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Medicaid Code of Administrative Rules, Section 210-RICR-50-00-6, "Financial Eligibility for Medicaid LTSS"
Response to Comments Received as of October 24, 2018

	Respondent	Nature of the Comments	EOHHS' Response
	Mark Heffner. Letter received 10/16/2018	The proposed rule changes current DHS policy and did so in a manner purposely intended to divert attention from the change.	The commenter contends that the crosswalk provided by the State is purposely misleading and does not accurately show the connection between the rule now in effect and the proposed rule on the return of assets. Section 0384.35, titled "Exceptions to a Period of Ineligibility", establishes the circumstances in which a transfer does not result in a penalty. The crosswalk directs the reader to §50-00-6.6.1 E (3), pertaining to the imposition of penalties in special circumstances. The appropriate reference in the new rule is §50-00-6.6 B (1), which pertains to "Allowed Transfers". The crosswalk mistakenly shows section 0348.10, titled "Individuals Ineligible for Nursing Facility Payment", as being the section that corresponds to §50-00-6.6 B (1). Although sections 0348.10 and 0348.35 contain similar provisions, the State understands the commenters confusion and concern over intent given the nature of the issue at hand. Note, however, §50-00-6.6 B (1) is identified as being related to ineligibility due to transfers and is included in the penalty section of the crosswalk. The crosswalk prepared by the State is not a formal document included as part of the rule-making process. It was prepared as a guide to assist readers in tracking changes across several different rules and was distributed for that purpose only. Nonetheless, the crosswalk is being revised to direct readers to the specific corresponding sections so there is no further confusion. An updated version has been provided to assist in reviewing the revised proposed rule.
	Heffner and NAELA letter (3)	The rule changes current State policy on the partial	1. The section of the rule now in effect that the commenter indicates permits partial transfers does not establish a policy in the area. When

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		return of assets.	read in context, 0384.35, titled "Exceptions to a Period of Ineligibility", states only that a penalty period is not imposed if the "asset is returned to the individual". A plain reading of the provision in the context of the other exceptions listed in that section indicates that it addresses the treatment of a transfer that is **not** subject to a penalty. The return of an asset in full essentially nullifies the disqualifying transfer and treats it as if it never occurred. Section 0348.35's silence on the treatment of partial returns has been used to justify, "*de facto",* the current practice in which they have been allowed. The State does not have a formal written policy on the partial return of assets and the provision in question in the proposed rule was not meant to establish one. 2. The specific provision in the proposed rule of concern at §50-00-6.6.B (1)(f) was not intended to address partial transfers. This becomes clear if read in the context of the subpart, which specifically identifies "allowed transfers" that are "permissible in most circumstances" and therefore exempt from a penalty. However, paragraph (f), as written in the proposed draft, has a noticeable missing fragment that may have led to the assumption that it prohibits partial returns. The expressed purpose of the provision was, and remains, to establish the conditions for a disqualifying transfer to be nullified, as set forth in the Social Security Program Operations Manual (POMS) at SI 01150.124 (http://policy.ssa.gov/poms.nsf/lnx/0501150124). The provision was added to clarify the circumstances in which the uncompensated value of disqualifying asset does not have to be re-evaluated by the State. If an asset is returned in full in the same month of a transfer, it is presumed to have the same FMV. If an asset is returned in a subsequent month, the process differs irrespective of whether the asset is returned in part or full. Federal guidance provided directly from our CMS partners and in POMS indicate clearly that the State must re-evaluate the uncompensated value

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			of the asset (FMV when transferred v. FMV when returned) when assessing the impact of on a period of eligibility of a return in a subsequent month. Section §50-00-6.6 B (1)(f) has been revised to restore the missing fragment and clarify its intent. The issue of whether partial transfers are allowed or prohibited is not addressed. 3. The commenter also takes issue with §50-00-6.6.1 F, which deals directly with the expungement of a penalty. Again, the intent in this provision was not to prevent partial asset returns. Federal guidance from CMS provided to us on this point focused on the date expungement takes effect rather than the portion of the asset returned. We were advised to add the provision subsequent to the issuance of guidance by CMS on the CSRA and penalty start dates for HCBS recipients. The provision refers only to expungement of an asset in its entirety because a partial return may not fully cure a penalty. (Expungement would only occur if the penalty days served are sufficient to cover the remainder of the disqualifying transfer.) In short, federal guidance does not speak to expungement of a penalty period for partial transfers and neither does the proposed rule in this section. Changes have been made to the language of this particular provision to ensure that it cannot be misinterpreted as a prohibition on partial asset returns. The State is open to removing this provision in its entirety if the change in language does not ameliorate concerns. 4. In discussing asset returns with CMS and reviewing applicable sections of POMS in this area, the State was advised that a redetermination of financial eligibility is required if an asset is returned prior to the end date of the penalty. Although this requirement is not included in the propose rule, the guidance below speaks to both the asset return and expungement issues:

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			"States should be aware that imposition of a penalty period for new applicants for Medicaid requires a denial notice. To commence a penalty period, a Medicaid application must be filed followed by a denial notice which states 1) the length of the applicable penalty period, and 2) the date on which Medicaid will begin paying for services. Under this scenario, it is not necessary to file a second Medicaid application as the denial notice itself also serves as the acceptance for benefits to begin at a later date. Further proof will be necessary at the time services are to begin that assets are below the resource allowance and showing how the money was spent during the penalty period. If a portion of the penalty period is "cured" through a partial return of funds, then a re-determination would become necessary in order to seek Medicaid services at an earlier date than that specified in the denial notice." The State will keep interested parties informed of rule and procedural changes in this area as they develop to ensure compliance with federal guidance.
	Heffner letter and NAELA letter of October 17, 2018	Question pertaining to the authority of EOHHS to adopt LTSS financial eligibility rules that deviate from State DHS establishing state policy	1.Since 2011, the EOHHS has been designated as the single state agency for Medicaid in both RI statute (§42-7.2-2(6)). As the Medicaid single state agency, EOHHS is responsible for administering the Medicaid program and establishing rules, regulations, policies and procedures related to program operations (see 42 CFR §431.10). The EOHHS has delegated to DHS in an interagency service agreement the responsibility to determine Medicaid eligibility in accordance with these rules, regulations, policies and procedures. Therefore, DHS serves as the EOHHS' agent on policy matters related to eligibility and has no formal policy making authority in this area on its own. 2. Section 1 of Article 13 of the SFY 2019 RI State budget amends §40-8-15(2)(i) to authorize EOHHS to: *(2) Apply the provisions required under §§ 1902(a)(18) and 1917(c) of the Act*

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			pertaining to the disposition of assets for less than fair-market value by applicants and beneficiaries for Medicaid long-term services and supports and their spouses, without regard to whether they are subject to or exempted from resources and asset tests as mandated by federal guidance; and (3) Pursue any state plan or waiver amendments from the U.S. Centers for Medicare and Medicaid Services and promulgate such rules, regulations, and procedures he or she deems necessary to carry out the requirements set forth herein and ensure the state plan and Medicaid policy conform and comply with applicable provisions of Title XIX. This same authority is confirmed in Section 7 (d) of Article13, which says in part: [*T]he Executive Office proposes to adopt new or amended rules, policies, and procedures for LTSS applicants and beneficiaries, inclusive of those eligible pursuant to §40-8.12, that conform to federal guidelines related to the transfer of assets for less than fair market value established in Title XIX and applicable federal guidelines. State plan amendments are required to comply fully with these mandates.* 3. Federal law and regulations do not address the partial return of an asset. As indicated below, CMS guidance on this issue clearly indicates that states have the discretion to determine whether to recognize or disregard a partial return of an asset. (See page 3 of McGreal letter attached.) 4. Again, the State does not have a formal written policy (rule or law) that pertains to the partial return of an asset. What is referred to as "DHS policy" by the commenter is a business "practice" that evolved due to the absence of a formal written policy. 5.Federal regulations pertaining to the single state agency's duties and guidance issued from CMS on the implementation of the DRA since its enactment require that the State adopt regulations, rules, and/or procedures and a complementary State Plan Amendment that establish policy related to transfer of assets, including in those areas where the

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			State has discretion. The EOHHS believes that establishing a rule and accompanying State Plan Amendment related to the treatment of partial returns is necessary to comply with this policy. EOHHS is confident that it has sufficient authority under State and federal law and regulations to adopt a policy related to partial asset returns by rule. Given the limited timeline and thus opportunity for public input in the preparation of the proposed rule, the leadership has elected not to establish a formal policy at this time. The proposed rule therefore has remained silent. However, the EOHHS plans to initiate rule making that addresses partial asset returns and other areas in which the DRA provides the states with discretion in the months ahead.
	NAELA letter	Failure to disclose change in policy	The EOHHS has been transparent with the adoption of the revised and reformatted LTSS rules through the entire process. We have held both informal community meetings at our own initiative and upon request. In addition, the core elements of the LTSS determination process – including policy on LTSS Medically needy eligibility – where established in §50-00-1, which took effect on 7/15/2018. (See https://rules.sos.ri.gov/regulations/part/210-50-00-1)
	NAELA letter	Failure to disclose adoption of Section 210-RICR-40-00-3.	1. Section 210-RICR-40-00-3 applies to all populations whose eligibility is determined using the SSI methodology. Since Title XIX was enacted, eligibility has been tied to federal public assistance programs – SSI for elders and adults with disabilities and AFDC for children and families. Since 2014, the AFDC related provisions have been replaced with the Modified Adjusted Gross Income (MAGI) standard and method established under the federal Affordable Care Act (ACA) of 2010. Under RI rules, coverage groups subject to the MAGI have been referred to the Medicaid Affordable Care Coverage (MACC) groups; the relevant provisions for the MACC groups are in Chapter 3 in the new code.

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			2. Prior to 2014 and the adoption of the amended APA and the subsequent implementation of the Office of Regulatory Review's (ORR) regulation guidelines, the rules governing the application of the SSI method were repeated, virtually verbatim, in the sections pertaining to each of the Integrated Health Care Coverage Groups (IHCC). The IHCC category includes all non-MAGI eligibility pathways for adults (sometimes called complex Medicaid): non-LTSS Community Medicaid for low income elders and adults with disabilities, Medicaid LTSS, SSI protected status groups, medically needy eligibility and the Medicare premium payment program. To avoid confusion and streamline the rules on SSI financial eligibility, these rules were consolidated into a single chapter through the formal rule-making process and noticed and adopted twice: once in 2015 and once in 2016 as Chapter 1400 in the old rule format. The rule was amended and adopted again early in 2017 when changes were made to the income and resource tables. Earlier this year, the rule was reformatted and repromulgated, again through the formal rule-making process in 3/2018. In short, the SSI financial eligibility rules have been open for public comment on multiple occasions during the just over two years they have been in effect. 3. The eligibility coverage groups subject to the SSI methodology are identified in the State's current waiver under section V, Tables 1 through 3 and include Budget Populations #1 and #2 (SSI beneficiaries, categorically needy low income elders and adults with disabilities with income up to 300% of the SSI level, and medically needy children, parents, adults with disabilities and elders with income above the applicable limits for each coverage group; Budget Population #4, Katie Becket children eligible under federal TEFRA; and Budget Populations #13 through #15, waiver and medically needy eligible HCBS for elders and adults with disabilities.) [1]2. The separation of coverage groups by

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			financial eligibility requirements is consistent with federal law and regulations, state law, RI's Section 1115 waiver. Citations are available upon request. 4. Under federal law, the State is prohibited from using financial eligibility criteria for determining eligibility for the IHCC groups that are more restrictive than those used to determine SSI by SSA. (See RI Section 1115 waiver, section 5, paragraph 23). The provisions in §40-00-3 are consistent with this requirement. The only changes that were made when the rule was initially promulgated were to: (1) bring several requirements into alignment with the SSI regs; and (2) use the State's discretion to liberalize certain requirements (e.g., life insurance and burial contracts) in response to State Plan and/or waiver changes and public comment. 6. The SSI methodology for evaluating countable income and resources has not fundamentally changed since 2004, except in the areas noted. The commenter's concern, therefore, appears to be less with the application of these rules to the determination of financial eligibility and more to do with their implications for CSRA. 7. CSRA is separate from the determination of financial eligibility. There are areas in which the SSI regs and accompanying guidance in POMS are silent as to the application of standing provisions for CSRA – e.g., retirement funds. To the extent that the State has established a policy on these areas, the provisions in §40-00-3 and §50-00-6 are cross referenced. 8. The State has chosen to remain silent on the application of the SSI financial eligibility requirements for CSRA in several areas of the proposed rule until such time as the agency reaches a policy decision. Until that time, current practices are expected to continue providing they are consistent with the relevant provisions in §40-00-3 and §50-00-6.

1 http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/1115Waiver/RhodeIsland_Approved_STCs_FINAL4.25.18.pdf

	Respondent	Nature of the Comments	EOHHS' Response
			9. The Section 1115 waiver and the State Plan must only be amended when the State is seeking to change or add new federal authorities. For example, the State chose to eliminate the limitations in the scope of Medicaid coverage for medically needy beneficiaries in 2012. This change required a State Plan Amendment and, subsequent to the SPA's approval, adoption of the higher medically needy limits on resources across all coverage categories. No such changes are included in the proposed rule. In any case, the EOHHS has been authorized to pursue any waiver or State Plan Amendments required to assure compliance with applicable federal laws, regulations and guidance. Chapter 40 revisions are consistent with this authority.
	NAELA letter (4) Peter Hainley Letter 10/24/2018 (1)	The definition of the point of continuing institutionalization (POCI when determining the community resource allowance (CSRA) requires clarification	§50-00-6.5.2 B (1) has been revised a second time to eliminate the reference to LTSS and to incorporate suggested language that clarifies the meaning of the POCI for institutional care for the purposes of a CSRA. As noted previously, for eligibility purposes, the applicable rule is in §50-00-1.7. Note that the applicable provision in 42 USC 1396r-5 (g) defines institutionalized spouse as an individual who: (A) "is in a medical institution or nursing facility or who otherwise, on the basis of a reduction of income based on the costs for medical or remedial care is eligible for [HCBS] and is (B) married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days. The definition of an institution for Medicaid purposes is very specific and no longer refers as a matter of policy to "institutionalization.[2] Note that the focus on LTSS in CMS documents is entirely consistent with the State's understanding of the term.
	NAELA letter (4)	The POCI date for HCBS is	The State has revised the definition in the proposed rule to correspond to

2 See https://www.medicaid.gov/medicaid/ltss/institutional/index.html

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	Peter Hainley Letter 10/24/2018 (2)	unclear and needs further explanation.	recent guidance issued by CMS.[3]
	NAELA Letter (1) Peter Hainley email Peter Hainley Letter 10/24/2018 letter (3)	LTSS Medically Needy rules and requirements are out of synch and will limit eligibility.	1. The commenter makes note of the fact that several facets of the State rules and requirements with respect to LTSS medically needy are out of alignment and that changes now in effect will impact eligibility. The State was advised by CMS that LTSS medically needy requirements, policies, procedures and practices were significantly out of compliance with federal regulations and guidance in this area. The State was advised both verbally and in writing that failure to bring LTSS medically eligibility into compliance as soon as possible would result in the loss of federal matching funds. 2. The State's authority to bring requirements, policy, procedures into compliance is firmly established in the SFY 2019 budget article cited above. Waiver authority was not required. The State Plan section pertaining to LTSS medically needy eligibility is consistent with the new rule. The old rule has been repealed as it was out of compliance with federal regulations and the State Plan. 3. The LTSS Medically Needy eligibility requirements were established first and clearly at §50-00-1.9; the specific issue of concern, the cap on income eligibility is set forth in §1.9 A (2) (b) (5). In addition, the EOHHS held two community meetings on the LTSS medically needy rule before it was posted for comment. One of these meetings was for the members of the estate attorneys group. The State did not receive any public comments or a request for a hearing on §50-00-2. 4. One point of confusion and concern appears to be the State's use of the terms "cost of care" and "excess income". Both are terms of art for Medicaid eligibility purposes. Under federal regulations, the cost of care

3 See https://www.medicaid.gov/federal-policy-guidance/downloads/smd18004.pdf

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			for an institutional setting is the average private pay rate established in the institutional cost comparison not the amount the applicant is paying for care. Anyone who has countable income above the average private rate for the institutional level of care they are seeking is ineligible for Medicaid, no matter how high their monthly expenses. This is federal policy to ensure equity and fairness in access to Medicaid coverage. "Excess income" is used to describe anyone who has countable income above the categorically needy limit of 300% of the SSI level; it does not mean the difference between that limit and the spenddown in this context. To address both these issues, the State has made clarifications in all three rules: the LTSS medically needy rule already in effect and the two proposed rules. As the amendments to the LTSS medically needy rule are technical corrections we will file accordingly so the changes in all three rules take effect at the same time. 5. A second point of contention is the allowable expenses accepted for a spenddown. In accordance with prevailing federal regulations, the State average reimbursement rate is the maximum allowed. As we indicated in our meeting with the estate attorneys, this change will NOT affect LTSS medically needy beneficiaries who are subject to the post eligibility treatment of income (PETI). The PETI process determines beneficiary liability for the cost of care and is required for anyone receiving Medicaid LTSS coverage. As a person in a penalty is not eligible to receive Medicaid LTSS coverage, they are not subject to this process and must spenddown to the medically needy eligibility limit with allowable expenses each month. However, a person in a penalty is not required in any way to enroll as LTSS medically needy. The past practice of requiring a person in a penalty to enroll for non-LTSS Medicaid is a convention that appears to be tied to a misinterpretation of the meaning of "otherwise eligible." CMS has made it clear verbally and in writing that

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			otherwise eligible means the date a person with a disqualifying transfer has met all other LTSS requirements and would be eligible for Medicaid LTSS were it not for the transfer. It is the date specified in our State Plan, federal regulations, and law as the date the penalty period begins. The LTSS medically need rule is in effect and both system and business practices will be fully aligned with all of the new provisions in March of 2019. §50-00-6.6.1 B (2) (2) has been amended to incorporate language recommended by one of the commenters. In addition, §50-00-2 will be amended to clarify in the definitions the meaning of cost of care. The EOHHS is prepared to provide a more in-depth training on LTSS medically needy eligibility upon request. .
	NAELA letter (5) Peter Hainley Letter 10/24/2018 (4)	Clarification for LTSS financial eligibility is necessary to explain the treatment of certain jointly owned financial instruments and holdings in which the co-owner does not cooperate.	§50-00-6.5.4 has been amended to incorporate federal regulations pertaining to this issue. The related sections in §40-00-3.5.5 A (2) (c) that specifically speak to the treatment of these instruments and holdings will be amended to add language from 0382 as well to avoid any confusion.
	Peter Hainley Letter 10/24/2018 (5)	Questions State's rationale for including section on allowable transfers and provision on expungement and requiring a re-evaluation of a returned asset.	1. Please see the State's response on partial transfers in response to the Heffner letter above on partial asset returns. 2. The section of the proposed rule pertaining to allowed transfers accurately reflects current State policy and practice and is consistent with CMS guidance on implementation of the DRA as well as the provisions in place in the majority of the states in the region, 3. Both written and verbal comments we received in response to the initial promulgation of §40-00-3 specifically requested that the State

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			include a section that sets forth the range of allowable transfers to assist applicants and beneficiaries in making decisions on their own, as most do not have or seek legal counsel. We agreed and are confident that the including this section is well within the EOHHS' scope of authority. 4. Both POMS and federal guidance, cited above, require that the State reassess the value of a returned asset. In instances in which the asset transferred is not cash, this is crucial. Example: Grandpa Joe transfers $90,000 worth of stocks to his grandson in January and applies for Medicaid in March. In May, his grandson returns all of the stocks, the FMV of which has decline appreciably and now have a FMV of only $30,000. The penalty is not cured in this instance, according to POMS, because the FMV of the asset returned does not equal the FMV of the asset at the time of the return. In short, when assets are returned in more than 30 days after the transfer, the State must redetermine eligibility before adjusting the penalty period as indicated in the guidance from Mr. Coffey above.
	NAELA letter (9) Peter Hainley Letter 10/24/2018 (6)	Provisions on retirements in §40-00-3 are confusing and inconsistent with provisions in 0382	The State has made amendments to clarify the retirement provision and ensure that it more closely mirrors the language in 0382 and the intent of SSI regulations. The treatment of retirement funds for the purposes of the CSRA….
	NAELA letter (10) Peter Hainley email Peter Hainley Letter 10/24/2018 (7)	The provisions on annuities in the proposed rule are not clear	A fragment was lost in the document conversion process. The rule has been restored and now accurately reflects federal regulations

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	NAELA letter (6) Peter Hainley Letter 10/24/2018 (8)	The proposed rule does not specify how long-term care insurance disbursements are treated for income eligibility.	The State has added a new provision to the Part 6.4 of the proposed rule to address this matter. As indicated therein at §50-00-6.4 G, disbursements made to pay for LTSS are excluded in the determination of countable income.
	NAELA letter Peter Hainley Letter 10/24/2018 (9)	§40-00-3.5.5 B pertaining to guardianship is inaccurate and should be replaced with 0384.35	
	NAELA letter (5) Peter Hainley Letter 10/24/2018 (10)	Provisions related to spousal refusal – as distinct from spousal estrangement -- from previous rule are missing.	The omission has been corrected to incorporate the rule now in effect. The amendment is located at §50-00-6.5.2 F (1) and (2). Additional amendments have been made to incorporate suggested language.
	Peter Hainley Letter 10/24/2018 (11)	There is confusion about language related to promissory notes, loans and mortgages.	The section in the proposed rule pertaining to mortgages, loans and promissory notes was derived from SSI regulations and was designed to address eligibility rather than CSRA determinations. To improve the clarity of the proposed rule, the State has made the recommended changes in language. Elements of the commenters concerns need further clarification.
	Peter Hainley Letter 10/24/2018 (12)	Clarification required as to the penalty divisor now in effect.	The system is currently programmed to use the divisor in the LTSS medically needy rule. The institutional cost comparison, which establishes the average private pay rate, is always used as the divisor even though the naming conventions in the old and propose rule differ. It is therefore in effect and should be used when determining the penalty period for disqualifying transfers. Bridges is using this number as the divisor as well.
	Peter Hainley	Treatment of education	Current SSI guidance provides the State with latitude to exclude these

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	Letter 10/24/2018 (13)	funds requires additional clarity.	funds entirely only for spouses and dependents. The provision in the proposed rule has been amended to correspond to this guidance and State policy and flexibility on the treatment of these funds across Medicaid eligibility categories.
	Peter Hainley Letter 10/24/2018 (14)	Question about the application of the burial space and fund exclusion.	An applicant may set aside funds for a burial space and have a prepaid irrevocable burial contract as long as the contract does not cover burial spaces. The value of the burial contract above the limit counts as a resource.
	Peter Hainley Letter 10/24/2018 (15)	The section on irrevocable trusts is not accurate and needs to be revised.	
	Peter Hainley email	The home equity limit in section 40-00-3.1.7 includes the federal minimum and maximum and therefore is confusing as to current state policy.	There was an error in transferring this information from the previous rule. §40-00-3.1.7(7)(e) has been corrected to show the current home equity limit in RI.
	Peter Hainley Letter 10/24/2018 (16)	Adverse action business practice is confusing and may make start dates for penalties in accurate	Sarah Harrigan is leading a work group to look into this issue. We will advise members of the group of the outcome
	Peter Hainley Letter 10/24/2018 (17) to (20)	The home equity limit in section 40-00-3.1.7 includes the federal minimum and maximum and therefore is confusing as to current state policy. In	There was an error in transferring this information from the previous rule. §40-00-3.1.7(7)(e) has been corrected to show the current home equity limit in RI. We have corrected all other remaining typos.

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		addition, there are several other typos that warrant correction.	