • Participant Directed Goods and Services • Financial Management Services (Fiscal Intermediary) • Senior Companion (Adult Companion Services) • Assisted Living • Personal Care Assistance Services • Respite • Rehabilitation Services		
(35)	Opioid Treatment Provider Health Home		

1475.28 to 1475.39 Reserved

1475.40 Medicare-Medicaid Plan (MMP)

A. MMP Overview

Under the authority of a special federal demonstration program, the MMP is designed to manage and coordinate the full spectrum of both Medicaid and Medicare services for Medicare and Medicaid (MME) adults. Enrollment is voluntary for eligible beneficiaries. A three-way agreement between EOHHS, the MCO operating the MMP, and the federal Centers for Medicare and Medicaid Services (CMS) governs the organization, financing, and delivery of Medicaid and Medicare services to MME beneficiaries who choose to participate. Neighborhood Health Plan of RI is currently the only MCO offering an MMP in Rhode Island.

B. MMP Participation Criteria

MME beneficiaries are eligible for participation in the MMP if they are age twenty-one (21) and older as follows:

(1) **MME Enrollees** – Medicare-Medicaid beneficiaries who are receiving Medicaid Health Coverage, enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D. Includes MME and other Community Medicaid IHCC group beneficiaries as well as those who need LTSS. Eligible MME beneficiaries include:

- Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;
- MAGI-eligible adults in the MACC group for parents/caretakers;
- LTSS recipients residing in institutional or home and community-based settings including those qualifying for the level of care provided in a nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID) – e.g., nursing facility, assisted living and ID group home residents as well as those residing in their own homes; and
- Persons with End Stage Renal Disease (ESRD) at the time of enrollment.

MME beneficiaries are entitled to Medicaid State Plan and Section 1115 waiver services that are not covered by Medicare. These Medicaid so-called "wraparound" services for MME beneficiaries can also be managed and coordinated through RHO and PACE.

(2) **Excluded Beneficiaries** – Certain Medicaid beneficiaries are excluded from participating in the MMP as indicated below:

Beneficiaries Excluded from the MMP
(a) Medicare beneficiaries who are not eligible for Medicaid Health Coverage, including partial dual eligible beneficiaries who participate in the Medicaid Premium Payment Program as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs)
(b) Dual Eligible beneficiaries who are not qualified to enroll in all segments of Medicare
(c) Medicaid beneficiaries residing in Tavares, Eleanor Slater, or out-of-state hospitals
(d) Beneficiaries who are in hospice on the effective enrollment date. Enrollees who elect hospice care after they are enrolled in the MMP can remain in the MMP
(e) Beneficiaries who reside out-of-state for six (6) consecutive months or longer
(f) Beneficiaries who are eligible for the Medicaid Buy-In Program for Working People with Disabilities (known as the "The Sherlock Plan" in Rhode Island)
(g) Dual eligible beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from enrollment in managed care and receive all Medicaid health coverage on a fee-for-service basis
(h) Beneficiaries who are determined eligible as medically needy for Community Medicaid due to excess income and resources are exempt from enrollment in managed care

C. MMP Service Delivery Option

MMP participating beneficiaries receive services through a managed care arrangement operating under contract with EOHHS and CMS. MMP enrollees receive services through a health plan offered by an MCO. The operations of the MMP are bound by a three-way agreement with EOHHS and CMS to integrate the full range of Medicare and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) in accordance with a rate structure that includes federal and state

funding streams for all MME adults. Accordingly, the MMP must provide accessible, high-quality services and supports focused on optimizing the health and independence of one of the most fragile Medicaid populations. Enrollment in the MMP is voluntary.

D. MMP Enrollment

The MMP offers MME beneficiaries the opportunity to obtain comprehensive integrated services through a single health plan.

(1) **Passive or Auto-Enrollment** – No earlier than October 1, 2016, eligible beneficiaries who are enrolled in an RHO plan operated by the same MCO as the MMP may be passively enrolled, or auto-enrolled, in the MMP unless they are *excluded* from passive enrollment on the basis of one of the following criteria:

- The MME beneficiary is enrolled in a Medicare Advantage plan that is not operated by the same MCO as the MMP;
- The beneficiary has been auto-enrolled by CMS into a Medicare Part D plan in the same calendar year that the MME would qualify for the MMP;
- The MME is currently enrolled in comprehensive health insurance coverage through a private commercial plan or group health plan provided through an employer, union, or TRICARE; or
- The beneficiary has affirmatively opted-out of passive enrollment into an MMP or a Medicare Part D plan.

(2) **Opt-in Enrollment** – Beginning July 1, 2016, eligible beneficiaries may opt into the MMP. MME beneficiaries who are not eligible for passive enrollment will be offered the opportunity to opt-in to an MMP by completing an application in writing or via phone. Individuals enrolled in PACE may elect to enroll and participate in the MMP if they choose to disenroll from PACE.

E. Enrollment Information

EOHHS is responsible for ensuring that all MME beneficiaries who meet the criteria to participate in the MMP have access to the information necessary to make a reasoned choice about their coverage options. As indicated in MCAR Section 1475.25 (B) (1), the person-centered planning process plays a critical role in ensuring that beneficiaries are aware of the full range of service delivery options available to them based on their level of need and personal goals. Accordingly, prospective participants are sent a written communication informing them of the option to enroll in an MMP, as well as information on the availability of independent enrollment options counseling and other supports to help beneficiaries make informed enrollment decisions. Eligible individuals who opt-out of or do not enroll in an MMP have the option to enroll in an RHO plan, PACE if eligible, or receive all Medicaid covered services – including LTSS – on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system.

Communications with MME beneficiaries who qualify to participate in the MMP includes information about each of the following:

(1) **Enrollment Opt-In and Opt-Out Process –** Participation in an MMP is voluntary. MME beneficiaries eligible for passive enrollment are informed that they may choose to opt out of enrollment in the MMP and are provided with instructions on how to proceed. MME beneficiaries eligible for passive enrollment who opt-out revert to RHO and may choose any of the alternative service delivery options for which they may qualify. Eligible beneficiaries who are not passively enrolled are provided with instructions on how to enroll in an MMP.

(2) **Decision Timeframe** – Eligible beneficiaries may enroll in an operational MMP at any time up until six (6) months prior to the end of the federal demonstration under which the MMP was implemented. As of July 2016, the federal demonstration is scheduled to end on December 31, 2020. Information is provided about enrollment decision time-frames as follows:

(a) **Passive Enrollment**. Beneficiaries eligible for passive enrollment into the MMP are sent a first notification that they will be passively enrolled between sixty (60) and ninety (90) days prior to the effective date of enrollment; a second reminder notification is sent to the beneficiary at least thirty (30) days prior to the effective date of enrollment. If the beneficiary makes an enrollment choice within the specified timeframe, EOHHS initiates enrollment accordingly. If a beneficiary does not respond within the specified timeframe, enrollment in the MMP proceeds in accordance with the terms specified in the initial communication from EOHHS.

(b) **Opt-in Enrollment**. MME beneficiaries who are eligible for the MMP but are not passively enrolled are sent a notification that they have the option to enroll in an MMP. Opt-in enrollment requests received through the 10th day of the month will take effect on the first day of the following calendar month. Opt-in enrollment requests received on the 11th day of the month or later will take effect on the first day of the second month after the request was submitted. Beneficiaries do not need to make an enrollment decision to opt into the MMP within a specified timeframe after receiving notice from EOHHS informing them that they are eligible to enroll in the MMP. However, no new enrollments will be accepted during the six (6) months prior to the end date for the federal demonstration under which the MMP was implemented. As of July 2016, the federal demonstration is scheduled to end on December 31, 2020.

(3) **Opportunity to Change –** Beneficiaries who are being passively enrolled or who opt-in to an MMP may cancel their enrollment any time prior to their effective enrollment date. Once enrolled, beneficiaries may change service delivery options on a monthly basis at any time, but enrollment in the MMP will continue through the end of the month. The requested change will be effective on the first day of the following month. Beneficiaries who cancel enrollment into or voluntarily disenroll from an MMP will be enrolled in RHO, effective the first day of the following month. Once enrolled in RHO, beneficiaries can their change service delivery option according to the disenrollment processes for RHO. Beneficiaries who voluntarily disenroll from the MMP plan can choose to re-enroll in the plan on a monthly basis if they continue to be eligible for enrollment in the MMP, but they will not be passively enrolled in the MMP. Beneficiaries may also be eligible for enrollment in PACE (see MCAR Section 1475.70).

(4) **Auto Re-Assignment after Resumption of Eligibility** – MME beneficiaries who are disenrolled from an MMP due to a loss of eligibility are eligible for re-enrollment in the plan if eligibility is reinstated and they otherwise meet the requirements for enrollment. Beneficiaries eligible for re-enrollment will be passively enrolled if they meet the requirements for passive enrollment. Otherwise, they will be offered opt-in enrollment.

F. MMP Member Disenrollment

(1) **EOHHS Initiated Disenrollment** – Reasons for EOHHS disenrollment from an MMP include but are not limited to:

- Death;
- No longer eligible for Medicaid;
- Loss of Medicare Part A and/or Part B;
- Enrollment into a Medicare Advantage (Part C) plan or Medicare Part D prescription drug plan;
- Eligibility error;

- Placement in Eleanor Slater Hospital, Tavares, or out-of-state residential hospital;
- Incarceration;
- Changed state of residence;
- Enrollment in PACE; and
- Opt-out to fee-for-service.

Beneficiaries who are involuntarily disenrolled because of incarceration are provided Medicaid coverage on a fee-for-service basis. Beneficiaries who are involuntarily disenrolled for any other reason are enrolled in RHO, pending a review of Medicaid eligibility criteria. Once enrolled in RHO, beneficiaries can their change service delivery option according to the disenrollment processes for RHO.

(2) **Medicare-Medicaid Plan Disenrollment Request** – The Medicare-Medicaid plan may make a written request to EOHHS and CMS asking that a particular member be disenrolled. Any such request is only considered by EOHHS and CMS when made on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members, the member knowingly provided fraudulent information on the MMP enrollment form that materially affected his or her eligibility to enroll in the MMP, or the member intentionally permitted others to use his or her member identification card to obtain services under the MMP. EOHHS and CMS do not permit disenrollment requests based on:

- An adverse change in the member's health status;
- The member's utilization of medical services;
- Uncooperative or disruptive behavior resulting from the member's special needs;
- The member exercising treatment decisions with which the MCO or the MCO's provider(s) disagree; or
- Diminished or diminishing mental capacity of the member.

Beneficiaries who are involuntarily disenrolled based on a written request by the MMP receive their Medicaid benefits on a fee-for-service basis.

(3) **Disenrollment Review** – All disenrollments are subject to approval by EOHHS and CMS. Beneficiaries have the right to appeal EOHHS' and CMS' disenrollment decision (see MCAR Section 0110). EOHHS and CMS determine jointly the disenrollment date as appropriate.

G. Grievances, Appeals and Hearings

MMP members have multiple avenues for contesting decisions that affect their health coverage, including EOHHS and CMS administrative fair hearings. The process is as follows:

(1) **MMP Grievances –** Grievances directed toward the MMP may be internal or external.

(a) **Internal or plan level grievances.** MMP members, or their authorized representatives, can file a grievance with the MCO or a participating provider at any time by calling or writing the MCO or the provider. The MCO must require providers to forward grievances to the MCO. If the MMP member is requesting remedial action related to a Medicare issue, the member must file the grievance with the MCO or the provider no later than ninety (90) days after the event or incident triggering the incident (see MCAR Section 0110 for information of Medicaid

rules related to grievances). The MCO must respond, orally or in writing, to an internal grievance within thirty (30) days after the MCO receives the grievance. The MCO must respond, orally or in writing, within twenty-four (24) hours whenever the MCO extends the timeframe for a decision or refuses to grant a request for an expedited grievance.

(b) **External.** MMP members, or their authorized representatives, can file a grievance by contacting 1-800-MEDICARE or EOHHS. Any grievance filed with EOHHS will be reviewed by a joint EOHHS-CMS contract oversight team and be made available to the MCO.

(2) **MMP Appeals** – The process for handling appeals varies depending on whether the beneficiary is disputing an action related to Medicaid or Medicare coverage. For services covered under Medicare Part D, MMP members must follow the appeals process established by CMS in Subparts M and U of 42 C.F.R. Part 423. For services covered by Medicare Part A, Medicare Part B, and/or Medicaid in-plan services, MMP members must complete at least one level of internal appeal before requesting an external review. Regulations governing the appeals process for Medicaid out-of-plan services are found in MCAR Section 0110. The process for filing subsequent appeals after the first level internal appeal is as follows:

(a) **Services covered by Medicare Part A and/or B**. Subsequent appeals after the first level internal appeal for traditional Medicare A and B services that are not fully in favor of the Enrollee will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the MMP.

(b) **Services covered by Medicaid only.** The MMP must offer a second level internal appeal to MMP members for services covered by Medicaid only, if the first level internal appeal is not fully in favor of the member. Subsequent appeals for services covered by Medicaid only (including, but not limited to, LTSS and behavioral health) may be made to the EOHHS Hearing Office and/or to the Rhode Island External Review Entity per State regulations R23-17.12-1-UR after the second plan-level Appeal has been completed. If an appeal is filed with both the Rhode Island External Review Entity and the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member. Appeals related to drugs excluded from Medicare Part D that are covered by Medicaid must be filed with the MMP in accordance with MCAR Sections 1311 and 0110 and the requirements contained herein.

(c) **Services covered by both Medicare and Medicaid.** After the first level internal appeal, appeals for services for which Medicare and Medicaid overlap (including, but not limited to, home health, durable medical equipment, and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the MMP. The MCO must offer a second level internal appeal to members for services for which Medicare and Medicaid overlap if the first level internal appeal is not fully in favor of the member.

After the second plan-level appeal for Medicare and Medicaid overlapping services, a member may file a request for a hearing with the EOHHS Hearing Office. After the second plan-level appeal for Medicare and Medicaid overlap services, a member may also file a request for a hearing with the Rhode Island External Review Entity per State regulations R23-17.12-1-UR. If an appeal is filed with both the IRE and either the Rhode Island External Review Entity or the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member.

(3) **Internal appeals timeframes.**

(a) **First Level**. An MMP member must file a first-level internal appeal with the plan within ninety (90) calendar days following the date of the notice of adverse action that generates the appeal.

(b) **Standard appeals**. For first-level internal appeals, the MMP must render a decision within thirty (30) calendar days of the date that the appeal request has been received by the managed care entity. For second-level internal appeals, the MMP must render a decision within fifteen (15) calendar days of the date that the appeal request has been received by the managed care entity. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary's best interest.

(c) **Expedited appeals.** For first and second-level internal appeals, the MMP must render a decision within seventy-two (72) hours of the date that the appeal request has been received by the managed care entity when either the MMP or the member's provider determines that standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary's best interest.

1475.41 MMP Benefit Package

The MMP provides a comprehensive benefit package to members that includes a full continuum of Medicare and Medicaid services as follows:

(1) **Medicare –** Medicare Parts A, B, and D-funded medically necessary services.

(2) **Medicaid Services** – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider. Medicaid services may be in-plan or out-of-plan. In-plan services are paid for on a capitated basis. Certain Medicaid-covered services are considered "out-of-plan" and are provided on a fee-for service basis. The MMP is not responsible for delivering or reimbursing out-of-plan services, but is expected to coordinate in-plan services with out-of-plan services. Out-of-plan services are provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a fee-for-service basis. The Medicaid coverage provided through the MMP is categorized as follows:

MMP Medicaid Benefits			
(a) In-Plan		***(b) Out-of-Plan***	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)
(03)	Physical Therapy Evaluation and Services	(03)	Residential Services for Clients with Intellectual and Developmental Disabilities
(04)	Physician Services	(04)	Home Stabilization Services
(05)	Care Management Services		
(06)	Family Planning Services		

MMP Medicaid Benefits		
(a) In-Plan		***(b) Out-of-Plan***
(07)	Prescription Drugs	
(08)	Non-Prescription Drugs	
(09)	Laboratory Services	
(10)	Radiology Services	
(11)	Diagnostic Services	
(12)	Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient	
(13)	Home Health Services	
(14)	Home Care Services	
(15)	Emergency Room Service and Emergency Transportation Services	
(16)	Nursing Home Care and Skilled Nursing Facility Care	
(17)	Services of Other Practitioners	
(18)	Podiatry Services	
(19)	Optometry Services	
(20)	Oral Health	
(21)	Hospice Services	
(22)	Crossover Claims	
(23)	Durable Medical Equipment	
(24)	Adult Day Health	
(25)	Nutrition Services	
(26)	Group/Individual Education Programs	
(27)	Interpreter Services	
(28)	Transplant Services	
(29)	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those that are at High Risk for Acquiring HIV	
(30)	AIDS Medical Case Management	
(31)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court	
(32)	Court-ordered Mental Health and Substance Abuse Treatment – Civil Court	
(33)	Preventive Services, including: • Homemaker • Minor Environmental Modifications • Physical Therapy Evaluation and Services • Respite	
(34)	Long Term Services and Supports, including: • Homemaker • Environmental Modifications (Home Accessibility Adaptations) • Special Medical Equipment (Minor Assistive Devices)	

MMP Medicaid Benefits		
(a) In-Plan		***(b) Out-of-Plan***
	• Meals on Wheels (Home Delivered Meals) • Personal Emergency Response (PERS) • Skilled Nursing Services (LPN Services) • Community Transition Services • Residential Supports • Day Supports • Supported Employment • RIte @ Home (Supported Living Arrangements-Shared Living)* • Private Duty Nursing • Supports for Consumer Direction (Supports Facilitation) • Participant Directed Goods and Services • Financial Management Services (Fiscal Intermediary) • Senior Companion (Adult Companion Services) • Assisted Living • Personal Care Assistance Services • Respite • Rehabilitation Services	
(35)	Opioid Treatment Provider Health Home	

1475.42 to 1475.49 Reserved

1475.50 Prescriptions: Generic Policy

For RHP, RHO, and MMP enrolled members, Medicaid prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

(a) Availability of suitable within-class generic substitutes or out-of-class alternatives.

(b) Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

(c) Relative disruptions in care that may be brought on by changing treatment from one drug to another.

(d) Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

(e) Relative clinical advantages and disadvantages of drugs within a therapeutic class.

(f) Cost differentials between brand and generic alternatives.

(g) Drugs that are required under federal and State regulations.

(h) Demonstrated medical necessity and lack of efficacy on a case by case basis.

For the MMP, the generic policy applies only to Medicaid covered drugs that are not part of the Medicare Part D formulary covered by the MMP. The MMP may cover brand name drugs as part of its Medicare Part D formulary.

1475.51 Home Stabilization Services Policy

Home stabilization services are available for beneficiaries eligible for enrollment in RHP, RHO, or an MMP as follows:

A. No LTSS Eligibility

Home stabilization services are available for RHP, RHO, and MMP-eligible beneficiaries who are homeless or at-risk for homelessness or transitioning to the community from institutional settings *and do not qualify for such services through any other federally-funded program administered by the State*. Home stabilization services encompass a broad range of time limited tenancy support services assisting with home find, tenancy and lease compliance, living and household management, entitlement assistance and financial counseling to health and wellness. To qualify for home stabilization services, EOHHS or the agency's authorized representative must determine that beneficiaries meet the following criteria:

(a) Beneficiary is considered homeless or at-risk of homelessness according to the HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009;

(b) Beneficiary has history of homelessness as defined by HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009; or

(c) Ability of the beneficiary to retain current housing situation is jeopardized because non-payment of rent, unsafe living conditions, or repeated episodes of conflict in the housing community as substantiated by a housing or licensed health care provider; and

(d) Beneficiary is not receiving Medicaid-funded home stabilization services through a program administered by the State such as the Assertive Community Treatment (ACT) team operating under the auspices of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

B. LTSS Eligible

Access to home stabilization services for LTSS beneficiaries is provided in accordance with the applicable provisions set forth in MCAR Section 1500, related to available services and supports.

1475.52 Non-Emergency Transportation Policy

Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of the medical provider does not permit the use of bus transportation, non-emergency transportation for the Medicaid enrollee may be arranged for by EOHHS, or its agent, in accordance with the provisions established in MCAR Section 1360.

1475.53 Interpretation Services Policy

EOHHS will notify the health plan when it knows of members who do not speak English as a primary language who have either selected or been assigned to the plan. If more than fifty (50) members speak a single language, the RHP or RHO health plan must make available general written materials, such as its member handbook, in that language. If more than five percent (5%) or fifty (50) members, whichever is less, speak a single language, the MMP must make available general written materials, such as its member handbook, in that language. Interpreter services, including sign language interpreters, are covered for any RHP, RHO, or MMP member who speaks a non-English language as a primary language or who is deaf or hard of hearing.

1475.54 Tracking, Follow-up, Outreach

Tracking, follow-up, and outreach services are provided by the health plan in association with an initial visit with the member's PCP, preventive visits and prenatal visits, referrals that result from preventive visits, and preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve language, transportation, and other barriers to care.

1475.55 Mainstreaming/Selective Contracting

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of RHP, RHO, and MMP. The MCO therefore must ensure that all of its network providers accept its members for treatment. The MCO also shall accept responsibility for ensuring that network providers do not intentionally segregate RHP, RHO, and MMP members in any way from other persons receiving services. MCOs may develop selective contracting arrangements with certain providers for the purpose of cost containment, but shall adhere to the access standards as defined in the MCO contracts.

1475.56 to 1475.69 Reserved

1475.70 Program of All-Inclusive Care for the Elderly (PACE)

A. Overview

PACE provides a managed plan of coordinated Medicare and Medicaid covered services from across the care continuum to certain beneficiaries age fifty-five (55) and older. The operations of PACE are bound by a three-way agreement between EOHHS, CMS, and the PACE provider to integrate the full range of Medicare (if eligible) and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) for PACE participants.

B. EOHHS Responsibilities

EOHHS is responsible for the eligibility and enrollment functions set forth in MCAR Section 1475.25 (B), establishing PACE provider standards, and oversight and monitoring of all aspects of the PACE program.

C. PACE Provider Responsibilities

The PACE provider is responsible for:

- Point of entry identification;

- Submitting all necessary documentation for initial determinations and reevaluations of a level of need and referral to EOHHS for a determination of financial eligibility;
- Verifying PACE enrollment prior to service delivery;
- Verifying and collecting required beneficiary liability (cost-share amount);
- Providing and coordinating all integrated services;
- Reporting changes to the PACE-eligibility status of participants; and
- Adhering to all PACE provider requirements as outlined in the PACE Program Agreement between EOHHS and CMS, and to all credentialing standards required by EOHHS including data submission.

D. PACE Participation Criteria

To qualify as a Medicaid-eligible PACE participant, an individual must:

- Be fifty-five (55) years of age or older;
- Meet the criteria for a high or the highest need for a nursing facility level of care in accordance with MCAR Section 1500; and
- Meet all other financial and non-financial requirements for Medicaid LTSS such as, but not limited to, citizenship, residency, resources, income, and transfer of assets.

Medicaid-eligible PACE participants may be, but are not required to be, enrolled in Medicare.

E. PACE Disenrollment

(1) **Reasons for PACE Disenrollment** – Reasons for disenrollment from PACE include but are not limited to:

- Death;
- Loss of Medicaid eligibility;
- Eligibility error;
- Placement in an out-of-state residential hospital;
- Incarceration;
- Change of state residence;
- Loss of functional level of care; and
- Voluntary opt-out to Medicaid FFS.

The PACE provider may also request in writing that a member be disenrolled on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members. In such instances, EOHHS will notify the PACE provider about its decision to approve or disapprove the disenrollment request within fifteen (15) days from the date EOHHS has received all information needed for a decision. Upon EOHHS approval of the disenrollment request, the PACE provider must, within three (3) business days, forward copies of a completed Disenrollment Request Form to EOHHS and to the Medicare enrollment agency (when appropriate). The PACE provider must also send written notification to the member that includes:

- A statement that the PACE provider intends to disenroll the member;
- The reason(s) for the intended disenrollment; and

- A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

(2) **Disenrollment Requests Not Allowed**. EOHHS does not permit disenrollment requests based on:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

(3) **Voluntary Disenrollment** – PACE participants may voluntarily disenroll from PACE at any time. A voluntary disenrollment from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

(4) **Disenrollment Process.** Regardless of the reason for disenrollment, EOHHS is responsible for completing all disenrollment actions. Disenrollments requested by the PACE provider on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members are subject to EOHHS approval. Beneficiaries who are disenrolled from PACE but retain Medicaid eligibility will be enrolled in Medicaid fee-for-service and may subsequently choose or be enrolled in an alternative service delivery if they qualify. Beneficiaries have the right to appeal EOHHS's disenrollment action (see MCAR Section 0110).

(5) **Disenrollment Effective Date.** Regardless of the reason for disenrollment, all disenrollments from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

F. Disenrollment Appeal – If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the disenrollment shall be delayed until the appeal is resolved.

G. Re-enrollment and Transition Out of PACE – All re-enrollments will be treated as new enrollments except when a participant re-enrolls within two months after losing Medicaid eligibility. In this situation, the participant's re-enrollment will not be treated as a new enrollment. The PACE provider shall assist participants whose enrollment ceased for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participant's new service providers, and (if applicable), by working with EOHHS to reinstate the participant's benefits.

1475.71 PACE Benefit Package

CMS and EOHHS approve PACE providers who are responsible for providing the full scope of Medicare (if eligible) and Medicaid State Plan and waiver services, including but not limited to:

- Multidisciplinary assessment and treatment planning;
- Case Management services;
- Personal Care;
- Homemaking;
- Rehabilitation;
- Social Work;
- Transportation;

- Nutritional Counseling;
- Recreational Therapy;
- Minor Home Modifications; and
- Specialized Medical Equipment and Supplies.

The PACE program is voluntary for any eligible person, but if an individual selects this program, he/she must get all medical and support services through PACE. There are no benefits outside of the PACE program.

1475.72 to 1475.79 Reserved

1475.80 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

July 21, 2016
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