210-RICR-40-00-1

Title 210 - Executive Office of Health and Human Services

Chapter 40 Medicaid Integrated Health Care Coverage

SUBCHAPTER 00 – N/A

Part 1 – Overview of Medicaid Integrated Care Coverage

1.1 Overview of this Chapter

A. This chapter establishes the Medicaid "Integrated Health Care Coverage (IHCC)" groups for elders, adults with disabilities, and certain individuals who qualify as medically needy (MN) due to high health care expenses. In addition, sections of this chapter set forth the basic tenets of the SSI methodology for determining Medicaid eligibility in general and, specifically, for those applicants and beneficiaries seeking coverage through an IHCC Community Medicaid eligibility pathway. The term Community Medicaid refers hereinafter to anyone applying for or renewing eligibility for non-LTSS Medicaid health coverage as MN or through a pathway for elders and adults with disabilities on the basis of Supplemental Security Income (SSI), an SSI-related characteristic (that is, age, blindness or disabling impairment), or special requirements related to a particular characteristic, condition or circumstances. Community Medicaid also encompasses Medicare beneficiaries seeking financial assistance through the State's Medicare Premium Payment Program (MPPP). Although all the IHCC groups for MN and elders and adults with disabilities are described in this chapter – both Community Medicaid and LTSS, there are separate sections, as indicated below, that provide more in-depth provisions related to IHCC groups, as follows:

1. The Sherlock Plan provides an eligibility pathway for adults with disabilities who are working. Although referenced in this section as one of the IHCC groups subject to the SSI methodology, the Sherlock Plan is covered in detail in a separate section (MCAR, Section 1373) along with other eligibility opportunities for persons with disabilities who are working.

2. An overview of the LTSS coverage groups subject to the SSI methodology is included in this chapter to show areas of overlap in the application process and determination of financial eligibility.

3. Children and families in the IHCC category who are eligible on the basis of their participation in other programs – e.g., children in foster care or SSI-eligible -- are addressed in Section 210-RICR-30-00-2.

1.2 Authority

A. This chapter of rules entitled, "Medicaid Code of Administrative Rules: "Medicaid Integrated Health Care Coverage (IHCC)" is promulgated pursuant to the authority set forth in Rhode Island General Laws Chapters 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); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

1.3 Scope and Purpose

A. This section provides an overview of the IHCC groups included in this chapter. The rules governing the IHCC groups have been amended and revised as set forth herein to reflect programmatic changes resulting from the following State and federal Medicaid initiatives:

1. Extension of Rhode Island's Section 1115 demonstration waiver – In December 2013, the State's Section 1115 demonstration waiver was reauthorized and extended until 2018. The rules in this chapter implement Section 1115 waiver authorities that streamline and refine SSI-based eligibility determinations, enhance the availability of cost-effective primary care, and improve the integration of services and a wider range of supports across the care continuum.

2. ACA Implementation – The federal Affordable Care Act of 2010 mandated changes in the way states organize Medicaid coverage groups, the standards they use for determining income-based eligibility, and the application and renewal processes for all eligible populations. This chapter establishes administrative rules that implement ACA reforms related to eligibility and the application and renewal process for the IHCC groups to ensure they match those already in effect for MACC groups subject to the MAGI.

3. Integrated Eligibility System ---– "RI Bridges" is the State's new integrated health and human services eligibility system (IES) launched in September 2016. The State's IES provides the State with the system capacity to implement all programmatic changes required by the ACA and authorized under the Section 1115 waiver. In addition to automating most facets of the application, eligibility determination and enrollment processes, the State's IES also conducts a multi-tiered evaluation of eligibility that makes it possible to consider applicants for most forms of publicly financed health coverage and various other State-administered health and human services through a single application process.

1.4 Definitions

A. For the purposes of this chapter, the following definitions apply:

1. "Affordable Care Act (ACA)" means The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

2. "Applicant" means the person in the household who, if determined eligible, would qualify for Medicaid in one of the Integrated Health Care Coverage groups on the basis of the provisions set forth herein.

3. "Calendar quarter" means a period of three full calendar months beginning with January, April, July, or October.

4. "Community Medicaid" means the term used to refer to IHCC groups that are provided with Medicaid health coverage for essential primary care and limited preventive services in some circumstances, but does not include more than thirty (30) days of continuous LTSS.

5. "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.

6. “Dual Eligible Beneficiary” means a person who is enrolled in Medicaid and Medicare. The term includes elders and adults with disabilities who are enrolled in Medicare and receive Medicaid health coverage and/or financial assistance through the State’s Medicare Premium Payment Program (MPPP).

7. “Income Standard” means the maximum amount of countable income a person can have for Medicaid health coverage through an eligibility pathway or coverage group subsequent to all required exclusions, disregards, and deductions. Also referred to as the “income limit.”

8. “Long-Term Services and Supports (LTSS)" means a spectrum of services covered by the Rhode Island Medicaid program for persons with clinical and functional impairments and/or chronic illness that require the level of care typically provided in a health care institution. Medicaid LTSS includes skilled or custodial nursing facility care, therapeutic day services, and personal care as well as various home and community-based services. Medicaid beneficiaries eligible for LTSS are also provided with primary care essential benefits.

9. “Managed Care Arrangement (MCA)” means a system, often a managed care organization (MCO) that uses capitated financing to deliver high quality services and promote healthy 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. Section 210-RICR-40-10-1 identifies the Medicaid managed care arrangements that serve IHCC elders, adults with disabilities and beneficiaries requiring LTSS; Sections 1309 to 1314 pertain to managed Medicaid delivery systems for the MACC populations without regard to the basis for eligibility – MAGI, SSI, special requirements, etc.

10. “Medicaid Affordable Care Coverage (MACC) Groups” means the populations whose income eligibility for Medicaid is determined on the basis of the Modified Adjusted Gross Income (MAGI) standard. Includes children up to age 19, parents/caretakers, pregnant women, and otherwise ineligible adults 19 to 64 in accordance with the provisions established in Chapter 1300.

11. “Medicaid Code of Administrative Rules (MCAR)” means the collection of administrative rules governing the Medicaid program in Rhode Island.

12. “Primary Care Essential Benefits” means non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals. These essential benefits include, but are 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 visits, inpatient, home care, day care, etc.).

13. “Primary Care Provider” means a health care practitioner who is licensed as: (1) a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine and is responsible for monitoring a beneficiary’s overall health; or (2) a nurse practitioner, clinical nurse specialist, or physician assistant and, to the extent licensure allows, is responsible for, or collaborates with a physician, monitoring a beneficiary’s overall health.

14. “Resource Standard” means the maximum amount of resources a person can have for Medicaid health coverage through an eligibility pathway or coverage group subsequent to the application of all required exclusions. Also referred to as the “resource limit.”

15. “Wrap-around Coverage” means the Medicaid benefits provided to a beneficiary who has another form of health insurance – e.g., Medicare or commercial plan – that serves as the principal payer for his or her health care, but that does not cover those benefits.

1.5 IHCC Groups Subject to the SSI Methodology

A. On and after the effective date of this rule, the provisions of this chapter govern the following eligibility pathways that use the SSI methodology in whole or in part to determine eligibility for Medicaid benefits:

1. Elders and Adults with Disabilities (EAD) – Low-income elders who are sixty-five (65) and older and people living with disabilities who have income at or below one hundred percent (100%) of the Federal Poverty Limit (FPL) and resources at or under $4,000 for an individual or $6,000 for a couple.

2. Medically Needy (MN) – Elders, persons with disabilities, children, parents and caretakers of Medicaid-eligible children, and pregnant women who do not qualify for eligibility on the basis of income but have high health expenses and must spend or contribute income and/or resources above the applicable income eligibility standards to obtain or retain Medicaid eligibility. Section 210-RICR-40-05-01 pertains to the MN eligibility pathway for Community Medicaid.

3. Supplemental Security Income (SSI) Recipients – All persons receiving SSI cash assistance based on age or as an adult with a disability, as determined by the federal Social Security Administration (SSA). SSI recipients are automatically eligible for Medicaid on this basis and are not required to apply for Medicaid health coverage through the State. Program-specific provisions for SSI recipients twenty-one (21) and older are included in this chapter. The relevant provisions for Medicaid beneficiaries under 21 are located in the sections pertaining to coverage for children and families in Section 210-RICR-30-00-2.

4. State Supplement Payment (SSP) – Persons who qualify to receive the optional state-funded supplemental payment are automatically eligible for Medicaid health coverage under the Medicaid State Plan. This group includes beneficiaries eligible on the basis of SSI and EAD as well those with higher income who require Medicaid LTSS who meet the special living arrangement requirements for SSP set by the State.

5. SSI Protected Status Beneficiaries – This group – sometimes referred to “SSI- lookalikes” – includes persons who meet the age or disability criteria for SSI, but are -- or become -- ineligible for full SSI cash benefits or qualify for special treatment. To protect Medicaid health coverage for members of these coverage groups, federal law requires the application of special rules that confer or preserve Medicaid eligibility.

6. Medicaid Premium Payment Program (MPPP) for Medicare beneficiaries with income at or below 135% of the FPL. The MPPP provides financial help through Medicaid to assist in paying Medicare costs including premiums, deductibles, and coinsurance in amounts that vary depending on income and resources.

7. Sherlock Plan for Working Adults with Disabilities – The State’s program for working adults with disabilities. The Sherlock Plan provides Medicaid health coverage and/or services and supports to persons with disabilities who are working, and who otherwise meet the SSI disability criteria for Community Medicaid or, based on a functional and health status review, have the level of need required for Medicaid LTSS. As is set forth in greater detail in Section 1373, beneficiaries in this group may have countable income at or below two-hundred and fifty percent (250%) of the FPL and resources less than or equal to $10,000 individual and $20,000 for a couple.

8. IHCC Medicaid LTSS -- Consists of new applicants seeking Medicaid-funded LTSS and current IHCC group beneficiaries who develop a continuous need for the level of care typically provided in an institution (hospital, nursing facility, intermediate care facility for person with intellectual disabilities). Beneficiaries eligible in the MACC groups (see MCAR, Chapter 1300) who require LTSS are not subject to the SSI methodology; LTSS eligibility based on the SSI methodology and more generally is located in Section 210-RICR-50-00 and sections 0382 to 0384.

1.6 IHCC Special Coverage Groups

A. The IHCC category also includes members of the special coverage groups below who are subject to unique eligibility requirements waiving some or all facets of the SSI methodology due to specific conditions, circumstances or characteristics.

1. Low-income, uninsured women with breast or cervical cancer – Medicaid coverage group for uninsured women under age sixty-five (65) who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and are found to need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix.

2. Refugee Medicaid Assistance (RMA) – Federally mandated coverage group for individuals and families operating under the auspices of the U.S. Department of Health and Human Services, Office of Refugee Resettlement. Refugees who qualify for this program receive eight (8) months of Medicaid health coverage or commercial coverage with financial help through HSRI, depending on income. Eligibility is evaluated first using the MAGI methodology set forth in 210-RICR-30-00 and the SSI standards for Community Medicaid in Section 210-RICR-40-00-3. Only persons in this group who are ineligible for Medicaid or commercial plan with financial help and have income at or below 200 percent of the FPL may qualify for MN coverage under this chapter.

3. Emergency Medicaid – Medicaid health coverage available to non-citizens who have emergency health care needs who meet all the general and income requirements for coverage with the exception of immigration status.

1.7 The State's Integrated Eligibility System (IES)

A. With the implementation of the State's IES, all IHCC group members have the option of applying on-line, using a self-service portal, submitting a completed paper application, or in-person by visiting one of the field offices of the RI Department of Human Services (DHS). The IES also allows for the following important changes to the application and eligibility determination process:

1. Coverage Group Options – To maximize choice and ease of access, the State's IES evaluates all applicants for Medicaid health coverage using multiple eligibility pathways, within and across the major coverage group categories.

2. Streamlined Document Submission and Verification – The State's IES created the capacity for applicants and beneficiaries to upload important documents and verification materials on-line as well through more traditional means. The State is also building into the system access to a broader array of electronic data sources for verifying and updating critical eligibility information related to income and assets.

3. Modified Passive Eligibility Renewal – The eligibility renewal process for IHCC group members has been reformed to ease the burden on beneficiaries. The State's new passive renewal process requires beneficiaries to review the eligibility information in their accounts, including updates through electronic data sources, and notify the agency within a specified time period of any changes or discrepancies that may affect the continuation

of coverage. The renewal process and variations across coverage groups are set forth in Section 210-RICR-40-00-2.

1.8 Medicaid Benefits

A. The benefits that members of the IHCC groups receive are dictated by the Medicaid State Plan and the State's Section 1115 demonstration waiver. Medicaid benefits include health care services and supports or, if a beneficiary has third party coverage such as Medicare, wrap-around coverage and/or financial assistance in paying premiums, co-pays, and cost-sharing.

1. Premium Assistance/and Financial Help – Dual Medicare and Medicaid beneficiaries, including those participating in the MPPP may receive full Medicaid health coverage and/or financial help paying for Medicare. The scope of benefits dual eligible beneficiaries receive depends on their income and resources. Premium assistance is also available for some Community Medicaid beneficiaries who have access to employer-sponsored insurance through the RIte Share Premium Assistance Program as set forth in Section 210-RICR-30-00-1.

2. Health Care Services and Supports – The scope of services and supports beneficiaries receive varies as follows:

   a. Community Medicaid. Beneficiaries eligible for health coverage receive the full scope of primary care essential benefits – including acute, subacute and rehabilitative services – as well as thirty (30) days of LTSS and, based on need, a limited set of LTSS preventive services. Section 210-RICR-40-00-2 identifies the scope of covered services available through the managed care and fee-for-service delivery options for IHCC group beneficiaries eligible for full Medicaid benefits. Note:

      (1) The Medicaid benefits MPPP participants are eligible to receive may be limited to premium payment assistance only, depending on the basis of eligibility. See Section 210-RICR-40-00-1.

      (2) For the scope of services covered under the Sherlock Plan, see Section 210-RICR-40-00-3.

   b. Medicaid LTSS. Medicaid LTSS includes health supports, personal care, and social services in an institutional or home and community-based setting. The scope of Medicaid LTSS a beneficiary receives is based on need -- health status and functional ability -- and personal health preferences and goals. Persons eligible for Medicaid LTSS also receive the full scope of primary care essential benefits authorized under the Medicaid State Plan. To be eligible for Medicaid LTSS, a person must meet a specific set of financial and clinical criteria that do not apply to applicants seeking coverage through other Medicaid eligibility pathways.

3. Integrated Care -- The State's Integrated Care Initiative (ICI) provides IHCC group members who have Medicare and other forms of third-party coverage who qualify for LTSS in accordance with the provisions set forth in Section 210-RICR-50-00-2 to obtain the coordinated services they need across the care continuum through a single plan. Section 210-RICR-40-10-1 covers these options and the process for plan selection and enrollment.

4. Retroactive Eligibility – Up to three (3) months of Medicaid retroactive coverage is available for certain IHCC group beneficiaries. To qualify, the State must determine that a person would have met the applicable eligibility criteria for his or her coverage group if

the application was submitted during the retroactive period. The State provides reimbursement to providers only for Medicaid covered services, however. The provisions in Section 210-RICR-40-00-2 explain the process for obtaining retroactive coverage in greater detail.

1.9 Service Delivery Options

A. The service delivery options for IHCC group members are dictated in large part by type of Medicaid health coverage and eligibility pathway. Section 210-RICR-40-10-1.

B.

Overview IHCC Group Service Delivery	
Eligibility Pathway	Service Delivery Option
SSI, EAD with no Medicare	Rhody Health Partners
SSI, EAD with Medicare	Rhody Health Options, PACE, Fee-for- Service (FFS) w/Community Health Team, or FFS-only
LTSS No Medicare	Same as above
LTSS with Medicare	Rhody Health Options, Medicare-Medicaid Plan II, PACE
Sherlock Plan – EAD and LTSS	FFS
Medically Needy – non-LTSS	FFS

210-RICR-40-00-2

Title 210 - Executive Office of Health and Human Services

Chapter 40 Medicaid Integrated Health Care Coverage

SUBCHAPTER 00 – N/A

Part 2 – Application and Renewal Process for IHCC Groups

2.1 SCOPE AND PURPOSE

A. In September 2016, the State implemented its new integrated eligibility system (IES) which has the capacity to cross-walk with the State's health insurance marketplace, HealthsourceRI.gov (HSRI) and, through a single application process, evaluate eligibility for publicly financed health coverage and needs-based programs administered by DHS and other EOHHS agencies. This section focuses on the application and renewal processes that have been established in conjunction with the implementation of the IES.

2.2 ACCESS POINTS

A. The State is committed to pursuing a "No Wrong Door" policy that offers consumers multiple application and renewal access points which all lead to the State's IES.

1. Self-Service – Persons seeking initial or continuing eligibility have the option of accessing the eligibility system 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 self-service portal. The information applicants provide on-line is entered directly into the eligibility system and processed electronically in real-time. For these reasons, the Medicaid agency encourages all new applicants to select the self-service portal option and complete and submit the application electronically whenever feasible.

2. Assisted Service – Applicants and beneficiaries may also apply on paper and submit forms via mail, fax, or e-mail or deliver in person to DHS field offices. Agency eligibility specialists are available to provide help, as are HSRI representatives and various certified assisters located at community agencies. Applications that are completed on paper are scanned into the IES agency portal.

3. 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, by telephone, or in person at any DHS field office. Information provided on the paper application is directly scanned or entered into the eligibility system through an agency portal by eligibility or LTSS specialists on the applicant's behalf.

2.3 Application and Renewal Assistance

A. The State provides application and renewal assistance through eligibility specialists in the DHS field offices and HSRI Contact Center and trained assisters, certified in accordance with 42 CFR 435.908. This assistance must be provided in a manner that is accessible to persons with disabilities and those who have limited English proficiency. Information on obtaining application/renewal assistance is available by calling 855-MYRIDHS (1-855-697-4347) as well as

on-line through the DHS, HSRI and EOHHS websites using the links specified in this section. In addition, eligibility specialists and certified assisters are responsible for upholding the following rights of current and perspective Medicaid beneficiaries:

1. Eligibility and Renewal Help – Including help provided by DHS, EOHHS, and HSRI eligibility specialists and certified assisters in completing all necessary forms, obtaining and submitting required documentation, and responding to inquiries or requests for information. Assisters may provide help or act on behalf of the applicant or beneficiary in dealing with agency representatives, but are not permitted to make determinations of eligibility.

2. Translation Services – An interpreter or translator is available to assist in the application process upon request.

3. Protection of Privacy -- All information applicants provide is kept confidential unless the agency is otherwise authorized to share with other state and federal agencies for the purposes of verification and enrollment.

4. Timely Determinations – Eligibility determinations, including providing a notice of the agency's decision, must be made in accordance with the timelines indicated in subsection 210-RICR-40-00-2.4(A)(8) below.

5. Appeals - The agency accepts appeals and holds hearings on actions related to eligibility decisions in accordance with MCAR, Section 0110 or any successor regulation.

6. Non-discrimination –Applicants are treated in a manner that is free from discrimination on the basis of race, color, national origin, sex, gender identity or sexual orientation, age or disability.

2.4 Completing and Submitting the Application

A. In general, the process of completing and submitting an application proceeds in accordance with the following:

1. Account Creation – To initiate the application process, a person must create a login and establish an account in the eligibility system. This can be done through the self-service portal by the person alone or with the help of an eligibility specialist or certified assister.

    a. Identity proofing. The applicant must provide personally identifiable information for the purpose of creating an on-line account as a form of identify proofing during the process of applying for Medicaid. Verification of this information is automated. 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, or to a DHS Office.

    b. Account matches. Once identity is verified, account matches are conducted to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits.

2. Account Duration – An application account is open for a period of ninety (90) days. 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.

3. Application Materials – The application materials a person seeking Medicaid coverage must have on hand may vary depending on the application processing flow:

   a. MAGI-based eligibility. As indicated in Section 210-RICR-40-00-2.6.2 applicants who are under sixty-five (65) are generally evaluated first for eligibility in one of the Medicaid Affordable Care Coverage (MACC) groups before being considered for the IHCC groups. The MACC group, MAGI-based application process is explained in greater detail in MCAR, Section 1303.04. This eligibility process generally requires applicants to provide information used when filing federal tax forms and/or documents commonly used for identification and income verification purposes.

   b. SSI-based eligibility. The IHCC application process builds on the MAGI review unless a person is 65 or older. In all cases, self-attestation of income and resources begins the process. To the full extent feasible, electronic data matches are used to verify financial information. Documentation of certain information may be required, however. In addition, when using a paper application, access to certain types of materials may be necessary.

      (1) Materials that may be of assistance in completing the application include, but are not limited to:

          Federal tax filing status

          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, Medicare and other forms of coverage

          W-2 forms with salary and wage information if you work for an employer

          1099 forms, if you are self-employed.

      (2) Common types of documentation that may be needed to verify income and resources include the wage and earning and tax forms noted above and:

          Copies of checks or receipts for unearned or irregular income

          Bank statements

          Annuity/retirement fund statements for insurance companies

          Copies of bonds

          Stock ownership statements

          Copies of life insurance policies

Statements from insurance companies or companies providing annuities

Copies of burial purchase agreements.

(3) Common documents that may be required with respect to self-employment income include:

Tax forms such as 1040 Schedule ES (Form 1040), Schedule C or comparable State form or federal return with the "Self-Employment Tax" line completed.

Business records if the applicant has not been self-employed long enough to file taxes, including financial statements, gross receipts and expenses, quarterly reports, certified statement form licensed accountant.

For royalties, honoraria, and stipends, the nature and amount of payments, any Social Security of Medicare withholding, dates of payments and frequency of payments, and/or tax forms above or 1099 MISC and the name of the issuer.

(4) Common documents that are required related to health status or disability include:

Authorization to obtain medical and/or health care records, the names and addresses of the treating physicians and other providers, health care bills incurred or paid during the three month retroactive eligibility period, or that remain unpaid from any previous period.

4. Application Filing Date – The filing date of an application is the date used to determine when eligibility begins if it is approved. The filing date is not necessarily the date an application is complete, but is typically the date a signed completed application form is submitted through the self-service portal on-line or date-stamped as received by the agency or electronic means if uploaded, mailed, faxed, or scanned or delivered in-person. The filing date may be protected if the application is not complete due to outstanding verifications or required reforms. The timeline the agency must meet for making an eligibility determination does not begin until the date an application is complete, as indicated below, however.

5. Application Completeness – An application must be complete before a determination of eligibility can be made. An application is considered complete when all information requested, including any ancillary required forms and authorizations, are date-marked as received by the State. As the timelines for making a determination of eligibility specified in subsection (8) below begin on the date the application is complete, applicants are informed and offered the opportunity to provide any additional documentation or explanations necessary to proceed to the determination of eligibility in a timely manner. Such information is provided to applicants immediately through an electronic notification from the IES when applying on-line either through the consumer self-service portal or with the assistance of an agency representative. In cases in which an agency eligibility specialist or assister is entering information into an applicant's account or scanning a paper application, information about necessary documentation is generated immediately in the on-line account and must be made available as soon as feasible.

6. 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 representative. 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.

7. Self-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 signing a paper application in ink or by providing an electronic signature on-line under penalty of perjury. The IES verifies the information electronically to the fullest extent feasible and must verify applicant attestations in accordance with the procedures set forth MCAR, Sections 1303 and 1308.

8. Privacy of Application Information – Application information must only be used to determine eligibility and the types of coverage a person is qualified to receive. Accordingly, the EOHHS, the agencies under its umbrella, and all other entities serving as its agents in the Medicaid eligibility process maintain the privacy and confidentiality of all application information and in the manner required by applicable federal and state laws and regulations.

9. Eligibility Determination Timelines – Federal and State law set specific timeliness for making determinations of Medicaid eligibility. The timelines vary in length depending on whether a clinical eligibility determination is required that necessitates a review of information from second parties (e.g., health practitioner or provider) and/or third parties (e.g., insurers). In accordance with R.I.G.L 40-8.6(b)(2) (Public Law 16-150), the timeline for determining eligibility begins on the date a completed application, including any required forms and/or authorizations are received by the EOHHS, or its authorized eligibility agents, and ends on the date a notice is sent to the applicant explaining the agency's decision. The EOHHS is responsible for processing applications within these time limits for IHCC group members who have not been deemed or determined eligible on the basis of participation in another federal program (e.g., SSI, DCYF Foster Child, etc.). The timelines are as follows:

MACC and IHCC Eligibility Determination Timelines	
Coverage Group	Determination Timeline
MACC Groups	30 Days
Community Medicaid – Elders 65 and over	30 Days
Community Medicaid – Adults with Disabilities	90 Days
Sherlock Plan	If determination of disability has been made – 30 days If determination of disability or level of care is required – 90 days
Medically Needy – Persons with Disabilities	90 Days
Medically Needy – No Disability	30 Days

MACC and IHCC Eligibility Determination Timelines	
Coverage Group	Determination Timeline
LTSS	90 Days

2.5 Beneficiary Responsibilities

A. Medicaid beneficiaries must provide accurate and complete information about any eligibility factors subject to change at the time of the application and annual renewal. Accordingly:

1. Consent – At the time of the initial application or first renewal, Medicaid beneficiaries are required to provide the State 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 eligibility system. Once such consent is provided, the Medicaid agency may retrieve and review such information when conducting all subsequent annual renewals.

2. Duty to Report – Medicaid beneficiaries 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 consumer self-service portal as well as in person, via fax, or mail. Failure to report in a timely manner may result in the discontinuation of Medicaid eligibility.

3. 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.

4. Voluntary Termination – A Medicaid beneficiary may request to be disenrolled from a Medicaid health plan or to terminate Medicaid eligibility at any time. Such requests must be made in writing and preferably two (2) weeks prior to the date of disrenrollment or the date a beneficiary seeks to end eligibility.

5. Reliable Information – Medicaid applicants and beneficiaries must sign under the penalty of perjury that all information provided at the time of application and any annual renewals thereafter is accurate and truthful.

6. Change of Service Delivery Options – Medicaid beneficiaries may change Medicaid health plans during the annual open enrollment period. Notice of the open enrollment period is provided to beneficiaries at least thirty (30) days prior to the date the period begins. Beneficiaries may also request to change service delivery options at any other time in accordance with the procedures set forth in Section 210-RICR-40-10-1, or if MACC group eligible, Sections 1309 through 1312.

7. Alternative forms of Benefits/Assistance – Applicants and beneficiaries must, as a condition of eligibility, take any necessary steps to obtain annuities, pensions, retirement and disability benefits along with any other forms of assistance available for support and maintenance that may be identified by the agency, in writing, in accordance with Section 0308. Good cause exceptions are considered when requested in writing.

2.6 Application Review Process

2.6.1 Scope and Purpose

A. This section provides an overview of the application review process for all IHCC groups identified in this chapter and the specific provisions that apply to Community Medicaid populations subject to eligibility determinations made by the State. As a result of programmatic changes in the State's IES required by the ACA, people are no longer required to apply for one particular category of Medicaid eligibility. Instead, to maximize access and choice, applicants are evaluated across a variety of MACC and IHCC pathways which apply different eligibility standards, requirements, and criteria. In short, the denial or termination of eligibility in one category does not preclude eligibility through another pathway. The State must consider all bases of eligibility.

2.6.2 Conversion Process

A. The conversion to the State's new application review process requires new applicants and existing beneficiaries to be treated differently during the initial stages of implementation. A "new applicant", for these purposes, is a person who is not currently receiving Medicaid health coverage in any eligibility category. The conversion process is as follows:

1. New Applicants – New applicants are evaluated first using the MAGI methodology for the MACC groups.

2. Existing Beneficiaries – At the time of renewal, current IHCC beneficiaries are evaluated using the SSI income and resource standards to ensure continuity of coverage. In the process of this evaluation, an ancillary review of the information in the beneficiary's account along with updates from all available data sources is conducted to determine whether MAGI-based eligibility in one of the MACC groups is available. This review is only conducted if the beneficiary is under age 65 or 65 and older and the parent/caretaker of a Medicaid-eligible child. Upon completing this review, a notice is sent to the beneficiary indicating if an alternative form of coverage is available.

2.6.3 General Rules

A. To the extent feasible, the person seeking initial or continuing eligibility is provided with the choice of eligibility pathways within and, in some instances, across the MACC and IHCC group categories. Again, MACC group eligibility is primarily income-based and uses the MAGI standard established in conjunction with federal health care reform. IHCC group eligibility is much more varied and, when not automatic due to participation in another federal program or special requirements, is based on both the SSI methodology and SSI-related characteristics. As there are significant distinctions between these two categories for obtaining eligibility, when choosing a pathway, the following should be taken into consideration:

1. Limits on Choice – Although the scope of primary care essential health coverage across Medicaid in the broad IHCC and MACC categories does not significantly vary, there are certain differences that may affect a person's choice of or access to certain eligibility pathways. In addition, federal and State policies also impose restrictions. The most common include:

a. Retroactive coverage. Under the State's Section 1115 demonstration waiver, retroactive coverage is not available to MACC group beneficiaries, including those who qualify for LTSS. Retroactive coverage is an included benefit through many of the IHCC pathways in which the State determines eligibility for Community Medicaid and Medicaid LTSS, as indicated in Section 210-RICR-40-05-3.

b. Other Health Coverage. Federal law precludes persons who are eligible for or enrolled in Medicare from obtaining coverage through the MACC group for adults, ages 19 to 64. Other forms of health coverage, including both commercial insurance and government-sponsored, are generally not a bar to Medicaid eligibility through the MACC and IHCC pathways. In addition, the State's health insurance payment program – RIte Share – makes it possible for beneficiaries who have access to cost-effective Employer-Sponsored Insurance (ESI) to maintain coverage through work once they become Medicaid-eligible. Section 1312 provides details on RIte Share. The MPPP is also available to provide financial help to cover the costs of Medicare coverage for low-income elders and adults with disabilities.

c. Former SSI Recipients. All former SSI recipients who lose cash benefits due to increases in income are evaluated first for the SSI protected status groups located in section 210-RICR-40-05-1.5.3. In instances in which eligibility in one of these groups is unavailable, the person will be evaluated for the MACC and/or IHCC Community Medicaid pathways, to the extent the other limiting factors in this subsection allow, and provided with a choice of coverage options as appropriate.

d. Age. In general, persons 65 and older are ineligible for MAGI-based MACC group eligibility. Parents/caretakers of a Medicaid eligible child in this age group, including those enrolled in Medicare, are the only exceptions. Children and youth under 19 are generally not eligible in the IHCC groups. However, pregnant women, parents/caretakers and children with high health care expenses who have family income above the MACC group limit may seek MN eligibility through Community Medicaid using the SSI methodology. IHCC resource and deeming rules apply, unless the child is seeking LTSS through the Katie Beckett eligibility provision.

e. LTSS Preventive Level Services. These services are only available to adults with disabilities and elders who are eligible through the Community Medicaid pathways as EAD or MN.

f. Need for LTSS. All LTSS applicants are subject to a review of the transfer of assets, in accordance with applicable federal requirements and State laws and regulations governing estate recoveries, irrespective of whether initial income eligibility is determined using the MAGI standard or the SSI methodology. LTSS beneficiaries who are eligible through the MACC group pathway ARE NOT subject to resources limits, however.

g. Medically Needy (MN) Eligibility. For all non-LTSS applicants, MN eligibility is considered the last option for obtaining Medicaid coverage, both because the burden on beneficiaries is the most significant and the opportunities for coordinating and managing care are so limited. There is not a MN option for MACC group adults, unless they are eligible through the pathway for parents/caretakers. Accordingly, for these adults IHCC eligibility is the only avenue to MN coverage. For LTSS applicants, MN eligibility is also the last option; though the income eligibility limits are higher than through other eligibility pathways, beneficiary liability tends to be as well. In addition, access through this pathway limits access to SSP assistance (i.e., only available if income is at or below 300% of SSI) and the range of LTSS settings in some instances.

h. MPPP. Elders and adults with disabilities who are participating in the MPPP are only eligible for the MACC group for parents/caretakers. Otherwise, MPPP participants must access Medicaid financial help through the IHCC groups. In addition, participation in the MPPP has the potential to affect eligibility for

Medicaid health coverage through the Community Medicaid MN pathway. As indicated in Section 210-RICR-40-05-2, Medicare premiums are health expenses that count toward the amount a person must spenddown in order to obtain Medicaid coverage during the six month MN period. MPPP participants are not permitted to use these expenses toward a spenddown as they are paid by the State.

2. Eligibility Across Pathways – Eligibility specialists and application assisters must be available to provide applicants and beneficiaries with information about the impact the limits above have on the choice of eligibility pathways. Such information is also provided with paper applications and will be built into the self-service portal to assist applicants and beneficiaries in making reasoned choices about their Medicaid health options. The table below summarizes the major cross pathway eligibility opportunities by major Medicaid populations.

Selected Eligibility Cross Pathways By Population **(Excludes beneficiaries eligible on basis of other programs)**			
Population	MACC Group – MAGI-Based (No Retroactive Coverage)	IHCC Group SSI methodology-based (Retroactive Coverage Possible)	Both MACC and IHCC Eligibility determined using both
Children, no need for LTSS	Up to MACC income limit (261% of FPL +5% disregard)	MN only if income above MACC limit and have high health expenses	Not Applicable
Child requiring LTSS-health institution over 30 days	Not applicable	MN-LTSS	Not Applicable
Child requiring LTSS-HCBS	Up to MACC income limit for children	Family income above MACC limit – Katie Beckett eligibility based on child's income only MN-LTSS	Not Applicable
Pregnant Women	Up to MACC income limit (253% of FPL + 5% disregard)	EAD or MN if disabled, but only until next renewal or birth of baby, whichever comes first; MN if non-disabled and income above MACC limit and have high health expenses LTSS	Option for MACC and MPPP if have Medicare

Selected Eligibility Cross Pathways By Population (Excludes beneficiaries eligible on basis of other programs)			
Population	MACC Group – MAGI-Based (No Retroactive Coverage)	IHCC Group SSI methodology-based (Retroactive Coverage Possible)	Both MACC and IHCC Eligibility determined using both
Adults 19-64, no Medicare	Up to MACC income limit (133% FPL + 5% disregard), LTSS with no resource limit	EAD or MN if have a disability and are seeking retroactive coverage. LTSS	Not Applicable
Adults with disabilities 19-64	If no Medicare, up to MACC limit for adults, including while awaiting a disability determination by the State or SSA	EAD, MPPP and/or MN Sherlock Plan if working LTSS	Option MACC group for parents/caretakers and MPPP
Elders	Only if a parent/caretaker	EAD, MPPP, MN LTSS	Option MACC group for parents/caretakers and MPPP

3. Continuing Eligibility Reviews Prior to Termination of Coverage – The State must evaluate whether a beneficiary may qualify for Medicaid health coverage through an alternative pathway prior to the termination of eligibility. This requirement only applies when the reason for the termination is a change in an eligibility factor (e.g., age, income, resources or disability, relationship, etc.). The State uses any information known about the beneficiary through his or her account and electronic data sources to evaluate the options for continuing coverage. A beneficiary is informed in writing about this evaluation, which is referred to as an ex parte review, and of any additional materials that must be submitted to determine whether alternative forms of eligibility exist at least ten (10) days prior to the date the eligibility termination takes effect. Such notification is provided more than thirty (30) days in advance of the date of the agency action whenever feasible. In addition to evaluating beneficiaries for other forms of Medicaid eligibility, anyone under age 65 is also considered for commercial coverage with financial help through HSRI.

2.7 Renewal of Eligibility for IHCC Groups

2.7.1 SCOPE AND PURPOSE

A. One of the principal requirements of Medicaid is that continuing eligibility must be re-evaluated at least once a year. For the IHCC groups, this annual review was called a “redetermination” and, accordingly, often required beneficiaries to reapply for coverage. Current federal regulations (42

CFR 435.916(b) governing the IHCC groups now require that these annual reviews consider only those eligibility factors that are subject to change. Accordingly, the continuing eligibility of the IHCC group beneficiaries receiving Community and LTSS Medicaid is now conducted by requiring them to review their account information on key eligibility factors, as updated by internal and external data sources, and report any inaccuracies or changes in the manner described in this section.

B. The factors subject to change include income, resources, household composition (e.g., as a result of births, deaths, divorce, etc.), disability or clinical factors, access to third-party coverage, and changes in family size (e.g., due to death, marital status, birth or adoption of child), and/or immigration status. LTSS beneficiaries may be required to provide additional information related to change in care settings. Note: The provisions in this section do not apply to beneficiaries who are deemed eligible due to participation in other programs (e.g., SSI recipients), or that are determined eligible by the SSA. Special MPPP renewal provisions also apply.

2.7.2 AGENCY RESPONSIBILITIES

A. IHCC group renewals are conducted in accordance with the following:

1. Frequency – The Medicaid renewal process occurs at least once every twelve (12) months and no more frequently unless as result of a change in eligibility factors.

2. Types of Information – The eligibility renewal is based on information already available to the full extent feasible. Such information may be derived from reliable sources including, but not limited to, the beneficiary's automated eligibility account, current paper records, or databases that may be accessed through the IES. Information about eligibility factors that are not subject to change or matters that are not relevant to continuation of Medicaid eligibility are not requested or used at the time of renewal. Factors that are not subject to change include, but are not limited to, U.S. citizenship, date of birth, and Social Security Number.

3. Notice – Timely notice must be provided of:

   a. Renewal Date. A notice of the date of the annual renewal is sent at least thirty days (30) days prior to the renewal date. The beneficiary is also provided with a pre-populated form containing information from the Integrated Eligibility System and other sources on each relevant eligibility factor. In instances in which the Medicaid beneficiary is required to take action in addition to completing the pre-populated form, such as providing paper documentation or explaining a discrepancy, a timeline is included for completing the action as well as indication of the consequences for failure to do so.

   b. Renewal Action. At least ten (10) days prior to the renewal date, Medicaid beneficiaries are provided with a notice stating the outcome of the renewal process and explaining the basis for any agency action – continuation or termination of eligibility. The notice also contains the right to appeal and obtain an administrative fair hearing. Beneficiaries are also notified that they have the right to have their health coverage continued while awaiting a hearing if an appeal is filed in ten (10) days from the date of the renewal notice is received. The date the notice is received is presumed to be five (5) days from the date on the notice.

4. Consent – At the time of initial application, Medicaid beneficiaries sign or provide an electronic signature giving the State consent to obtain and verify information through external data sources and from certain providers for the purposes determining eligibility and renewing health coverage. The first time IHCC group beneficiaries are renewed through the IES, such consent must be provided if it does not already exist.

5. Modified Passive Renewal – All IHCC beneficiaries are subject to a modified passive renewal process that proceeds as follows:

   a. Initial Automated IES Renewal. During the first automated IES renewal, IHCC beneficiaries are provided with a pre-populated form containing all information related to eligibility on record, typically in their IES accounts, that has been self-reported and/or obtained through electronic data matches at application, post-eligibility verification, and change reports. Beneficiaries are required to review this form, make any necessary changes and required actions, and then attest to the accuracy and completeness of the information provided on any eligibility factor subject to change. In addition, the Medicaid beneficiary must provide consent to the EOHHS permitting automated data exchanges and/or retrieval of information on eligibility factors from outside sources for all future renewals.

   b. Continuing Renewals. After the initial automated renewal, IHCC beneficiaries receive a pre-populated form and are only required to return the form to self-report changes in eligibility factors or to respond to agency requests for information or documentation. If no such changes are required, the beneficiary is not required to take further action. Medicaid health coverage is renewed automatically and a new eligibility period is established.

2.7.3 BENEFICIARY RESPONSIBILITIES

A. Medicaid beneficiaries must meet the requirements associated with making and completing an application as set forth in Section 210-RICR-40-00-2.5.

210-RICR-40-00-3

Title 210 - Executive Office of Health and Human Services

Chapter 40 Medicaid Integrated Health Care Coverage

SUBCHAPTER 00 – N/A

Part 3 – SSI Financial Eligibility Determinations

3.1 Overview of the SSI Methodology

3.1.1 Scope and Purpose

A. All SSI recipients are automatically eligible for Medicaid. The State has agreed to determine the eligibility of persons who have an SSI characteristic – 65 and older, blind or disabled – but do not qualify for cash benefits using the SSI methodology and in a manner that is no more restrictive than the way it is applied for SSI. For the purposes of this chapter, the methodology applies to adults with an SSI characteristic – often called SSI lookalikes – who have income at or below the SSI eligibility standard of about 74.5 percent of the FPL as well as those in the State's optional coverage group for low-income elders and adults with disabilities and all populations that qualify for MN eligibility under the Medicaid State Plan. The SSI methodology also applies to persons seeking Medicaid LTSS as indicated in this section.

B. The basic tenets of the SSI methodology are established in the rules for determining eligibility for SSI are set forth in the Social Security Administration's regulations at 20 CFR 416.101, et. seq.

3.1.2 Organization of SSI Methodology Provisions in this Chapter

A. Sections pertaining the SSI treatment of income and resources and their application are as follows:

1. Section 210-RICR-40-00-3 – Overview of Methodology

2. Section 210-RICR-40-00-3.2 – Treatment of Income

3. Section 210-RICR-40-00-3.3 – Treatment of Resources

4. Section 210-RICR-40-05-1.11 — Application of SSI Financial Eligibility Rules for Community Medicaid

5. Sections 0380 through 0399– Application of SSI Financial Eligibility Rules for Medicaid LTSS

3.1.3 Definitions

A. For the purposes of this section, the following meanings apply:

1. "Child" means someone who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student for the purposes of IHCC group eligibility only. See definition of a child for MACC group eligibility in Section 1301.

2. “Couple” means a person seeking initial or continuing eligibility for Medicaid and his or her spouse, regardless of whether the spouse is also an applicant or beneficiary unless otherwise indicated.

3. “Federal Benefit Rate (FBR)” means the amount of the monthly cash assistance authorized for the recipients of the SSI program. The FBR is the SSI income eligibility standard, as adjusted for the number of cash recipients, living arrangement and SSP levels as indicated in the table in subpart (F) of this section.

4. “Financial Responsibility Unit (FRU)” means the group of persons living with the person seeking Medicaid benefits whose income and resources are considered available when determining financial eligibility and, as such, may count and/or be attributed to others in the household when the deeming process applies.

5. “Medicaid Eligibility Group” means the total number of persons counted in a household – that is, the family size involved – when identifying the FPL income level that applies when determining a person’s Medicaid eligibility.

6. “Medicaid Health Coverage” means the full scope of essential 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 does not apply to partial dual eligible persons who, under the provisions of this Chapter, qualify only for financial assistance through the MPPP to help pay Medicare cost-sharing.

7. "Medically Necessary Service" means a 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 slow or prevent a decremental change in medical and/or mental health status.

8. “Medically Needy (MN)” means the IHCC pathway for elders, persons with disabilities, parents/caretakers, and certain pregnant women and children with income above the limits for their applicable Medicaid coverage group who incur enough health expenses during a set period to spenddown to the eligibility threshold for coverage.

9. “SSI Income Methodology” 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 Administration (SSA) for the SSI program.

3.1.4Key Elements of the SSI Methodology

A. Though the application of the SSI methodology sometimes varies across coverage groups, there are several key common elements, as follows:

1. Financial Determination – The basis for determining financial eligibility using the SSI methodology is a multi-step process for evaluating income and resources, including the formation of the FRU and Medicaid eligibility groups and the application of exclusions, deductions and disregards, all of which may be applied differently depending on eligibility pathway.

2. Characteristic Requirements – Due to the historical tie to the SSI program, some IHCC Community Medicaid group members must have certain characteristics related to age, blindness and disability, or clinical status to qualify for Medicaid health coverage. General characteristic requirements that drive eligibility for Community Medicaid are located in Section 210-RICR-40-05-1.9.

3. LTSS Need and Level of Care – LTSS is a Medicaid State Plan benefit for both IHCC and MACC group beneficiaries who have the need for a level of care typically provided by a health care institution. Federal law defines “institution” narrowly in terms of three specific types of health facilities – nursing facilities (NF), intermediate care facilities for persons with developmental/intellectual disabilities (ICF-ID), and hospitals. To qualify for Medicaid- funded LTSS, MACC and IHCC group applicants and beneficiaries must meet these clinical criteria and additional financial requirements related to the transfer of assets. Section 0399 identifies the level of need criteria. Transfer of assets provisions are located in Section 0384.

4. General and Group Specific Eligibility Requirements - All persons seeking Medicaid benefits must also meet the general eligibility requirements related to residency, citizenship, third-party coverage and cooperation. The general eligibility requirements for IHCC Community Medicaid are specified in Section 210-RICR-40-05-1.9 as well as in the sections related to specific coverage group requirements. Documentation related to both financial and clinical eligibility factors is specified in these same sections.

5. Clinical Reviews – Clinical reviews are an important component of the eligibility determination process for many of the IHCC eligibility pathways. The criteria and processes for making these determinations may vary considerably in accordance with the type of Medicaid health coverage a person is seeking and the scope of Medicaid coverage available – for example, Community Medicaid v. Medicaid LTSS. The following identifies the entity responsible for clinical reviews and the associated coverage groups:

    a. The SSA conducts disability determinations for SSI and SSP recipients with income up to the SSI standard.

    b. The Medicaid Assessment and Review Team (MART) uses the SSA criteria to evaluate EAD applicants for disability.

    c. The Office of Medical Review (OMR) uses clinical/functional disability criteria to evaluate the need a person has for an institutional level of care in a nursing facility or hospital.

    d. Community Medicaid beneficiaries may be determined to be at risk for LTSS and eligible for a limited range of home and community-based services based on the criteria for a LTSS preventive level of need. LTSS preventive level services are described in Section 210-RICR-40-05-1.8; the criteria used to evaluate a level of need are set forth in Section 0399. Such determinations are also made by OMR.

    e. The Katie Becket Unit evaluates whether a child seeking Katie Beckett eligibility has a disabling impairment requiring an institutional level of care. The requirements for Katie Beckett eligibility are set forth in Chapter 0394.45.

    f. The Division of Developmental Disabilities of the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) determines whether a beneficiary meets the clinical criteria set in State law for a determination of disability associated with the level of care at an Intermediate Care Facility for persons with Intellectual/Developmental Disabilities (ICF-ID). BHDDH also determines whether certain behavioral health disabling conditions qualify for specialized services requiring a hospital level of care.

3.1.5Income

A. The evaluation of income is the process that determines the amount that counts when determining financial eligibility using the SSI methodology. For these purposes, income is defined as follows:

1. Earned Income -- Earned income is income from work and may be in cash or in-kind and may include more of a person's income than he or she actually receives if amounts are withheld because of a garnishment or to pay a debt or other legal obligation, or to make any other payments. See Section 210-RICR-40-00-3.3.5 for more detailed information.

2. Unearned Income – Unearned income is all income that is not earned through employment whether received in cash or in-kind. The provisions governing the counting of unearned income are also located in Section 210-RICR-40-00-3.

B. The rules governing the determination of countable income for Community Medicaid are in Section 210-RICR-40-05-1.11.4 and 210-RICR-40-05-1.11.5 and 0386 to 0392 for Medicaid LTSS.

3.1.6Resources

A. A resource is cash or other liquid assets or any real or personal property that a person (or spouse, if any) owns and could convert to cash to be used for support and maintenance. For the purposes of determining financial eligibility using the SSI methodology, the following distinctions apply:

1. Liquid Resources – A liquid resource is any resource in the form of cash, or any other form which can be converted to cash within twenty (20) business days. Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. Liquid resources, other than cash, are evaluated according to the person's equity in the resources.

2. Non-liquid Resources – A non-liquid resource is a resource that is not in the form of cash or in any other form which cannot be converted to cash within 20 business days. Examples of resources that are ordinarily non-liquid include loan agreements, household goods, automobiles, trucks, tractors, boats, machinery, livestock, buildings and land. Non-liquid resources are evaluated according to their equity value except when otherwise indicated. The equity value of an item is the price that it can reasonably be expected to sell for on the open market in the particular geographic area involved, minus any encumbrances.

B. Section 210-RICR-40-00-3.5 explains the types of resources and applicable exclusions in general. Section 210-RICR-40-05-1.11 focuses on Community Medicaid. Medicaid LTSS provisions are located in Sections 0380 to 0384.

3.1.7Income and Resource Standards

A. The following standards are used in the determination of the income eligibility of an individual or couple:

1. Monthly Federal Benefit Rate (FBR) – The FBR is set by the federal government and is based on the SSI monthly cash payment adjusted for living arrangement. Accordingly, the FBR serves as the SSI income eligibility standard and in the Medicaid eligibility

determination process for calculating allowances and deeming purposes. The FBR is adjusted annually, as necessary, to reflect changes in the cost of living. The difference between is the amount of the FBR used to determine the income or resources that apply when deeming and at what amount. The FBR is also the basis for the income eligibility cap for LTSS in certain circumstances.

Monthly Federal Benefit Rate (FBR) – 2017	
Living Arrangement	Monthly Payment
Individual - Own Home	$ 735
Couple - Own Home	$ 1,103
Individual - Home of Another	$ 490.14
Couple - Home of Another	$ 735.54
Couple and Individual - Own Home	$ 368
Couple and Individual - Home of Another	$ 245.40
Individual - Own Home	$ 1,470.39
Individual - Home of Another	$ 980.27
Couple - Own Home	$ 2,206.60
Couple - Home of Another	$ 1,471

2. Optional State Supplemental Payment (SSP)Limits – The limits for SSP eligibility are tied to SSI and EAD eligibility. No SSP benefit is available if the beneficiary has income in excess of the amounts below:

Optional State Supplement Payment (SSP) Limits: 2017		
Living Arrangement	**Individual**	**Couple**
Living in a residential care and assisted living facility	LTSS	

Optional State Supplement Payment (SSP) Limits: 2017		
Living Arrangement	**Individual**	**Couple**
– SSP Category D	$ 2,205 Community Medicaid $ 1,067	Limited to Individuals only
LTSS Living in a Community Support Living Program residence (assisted living or adult supportive care homes)– Category F	LTSS only $2,205	Not Applicable
Living in own household	$774.92	$1,182.38
Living in household of another	$542.06	$832.84
Living in a Medicaid-funded Institution Federal and State Supplement	$30 $50	$60 $100

Substantial Gainful Activity Limit -- $1,170 (blind $1,950)

Earned income breakeven point – $1,555 (I) $ 2,291 (C)

Unearned income breakeven point -- $ 755 (I) 1,123 (C)

3. Medically Needy (MN) Monthly Income Standards – There are different MN income standards for determining eligibility for Community Medicaid and LTSS.

   a. Community Medicaid. For persons seeking non-LTSS Medicaid MN coverage, previously known as the flexible test of income, eligibility is reserved for applicants with income above the eligibility standard and high health care expenses who are able to spenddown to the applicable income limit during a specified MN eligibility period of six (6) months. MN beneficiaries are eligible for Medicaid health coverage once they have spent down to this limit, as indicated below.

      (1) Community MN Populations, Under the RI Medicaid State Plan. MN coverage is available to elders and adults with disabilities, and MACC group parents/caretakers, children and pregnant women. There is no MN option for MACC adults, ages 19 to 64; members of this group who have a disability may apply through the EAD pathway and, if found to have a disability, may pursue MN eligibility if they have income above 100 percent of the FPL. All MN beneficiaries are subject to the SSI method for determining eligibility, though income limits vary as indicated in the table below. Accordingly, for the purposes of determining eligibility,

all are treated as members of the Community Medicaid group (hereinafter referred to as the Community Medicaid MACC group MN), even though the general population to which they belong is sometimes covered under a MACC group, using the MAGI-standard (e.g., children and pregnant women. Section 210-RICR-40-05-2 covers Community Medicaid MN eligibility in detail.

(2) Medically Needy Income Limit (MNIL). The MNIL provides the MN income eligibility threshold and is based on the limit set for the specific coverage group.

On the effective date of this rule, the MNIL for elders and adults with disabilities seeking Community Medicaid is set below the applicable income standard for EAD because of a federal regulation tying the limit to 133% of the Aid to Families and Dependent Children (AFDC) income eligibility level, as of July 16, 1996.

Effective February 1, 2018, the MNIL for members of this population increases to 100 percent of the FPL, the income limit for EAD eligibility, the coverage group now most closely tied to the relevant cash assistance program for elders and adults with disabilities under the State's Section 1115 waiver.

For beneficiaries who would otherwise qualify for Medicaid in the MACC groups using the MAGI (see Chapter 1300), the MNIL is the applicable income limit for the population (e.g., children 261% of FPL, parents/caretakers 133 141% of the FPL, pregnant women 253% of FPL) plus the five (5) percent disregard, when applicable, required by the ACA.

b. LTSS. Persons seeking Medicaid LTSS who have income above the eligibility limits, but below the cost of care in an institution or HCBS setting also may seek MN eligibility. The MN eligibility period for LTSS is one month.

c. MN Standards. Current MN income eligibility standards and amounts adjusted for family size are as follows:

Medically Needy Income Standards	
Coverage Group	**Medically Needy Monthly Income Limit**
Elders and Adults with Disabilities & Refugee Medical Assistance	$883 (Individual) $927 (Couple) Additional $353 per person in the FRU
Parents/Caretakers	146% FPL*
Pregnant Women	258% FPL*

Medically Needy Income Standards	
Coverage Group	**Medically Needy Monthly Income Limit**
Children Under Age 19	266% FPL*

*Includes 5% disregard.

4. Federal Poverty Level Income Guidelines – Changed annually, the IHCC group income limits and, where applicable, companion SSI-related limits are as follows:

Federal Poverty Level (FPL) Income Limits[1] **All IHCC Groups 2017**	
Coverage Group	**FPL Monthly Limits**
Elders and Adults with Disabilities (EAD)	At or below 100% FPL
Community Medicaid Elders and adults with Disabilities Medically Needy (MN)	Above 100% FPL Spenddown to $883
Refugee Medicaid Assistance (RMA) MN	At or below 200% FPL Spenddown to $883
Community Medicaid MACC Group MN	Varies by population as indicated above
QMB	100% Add $20
SLMB	120% Add $20

[1] FPL Guidelines and Eligibility Information appear on the EOHHS website at: http://www.eohhs.ri.gov/Consumer/FPLEligibilityInformation.aspx

Federal Poverty Level (FPL) Income Limits[1] All IHCC Groups 2017	
Coverage Group	**FPL Monthly Limits**
QI	135% Add $20
Sherlock Plan	250%
LTSS – SSI Pathway	Up to 300% SSI Level
LTSS – MAGI Pathway	Up to 133% of FPL and possible 5% disregard
LTSS Special Income/HCBS (217 lookalikes)	Up to 300% SSI Level
LTSS- MN Pathway	Up to cost of care

5. Resource Standards – Federal regulations requires states that have expanded IHCC group eligibility to low-income elders and adults with disabilities up to 100 percent of the FPL to use the same resource limits in effect for MN eligibility.

Resource Standards for IHCC Groups	
Coverage Group	**Limits**
Community Medicaid – EAD and MN	$4,000 (I) $6,000 (C)
Community Medicaid – MACC Group	Not Applicable
SSI –Protected Status	Varies by pathway. See Section 210-RICR-40-05-1.5
SSP – State Determination (EAD)	($4,000 (I) $6,000 (C)
SSP – SSA Determination	$2,000 (I) $3,000 (C)
Breast and Cervical Cancer	None

Resource Standards for IHCC Groups	
Coverage Group	**Limits**
Refugee Medicaid	None
Sherlock Plan	$10,000 (1) $20,000 (C)
LTSS – SSI	$2,000
LTSS – Special Income/HCBS (217 lookalikes)	$4,000
LTSS – Medically Needy	$4,000
MPPP	Varies by pathway – See Chart in Section 210-RICR-40-05-1.6

6. Student Earned Income Exclusion (SEIE) -- For students under age 22 and persons who are blind or living with a disabling impairment and regularly attending school, the SSI methodology provides the following income exclusion which is adjusted annually to reflect federal cost of living adjustments (COLAs), when there is one:

Student Earned Income Exclusion		
Year	Monthly	Maximum in a Calendar Year
2017	$1,790	$7,200
2016	$1,780	$7,180
2015	$1,780	$7,180

7. LTSS Spousal Impoverishment – Effective January 1, 2017 unless otherwise indicated

   a. Minimum Monthly Maintenance of Need Allowance -- $ 2,002.50 (effective 7-1-16)

   b. Maximum Monthly Maintenance of Need Allowance -- $ 3,022.50 (effective 7-1-16)

   c. Community Spouse Monthly Housing Allowance -- $600.75 (effective 7-1-16)

   d. Community Spouse Resource Standards:

   e. Minimum -- $24,180

   f. Maximum -- $120,900

   g. Home Equity Limits

h. Minimum -- $560,000

i. Maximum – $840,000

8. Medically Needy Standards – Effective January 1, 2017

Family Size	Proposed MNIL January 2017	Monthly
1	$10,600	$883
2	$11,100	$925
3	$13,700	$1,142
4	$15,600	$1,300
5	$17,500	$1,458
6	$19,700	$1,642
7	$21,700	$1,808
8	$23,900	$1,992
9	$25,700	$2,142
10	$27,900	$2,325
11	$29,900	$2,492
12	$31,900	$2,658
13	$33,900	$2,825
14	$36,000	$3,000
15	$38,000	$3,167

3.2 SSI Methodology: Treatment of Income

3.2.1 SCOPE AND PURPOSE

A. This section focuses on the treatment of income and, specifically, the way earned and unearned income are defined and evaluated when calculating countable income. For the purposes of this section, countable income is the total income available to a person seeking Medicaid benefits subsequent to the application of any required exclusions, disregards, and/or deductions and, as appropriate, deeming. Although the general rules for evaluating income do not vary across coverage groups, the manner in which they are applied when counting income differs for Community Medicaid versus LTSS Medicaid and, to a much more limited extent, for certain eligibility pathways.

3.2.2 DEFINITIONS

A. For the purposes of this section, the following definitions apply:

1. “Available Income” means when the person has a legal interest in a liquidated sum and has the legal ability to make that sum available for support and maintenance.

2. “Countable Income” means the total amount of earned and unearned income that is used to determine whether an applicant or beneficiary meets the standard for income eligibility for the applicable IHCC group.

3. “Deeming” means the process of attributing income and resources from non-applicant members of the household, a parent or spouse, to the person seeking Medicaid eligibility as low-income elder or adult with disabilities who is not seeking LTSS coverage.

4. “Infrequent Income” means income that is received no more than once in a calendar quarter from a single source.

5. “PASS” means a written employment plan approved by the SSA that protects an SSI recipient’s eligibility for Medicaid as long as the recipient continues to make progress toward work goals in accordance with a set timetable.

6. “Non-Applicant Person (NAPP)” means a parent, child or spouse of the applicant in the IHCC group who is NOT applying for or receiving Medicaid health coverage, but whose finances are considered for the purposes of determining income and resources.

7. “Unavailable Income” means the person cannot gain access to the income.

3.2.3 AGENCY RESPONSIBILITIES

A. In calculating countable income, all sources of income a person receives or may be eligible to receive is reviewed. Not all sources of income are reviewed when renewing eligibility as indicated in Section 210-RICR-40-00-2.7. When determining initial eligibility using the SSI methodology, agency responsibilities include, but are not limited to, the following:

1. Evaluation of Income – All income, earned and unearned, must be evaluated including any that is self-reported in the application process or that may become known through authorized electronic data matches using information from other health and human services programs (e.g., SNAP, RI Works, etc.) and outside data sources (State Wage Information Collection Agency or SWICA, SSA, DOH Vital Statistics, etc.).

2. Exclusions – Certain forms of earned and unearned income are excluded or treated as “not income” under federal law or regulations when determining income eligibility. The State also excludes certain types of income allowed under the Medicaid State Plan and Section 1115 waiver. All possible exclusions must be applied prior to the determination of eligibility.

3. Application of Disregards and Deductions – There are income disregards and deductions that apply when evaluating income. The State must apply these disregards and deductions in a specific order when calculating countable income.

4. Deemed Income, Non-LTSS only –A portion of the income of a non-applicant (NAPP) included in the FRU must be deemed as attributable if it is available to the applicant or beneficiary. Deeming is permitted from spouse-to-spouse, parent-to-child and sponsor to non-citizen included within the FRU, but never from sibling-to-sibling or child-to-parent. As only an applicant child seeking MN eligibility is subject to a State determination using the SSI methodology, the instances in which deeming will apply are limited. There is no resource limit in the MACC group for children, which is the principal eligibility pathway for person under age 19. The deeming of income is subject to conditions and limitations. Section 210-RICR-40-05-1.11.4 sets forth the deeming of income provisions that apply to Community Medicaid when eligibility is determined by the State.

5. Availability -- In evaluating income, whether it is available affects how it is counted. Specifically, under certain circumstances, the amount of income that is determined to be available may be greater than the amount a person will be able to use. Section 210-RICR-40-00-3.3 explains situations in which income may be unavailable.

6. Determination of Income Eligibility –Income evaluations are only one facet of the eligibility determination process that must be completed within the specific timeframes required set forth in Section 210-RICR-40-00-2.4(A)(9). As eligibility is considered across multiple pathways, failure to meet the income standard of one coverage group does not necessarily result in an immediate denial or termination of eligibility as indicated in Section 210-RICR-40-00-2.6.

3.2.4 BENEFICIARY RESPONSIBILITIES

A. All persons seeking initial or continuing Medicaid health coverage are required to provide timely and accurate information on all matters related to eligibility. In addition, although attestations and electronic verifications of income are conducted to the full extent feasible, supporting documentation must be provided in the manner indicated in the application process. Failure to provide timely and accurate information may result in delays in the determination process, reapplication, or denial of eligibility due to non-cooperation.

3.2.5 TYPES OF INCOME

A. When determining financial eligibility for Medicaid using the SSI methodology, income types are as follows:

1. Not Income – Some items or payment received by a person are not counted as income in the month received, though they may be treated as resources, as indicated in Section 210-RICR-40-00-3.6, if they are retained in the month after receipt. Items that are not income include, but are not limited to:

a. Converted resources including cash received from the sale of a resource, money withdrawn from a savings account or other liquid resources, reverse mortgages or home equity loans or lines of credit;

b. Distributions from health flexible spending arrangements or a health savings account;

c. Federal, state or local tax refunds;

d. Interest on excluded resources;

e. Health care services if given free of charge or paid for directly to the provider by someone else and room and board received during a medical confinement;

f. Assistance provided in cash or in-kind (including food or shelter) through a government program whose purpose is to provide health care services and supports, or social services (including vocational rehabilitation);

g. Cash provided by any non-government health care program or under a health insurance policy if the cash is either a reimbursement for service costs incurred and already paid or an advance for future services;

h. Direct payment of health insurance premiums by anyone on a person’s behalf;

i. Payments from the U.S. Department of Veterans Affairs resulting from unusual health care expenses (e.g., Aid and Attendance or Housebound Allowance);

j. Payments in cash or in-kind excluded by federal law, as indicated in subsection 210-RICR-40-00-3.3.

2. Countable Earned Income – Any earned income received as cash or an in-kind benefit a person receives in exchange for work must be considered in the financial eligibility determination process. Not all earned income is countable for Community Medicaid and several of the IHCC groups subject to the SSI methodology. In general, countable earned income includes, but is not limited to, the following with the exceptions noted:

a. Employee income. When derived from –

(1) Commissions

(2) Severance pay, based on accrued leave time

(3) Tips

(4) Vacation donation compensation

(5) Wages

(6) Any other forms of payment provided in exchange for work performed such as payment for babysitting, house-keeping, shoveling and so forth unless irregular or infrequent.

b. Irregular or infrequent income. Earned lump sum, non-gift, or income from an employer, trade or business above the first $30 received in a calendar quarter.

c. Net earnings from self-employment. This includes gross income minus all expenses the Internal Revenue Service (IRS) allows as a self-employment expense calculated on a taxable year basis.

d. Net rental income. The gross rental income minus verified rental and repair expenses, when the person spends an average of ten (10) hours or more per week maintaining or managing the property. Rental deposits are not income while subject to return to the tenant. Rental deposits used to pay rental expenses become income at the point of use. Verified expenses for providing a room or food or both to a roomer or boarder are subtracted from rental income.

e. In-kind. Earned in-kind income is a non-cash payment a person receives in place of wages or money from self-employment. In-kind earned income can be for food or shelter (e.g., free rent in exchange for apartment maintenance), or items that could be sold or converted to obtain food or shelter. The current market value of earned in-kind income is countable, unless the exclusions in Section 210-RICR-40-00-3.3.7 apply.

f. Other income. Income received in exchange for work or service, such as jury duty pay, picket duty pay, blood and blood plasma sales and royalties and honoraria.

3. Countable Unearned Income – Unearned income is cash received that does not require performing a work or service. The following types of unearned income are countable to the extent indicated when determining eligibility using the SSI methodology:

a. Adoption assistance involving Title IV-E funds. This assistance is counted dollar for dollar and is exempt from the $20 general disregard. See Section 210-RICR-40-00-3.3.3 below for types of adoption assistance that are not counted.

b. Alimony, spousal and other adult support. These payments are cash or in-kind contributions to meet some or all of a person's needs for food or shelter and are made voluntarily or because of a court order. Alimony payments are unearned income to an adult.

c. Annuities, pensions and other periodic payments. Payments counted in this category are usually related to prior work or service and include, for example, private pensions, Social Security benefits, disability benefits, Veterans benefits, Worker's Compensation, railroad retirement annuities and unemployment insurance benefits.

d. Child support and arrearage payments. When made for a deceased child, such payments are counted for the person who receives the payment. Otherwise, support payments are countable income for the child, excluding one-third, unless provided for health and/or other such purposes as indicated in Section 210-RICR-40-00-3.3.3.

e. Disability payments. If disability payments are part of an employer’s benefit package they are counted.

f. Extended income support payments through the Trade Adjustment Reform Act (TAA). The TAA is a federal program that provides support payments to individuals as a way of reducing the damaging impact of imports on certain sectors of the economy. Under the current structure, such payments are countable.

g. Foster care payments. When foster care payments are made under Title IV-E of the Social Security Act, they are countable income for the person receiving care. Such payments are federally funded and thus the income is not subject to the $20 general disregard. See subsection 210-RICR-40-00-3.3.4(A)(8) below for types of foster care payments that are not counted.

h. In-kind. Unearned in-kind income is a non-cash payment a person receives that is NOT in place of wages or self-employment monies. In-kind unearned income can be either food or shelter or any item that can be sold or converted to buy food or shelter. See subsection 210-RICR-40-00-3.3.7 for treatment of income.

i. Interest, dividends and certain royalties. Dividends and interest are returns on capital investments, such as stocks, bonds, or savings accounts. Royalties are compensation paid to the owner for the use of property, usually copyrighted material or natural resources. Such payments are countable as any income earned on resources unless specifically treated as non-countable under Section 210-RICR-40-00-3.5.

j. Irregular or infrequent lump sum. Unearned lump sum income that comes from an individual, organization, or investment if over $30 in a calendar quarter is counted. Treatment of lump sum income more generally is located in Section 210-RICR-40-00-3.3.4.

k. Net rental income. Net rental unearned income counts when the person spends an average of less than ten (10) hours per week maintaining or managing the property.

l. Regular and frequent gift income. Unearned income from gifts counts when receipt occurs on a continual basis, at expected intervals such as monthly, or periodically on an irregular basis.

m. Retirement, Survivor's, and Disability Insurance (RSDI). Monthly RSDI payments are countable as are other pensions and retirement pensions. The amount of any premiums deducted from RSDI for the optional Supplemental Medical Insurance (SMI) under Medicare are also counted.

n. Retroactive RSDI. Lump sum payments are counted in the month received. See Section 210-RICR-40-00-3.3.4 for information on the treatment of lump sum income more generally.

o. Severance pay. Countable as unearned income only when it is not based on accrued leave time.

p. Spousal maintenance or allowance.

q. Student financial aid, in the following situations:

(1) Earnings through the Federal Work Study program are counted only for the Sherlock Plan, in accordance with Section 1373 if average gross monthly earnings exceed $65 and Social Security and Medicare taxes are withheld; and

r. Distributions from a Coverdell Educational Savings Accounts are counted ONLY if not used or set aside for qualified educational expenses. Scholarships, grants, and fellowships. Unless authorized by Title IV of the Higher Education Act (HEA) or the Bureau of Indian Affairs (BIA), grants, scholarships, fellowships and other non-loan financial aid not used for or set aside for educational expenses is countable.

s. Tribal per capita payments from casinos.

t. Unemployment Insurance, including RI Temporary Disability Insurance (TDI) payments. Payments made through insurance programs that provide protection for lost wages as a result of an illness or injury that prevents work are countable unless explicitly prohibited by federal law.

u. Veteran's Administration (VA) benefits. Pensions are counted when not related to a disability. Any amounts allocated for a dependent child are not counted, however.

3.3 Factors Considered in the Treatment of Income

3.3.1 SCOPE AND PURPOSE

A. When calculating countable income using the SSI methodology, certain disregards and exclusions apply: some only to earned income, others only to unearned income, and a few apply to both earned and unearned income. The availability of income also affects whether it is counted. This section focuses on these and any other factors considered in the treatment of income for Medicaid eligibility purposes across populations. The specific rules for how they apply when determining income eligibility for Community Medicaid are located in Section 210-RICR-40-05-1.11 for Medicaid LTSS, the general rules are described in Sections 210-RICR-50-00-1 and 0382.

3.3.2 BOTH EARNED AND UNEARNED INCOME DISREGARDS AND EXCLUSIONS

A. The following disregards and exclusions apply to both earned and unearned income:

1. Infrequent/Irregular Income Disregards– Income is considered to be infrequent if received only once during a calendar quarter from a single source. Income is considered to be received irregularly if a person is not expected to receive such income on a routine basis. Treatment of irregular and infrequent income is as follows:

   a. Disregarded. Amounts less than $30 per calendar quarter of earned income and $60 per calendar quarter of unearned income is disregarded.

   b. Countable. If the amount of irregular/infrequent income is above the amount allowed to be disregarded, all of the income is countable.

   c. A “calendar quarter” is defined in Section 210-RICR-40-00-1.4(A)(3) herein.

2. $20/Month General Income Disregard –The first $20 per month of unearned income is disregarded. For the disregard to apply to unearned income, the income must NOT be a benefit of a government funded-program in which a person’s income was a factor in determining eligibility. The disregard is applied as follows:

   a. Order. The $20 disregard is applied to earned income only if it cannot be applied to unearned income.

   b. Limits. The dollar amount of the disregard is not increased when an applicant and NAPP spouse who are living together both have income. A couple, in which both spouses are Medicaid applicants or beneficiaries, receives one $20 exclusion per month.

3. PASS Disregard - Income, whether earned or unearned, of a person who is blind or living with a disabling impairment may be excluded if such income is needed to fulfill a Plan for Achieving Self-Support (PASS). This exclusion does not apply to applicants who are blind or a person with disabilities who is age 65 or older, unless the applicant was receiving an SSI or SSP related to blindness before reaching that age. For additional information on the PASS, see the federal SSI regulations at 20 CFR §§ 416.1180 through 416.1182.

4. Federally Mandated Exclusions – Certain federal laws other than the U.S. Social Security Act exclude various types of earned and/or unearned income from the calculation of countable income in the financial eligibility process. A list of these exclusions is located in Section 210-RICR-40-00-2.7 and is updated on a periodic basis.

3.3.3 EARNED INCOME DISREGARDS AND EXCLUSIONS

A. Deductions to earned income as a result of disregards and exclusions are applied in accordance with certain rules. First, earned income is never reduced below zero as a result of applying disregards and exclusions. Second, any unused earned income disregard or exclusion is never applied to unearned income. Last, any unused portion of a monthly exclusion cannot be carried over for use in subsequent months. Within these rules, disregards and exclusions are applied as follows:

1. $65 and 1/2 Earned Income Disregard – If the applicant or non-applicant spouse is employed, earned income of $65/month plus one half (1/2) of the balance is disregarded. When both eligible spouses are employed, income is combined and then the disregard is applied.

2. AmeriCorps -- Payments made to participants in AmeriCorps State and National and AmeriCorps National Civilian Community Corps (NCCC) are disregarded. These payments may be made in cash or in-kind and may be made directly to the AmeriCorps participant or on the AmeriCorps participant's behalf. These payments include, but are not limited to: living allowance payments, stipends, educational awards, and payments in lieu of educational awards.

3. Child Care Tax Credit – The child care tax credit is given to taxpayers at the end of the tax year for each dependent child who is under the age of 17. The credit is disregarded as earned income as it reduces the taxpayer's liability on a dollar-for-dollar basis.

4. Earned Income Tax Credit/Refund – The earned income tax credit (EITC) is not counted, The EITC is a special tax credit for certain low income working taxpayers authorized that may be provided as refund through the federal Internal Revenue Service under section 32 of the Internal Revenue Code (IRC) or as an advance payment from an employer under section 3507 of the IRC. Note: The EITC may or may not result in a payment to the taxpayer.

5. Impairment-Related Work Expenses – Earned income used by a person with disabilities to pay impairment-related work expenses is disregarded. For the disregard to apply, the person must be disabled but not blind and under age 65 or must have received SSI as a disabled individual (or received disability payments under a former State plan) for the month before reaching age 65. In addition, the following must be met:

    a. The severity of the impairment must require the person to purchase or rent items and services in order to work;

    b. The expense must be reasonable;

    c. The expense must be paid in cash (including checks, money orders, credit cards and/or charge cards) by the person and must not be reimbursable from another source (e.g., Medicare, private insurance); and

    d. The payment for the expense must be made in a month the person receives earned income and both worked and used the services or the item purchased, or the person must be working and pay the expense before earned income is received.

    e. Impairment-related work expenses that may qualify for this disregard are described in federal SSI regulations at 20 CFR 416.976.

6. Student Child Earned Income Exclusions (SEIE) – For a student under age 22 or a person who is blind or disabled and regularly attending school, a set amount of earned income per month up to a yearly maximum may be excluded. The federal government determines the monthly and maximum amounts based on variety of factors, and adjusts the figures annually to reflect increases in the cost living. (In 2016, the exclusion is $1,780 monthly up to a yearly maximum of $7,180.)

7. Work-Related Expenses of Blind Persons – Earned income used to meet any expenses reasonably attributable to the earning of the income by a person who is blind and under age 65 or received SSI as a blind person for the month before reaching the age 65. Further, expenses may be disregarded if the person has an approved plan for self-support (PASS). The amounts must be reasonable and not exceed the earned income of the blind person or a blind spouse. See references on PASS, including types of expenses that qualify for this disregard in subsection 210-RICR-40-00-3.3.2(A)(3) above.

3.3.4 UNEARNED INCOME DISREGARDS AND EXCLUSIONS

A. Exclusions on unearned income never reduce unearned income below zero. Except for the $20 general unearned income exclusion, no other unused unearned income exclusions may be applied to earned income. SSI methodology uses the following when considering whether an unearned income disregard or exclusion applies:

1. Assistance Based on Need – This is unearned income which is wholly funded by the State or a local subdivision. Assistance based on need is disregarded whether provided in-cash or in-kind as it is provided through programs that use a person's income as factor when determining eligibility for benefits or assistance. Assistance based on need that is not counted as unearned income includes the optional state supplemental payment (SSP).

2. Burial Funds – 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) but only if left to accumulate. If not left to accumulate (e.g., paid directly to the person, spouse or parent), the receipt of the interest may result in countable income.

3. Child Support and Arrearage Payments -- One-third of a child support payment made to or for a child by a non-custodial parent is excluded. A parent is considered non-custodial if the parent and the child do not reside in the same household. The other types of these support and arrearage payments that are excluded are--

    a. Court ordered health care support payments;

    b. Payments to reimburse the custodial parent for health care expenses; and/or

    c. Payments received and retained by the DHS child support enforcement unit on behalf of a child enrolled in RI Works, foster care, or Medicaid LTSS Home and Community Based Services (HCBS), including through the Katie Beckett eligibility option.

4. Death Benefits – A death benefit is something received as the result of another's death.

    a. Proceeds of a life insurance policy received due to the death of the insured;

    b. Lump sum death benefit from SSA;

    c. Railroad Retirement burial benefits;

    d. VA burial benefits;

    e. Inheritances in cash or in-kind;

    f. Cash or in-kind gifts given by relatives, friends or a community group to "help out" with expenses related to the death.

    g. Death benefits are excluded for any expenses paid by applicant or beneficiary related to the deceased's last illness and burial. Any benefits above the actual expenses paid are countable. Recurring survivor benefits such as those received under RSDI and private pension programs are not death benefits.

5. Disaster Assistance – 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. Under such circumstances, the value of disaster assistance provided by a government agency or an organization such as the Red Cross is excluded from countable income if the person resided in permanent or temporary housing in the disaster area prior to the date of the Presidential designation.

6. Federal Housing Assistance – The U.S. Department of Housing and Urban Development (HUD) and state and local governments and housing authorities provide various forms of assistance that help pay shelter costs. This includes subsidized housing, loans for modifications, mortgage supports and guaranteed loans. Housing assistance is excluded income if payment is made in the form of cash or a voucher and provided under the authority of any of the following, as amended:

    a. The United States Housing Act of 1937 (Section 8);

    b. The National Housing Act;

    c. Section 101 of the Housing and Urban Development Act of 1965;

    d. Title V of the Housing Act of 1949; or,

    e. Section 202(h) of the Housing Act of 1959.

7. Food and Nutrition Assistance – Federal and state governments provide food and nutrition assistance via SNAP, national school breakfast and lunch programs, WIC and several other publicly funded programs that serve elders, children and persons with disabilities. Food and nutrition assistance from these program is excluded income.

8. Foster Care Payments – In contrast to countable payments made under Title IV-E, Foster Care payments 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.

9. Gifts - Gifts from an organization which is tax exempt under the IRC to, or for the benefit of, a person under age 18, who has a life-threatening condition are excluded up to a maximum of $2,000 in a calendar year.

10. Grants, Scholarships, Fellowship – Grants, scholarships, and fellowships are educational financing instruments funded by private, nonprofit agencies, and federal, state and local governments. Any portion of a grant, scholarship or fellowship used to pay for qualified education expenses (tuition, fees or books, etc.) is not countable income. This exclusion does not apply to any portion set aside or actually used for room and board.

11. Home Energy Assistance Payments – Home energy or support and maintenance assistance is excluded if it is based on need and provided in-kind by a private nonprofit agency or 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.

12. Refugee Cash Assistance – Refugee cash assistance payments and federally reimbursed general assistance payments to refugees are disregarded under a PASS, but otherwise it is counted. The $20 general income disregard does not apply to this income.

13. Relocation Assistance – This form of assistance is provided to people who are displaced by government projects which acquire real property whether under imminent domain or a similar action. Assistance provided in these circumstances is excluded as income.

14. Reparation Payments – Reparations associated with the following are excluded from income:

a. Reparation payments received from the Federal Republic of Germany;

b. Austrian social insurance payments based in whole or in part on wage credits granted under the Austrian General Social Insurance Act;

c. Restitution payments made by the U.S. Government to Japanese Americans (or if deceased, their survivors) and Aleuts who were interned or relocated during World War II; and

d. Agent Orange settlement payments.

15. RI Works Under a PASS – RI Works payments under a PASS are excluded. However, RI Works payments unless excluded under a PASS, are countable income. The $20 general income disregard does not apply to this income.

16. Student Loans – Federal and State 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 loan to an undergraduate student for qualified education expenses made and/or insured by the federal government or the State's higher education financing authority is excluded as both an income and resource.

3.3.5 LUMP SUM INCOME DISREGARDS AND EXCLUSIONS

A. Lump sum income is irregularly or infrequently received income. It can be earned or unearned income. Whether lump sum income is countable when determining financial eligibility depends on what is received, how often it is received, and the health care program for which the person is eligible. Examples of lump sum income include:

1. Winnings (lottery, gambling), Insurance settlements

2. Worker's Compensation Settlements. Inheritances. Retroactive payments of RSDI, VA, and Unemployment Insurance

3. General Treatment of Lump Sum Income – For all IHCC groups subject to the SSI methodology, the following are excluded from lump sum income:

a. Costs associated with getting the lump sum, such as attorney's fees.

b. Any portion of the lump sum earmarked for and used to pay health expenses not covered by Medicaid or another form of insurance.

c. Any portion of the lump sum recovered by the EOHHS or its agents.

d. Any portion of the lump sum earmarked for and used to pay funeral and burial costs upon the death of a spouse or child.

4. RSDI and SSI Payments – When eligibility for RSDI and SSI benefits are first approved, beneficiaries often receive a one-time payment that includes retroactive payments back to the date of a disability. These RSDI and SSI payments are lump sums, and are treated somewhat differently depending on the person's Medicaid eligibility pathway:

a. SSI/SSP Pathway. Retroactive lump sum payments of SSI and all other lump sum income (including RSDI) of a SSI/SSP recipient are excluded even if the lump sum is a retroactive payment for a period in which the recipient is a Medicaid beneficiary. The only exception is that any portion of a lump sum

payment that is designated as a benefit for a dependent of the beneficiary is counted as unearned income to the dependent in the month received.

b. Community Medicaid, MPPP, and Medicaid LTSS pathways.

(1) Retroactive RSDI lump sum payments are counted as unearned income in the month received. If the beneficiary is not receiving SSI, the RSDI payment is a resource in the following month if retained. RSDI payments are not counted as a resource for nine (9) months once converted from income.

(2) Retroactive lump sum payments of SSI are excluded as income and resources in the month received.

(3) Any retroactive SSI or RSDI lump sum payment received before March 2, 2004 is excluded as a resource.

5. Medicare Part B Reimbursements – A dual eligible beneficiary's Medicare Part B premium could be reimbursed in a lump sum if determined retroactively eligible as a SLMB. In such cases, the beneficiary will receive a reimbursement check from the federal CMS after the State has provided back payment for those retroactive months. A Medicare Part B reimbursement is counted if the beneficiary used Medicare Part B premiums as all or a portion of a spenddown expense. The lump sum reimbursement is excluded if the beneficiary did not use Part B premiums as an expense for spenddown purposes. Such reimbursements may be counted in the month received for Medicaid LTSS beneficiaries receiving RSDI.

3.3.6 SELF-EMPLOYMENT INCOME

A. Self-employed beneficiaries are responsible for their own work schedule, and are not covered under an employer's liability insurance or Workers' Compensation. Depending on the type of self-employment, a beneficiary may or may not have Social Security tax (FICA) deducted from pay. Examples of self-employment enterprises include: Farming; Product Sales (e.g., involving personal goods such as jewelry, household goods, clothing and the like); Personal Training; Professional Consulting; Small businesses; Services (e.g., personal care or day care); and Skilled Trades (e.g., roofers, painters, home design, etc.). The process for evaluating self-employed income includes:

1. Treatment of self-employment income in general – Self-employment income is reported as earned or unearned on the application and is generally accepted as attested unless conflicts are identified. Net self-reported income – gross self-income minus allowable deductions for business – is countable as earned income.

2. Treatment of property related self-employment income – Certain types of self-employment involve use of real property. Deductions from gross self-employment income for allowable expenses are made in accordance with federal Internal Revenue Service (IRS) requirements associated with the business use of the home/vehicle. Special treatment is required with the following:

a. Rental income. Income from rental property is counted as earned income only in those months the applicant/beneficiary spends an average of at least 10 hours per week maintaining or managing the property. Otherwise, rent is treated as unearned income. Deductible expenses are subtracted from gross rent in the month they are incurred. Any expense over the income are subtracted from the next month's rent. Rental deposits used to pay rental expenses or repairs become income to the landlord at the point of use. Verified expenses for

providing a room or food or both to a roomer or boarder are subtracted from rental income.

b. Room/Board Income. Roomer/boarder situations include the following:

(1) A roomer lives with the household and pays for lodging only.

(2) A boarder eats with the household and pays for meals only.

(3) A roomer and boarder lives and eats with the household and pays for lodging and meals.

(4) Net self-employment income derived from room and board is countable. To determine net income in such cases, allowable expenses are deducted from gross receipts. For these purposes, allowable expenses include costs for providing a room, food or both to a roomer/ boarder; shelter costs based on percent of total rooms in the house that are for rent; and any costs related strictly to renting a particular room (e.g., accommodations related to a disability) or to a particular boarder (e.g., special diet).

c. In-home Day Care. When a person provides family child care services in a home in which he or she has an ownership interest, net self-employment income is countable. In such instances, allowable expenses are itemized as business expenses for tax filing purposes and include food (meal and snacks) and educational and entertainment materials in addition to transportation and shelter costs. If the care is provided in a home in which there is no ownership interest, the applicant/beneficiary is treated as a private contractor and these additional allowable expenses are not deducted from gross employment income. Payments made by the DHS to an in-home child care provider in association with the State's Child Care Assistance Program (CCAP) are countable.

3.3.7 IN-KIND INCOME

A. In-kind income, whether earned or unearned, is generally counted at market value. Special rules apply when such income takes the form of food or shelter:

1. Earned In-kind – Food and shelter provided in lieu of a cash payment for work is countable and subject to the applicable income disregards.

2. Unearned in-kind – When no work is performed in exchange for room and shelter, its value is determined as follows –

a. Assistance Household. If everyone in a household is receiving government assistance for income and maintenance based on need, income in the form of food or shelter is excluded regardless of value and source;

b. Living in household of another. When a person is living in the household of another for an entire month and they do not have an ownership interest or pay an appropriate share of the monthly expenses for maintaining that household, a portion of the value of the food and shelter they receive is excluded.

(1) If all meals and shelter are provided in-kind, the countable value is one-third of the FBR and the general income disregard does not apply. No other in-kind income is counted.

(2) If food OR shelter is provided but not both, the presumed maximum value (PMV) rule applies. The PMV is equal to one-third of the FBR and the $20 disregard. This amount is counted unless the person can provide documented evidence that the market value of the food or shelter is below the PMV. All other disregards and exclusions apply.

c. Living in own household. If the person lives in their own home and receives food and/or shelter in-kind, the PMV rule applies.

3.3.8 AVAILABILITY

A. Under the following circumstances, the availability of income determines whether it is counted:

1. Support Payments – When an individual has been court-ordered to pay child support and/or spousal support to a former spouse, these payments are not deducted from countable income to the applicant. When the child support/spousal support is paid directly to the former spouse or child's guardian by the employer or benefit payer, the income continues to be determined available to the applicant/beneficiary.

2. Income Deductions – Court-ordered income deductions are considered available income to the Medicaid beneficiary. A division of marital property in a divorce settlement is not considered a court-ordered income deduction in the context of this rule.

3. Loan Deductions – Deductions due to a repayment of an overpayment, loan, or other debt is considered as available income unless the amount being withheld to reduce a previous overpayment was included when determining the amount of unearned income for a previous month.

4. Garnishments and Liens – When either is placed against earned or unearned income of a person, the amount must not be deducted from countable income, regardless of the purpose for the garnishment or lien.

3.4 Federally Mandated Income Exclusions

Federally Mandated Income Exclusions
Agent orange settlement payments;
Child care assistance under the Child Care and Development Block Grant Act of 1990 (as in effect on February 1, 2016);
The first two thousand dollars per calendar year received as compensation for participation in clinical trials that meet the criteria detailed in section 1612(b) of the Social Security Act (as in effect February 1, 2016);
Payments made for supporting services or reimbursement of out-of-pocket expenses to volunteers participating in corporation for national and community service (CNCS, formerly ACTION) programs: AmeriCorps program; Special and demonstration volunteer program; University year for ACTION (UYA);
Retired senior volunteer program (RSVP)

Federally Mandated Income Exclusions
Foster grandparents program;
Senior companion program;
Energy employees occupational illness program payments;
Federal food and nutrition programs: Food assistance (formerly known as food stamps) U.S. department of agriculture food commodities distributed by a program (private or governmental); School breakfast, lunch, and milk programs; Women, infants, and children program (WIC); Nutrition programs for older Americans
Student financial assistance received under the Higher Education Act of 1965 (as in effect on February 1, 2016) or Bureau of Indian Affairs is excluded from income and resources, regardless of use: Pell grants; Student services incentives; Academic achievement incentive scholarships; Byrd scholars; Federal supplemental education opportunity grants; Federal educational loans (federal PLUS loans, Perkins loans, Stafford loans, Ford loans, etc.); Upward bound; Gear up (gaining early awareness and readiness for undergraduate programs); State educational assistance programs funded by the leveraging educational assistance program; Work-study programs.
Home energy assistance provided on the basis of need, in accordance with 20 C.F.R. 416.1157 (as in effect on February 1, 2016);
Matching funds that are deposited into individual development accounts (IDAs), either demonstration project or TANF-funded, in accordance with 42 U.S.C. 604 (as in effect on February 1, 2016);
Japanese-American and Aleutian restitution payments;
Payments to victims of Nazi persecution;

Federally Mandated Income Exclusions
Netherlands WUV payments to victims of persecution from 1940-1945;
Department of defense payments to certain persons captured and interned in North Vietnam, in accordance with the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 1998 (as in effect on February 1, 2016);
Radiation exposure compensation trust fund payments, in accordance with the Radiation Exposure Compensation Act of 1990 (as in effect on February 1, 2016);
Veterans affairs payments made to or on behalf of:
Certain Vietnam veterans' natural children regardless of or age or marital status, for any disability resulting from spina bifida suffered by such children; Certain Korea service veterans' natural children regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children; Women Vietnam veterans natural children regardless of their age or marital status, for certain birth defects;
Austrian social insurance payments received under the provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506 (as in effect on February 1, 2016). These payments must be documented and identifiable from countable insurance;
Payments made to Native Americans as listed in section IV of 20 C.F.R 416 Subpart K Appendix (as in effect on February 1, 2016);
Payments from the Ricky Ray hemophilia relief fund or the class settlement in the case of Susan Walker v. Bayer Corporation, et al. under the Ricky Ray Hemophilia Relief Fund Act of 1988 (as in effect on February 1, 2016)

3.5 SSI Methodology: Treatment of Resources

3.5.1 SCOPE AND PURPOSE

A. For the purposes of Medicaid eligibility, the assessment of resources is not tied, at least directly, to their availability to pay for health care. Instead, a resource is defined broadly as cash or other property that a person owns or has access to that is or could be used for personal support and maintenance. This section describes the general treatment of resources when using the SSI-methodology to determine eligibility for the IHCC groups to which it applies. There are differences in the types of resources that count and how they are reviewed for Community and LTSS Medicaid. Key differences in the review process are as follows:

1. Simplified Resource Review for Community Medicaid –States that have expanded eligibility for low-income elders and adults with disabilities up to 100 percent of the FPL have the authority under federal regulations to utilize a simplified standard when evaluating resources for initial eligibility and at renewal. Although the same resources are considered when using this simplified standard, they are evaluated in less depth than required for Medicaid LTSS eligibility because the provisions on resource transfers and spousal allocations do not apply. In addition, attestations with respect to certain resources are accepted at the time of initial application and the point of renewal. Depending on the availability of electronic data sources, verification through materials may be required subsequent to the determination of eligibility in the post-eligibility verification process. Note income and resource deeming is included in the simplified standard in RI.

2. Comprehensive Resource Review for LTSS – There are both MAGI and SSI-related eligibility pathways for LTSS that differ in terms of the treatment of income and resource limits, at least at the point in which an institutional level of care becomes required. Applicants evaluated using the SSI method (IHCC groups) are subject to a resource review; the resources of applicants seeking coverage through a MAGI pathway (MACC groups) are not an eligibility factor and therefore are not considered on that basis. However, all LTSS applicants, irrespective of eligibility pathway, are subject to an in-depth review of the transfer of assets – including income and resources – to ensure that the rules are applied equitably and in accordance with the standards set in federal and state laws and regulations governing estate recovery. The specific provisions applicable to the evaluation of resources and transfers if assets for Medicaid LTSS are set forth in MCAR, Section 0384.

3. Coverage Groups Exempt – Certain IHCC groups and individuals are exempt from the provisions of this section because they do not have a resource limit under applicable laws, and/or the Medicaid State Plan or the State's 1115 waiver; or their eligibility is tied to another federal or State program. Exempt groups are as follows:

    a. All beneficiaries automatically eligible for Medicaid on the basis of the current or past receipt of SSI.

    b. Beneficiaries receiving Transitional Medical Assistance (TMA) under Section 0342.50.

    c. Beneficiaries eligible for Medicaid While Working, the SSI protected coverage groups with 1619(b) status, pursuant to Section 210-RICR-40-05-1.5.2.

    d. Women who have met the eligibility criteria established by the RI Department of Health related to treatment for breast and/or cervical cancer in accordance with Section 210-RICR-40-05-1.7.2.

e. Children and youth eligible for Medicaid through the RI Department of Children, Youth and Families in conjunction with the foster care provisions under Title IV-E of the Social Security Act or the provisions of the Chafee Act. See Section 1316.

f. Medicaid beneficiaries receiving refugee cash assistance through the RI Department of Human Services.

3.5.2 DEFINITIONS

A. For the purposes of this section the following terms apply:

1. "Annuity" means a purchased contract in which one party (annuity issuer) agrees to pay the purchaser, or the person the purchaser designates (the payee or payees), a return on money deposited with the annuity issuer (either in the form of a single lump sum or several payments deposited over several months or years) according to the terms of the annuity contract.

2. "Available Resource" means that a person has the legal ability to access and use the resource(s) for support and maintenance. A resource is considered unavailable when there is a legal impediment that prevents the person from utilizing it for such purposes.

3. "Burial Expense Fund" means any resources set aside for the payment of burial services or expenses. Includes burial fund and burial space funds designated for a person or a person's spouse related to burial, cremation or other burial-related expenses. May take the form of revocable burial contracts, revocable burial trusts, other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces); cash accounts and other financial instruments with a definite cash value or irrevocable burial contracts.

4. "Equity Value" means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances.

5. "Fair Market Value" means a certified appraisal or an amount equal to the price of the property on the open market in the locality at the time of the transfer or contract for sale, if earlier.

6. "Guardian" means a person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a person with disabilities.

7. "Home" means a residential property in which the person and/or person's spouse possess an ownership interest providing it also serves as the principal place of residence of the applicant and/or the applicant's spouse or dependent child.

8. "Intent to Return" means an expression by a person indicating that he or she plans 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 beneficiary, or an authorized representative, and take the form of a signed, written statement.

9. "Life Estate" means a legal arrangement entitling the owners to possess, rent, and otherwise profit from real or personal property during their lifetime.

10. "Liquid Resources" means cash or other personal property that can be converted to cash within twenty (20) working days.

11. "Non-Liquid Resources" means property that is not cash, including real and personal property that cannot be converted to cash within twenty (20) working days.

12. “Ownership Interest” means the person seeking Medicaid 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.

13. Principal Place of Residence” means the residential property where the beneficiary, and/or in the instances specified the spouse or a dependent child of such a person lives the majority of the time during the year – one hundred and eighty-three (183) days in the previous twelve (12) months.

14. “Real Property” means land and generally whatever is erected, growing on, or affixed to land.

15. “Representative payee” means an individual, agency, or institution selected by a court or the Social Security Administration to receive and manage benefits on behalf of another person.

16. “Resource Transfer” means 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.

17. “Temporary absence” means a limited period in which an applicant/beneficiary is not residing in the home in which he/she has an ownership interest due to a hospitalization or convalescence with a relative. Temporary absences do not affect the determination of a person’s principal place of residence.

18. “Trust” means property that is legally held or managed by a person or organization other than by its owners.

3.5.3 AGENCY RESPONSIBILITIES

A. In calculating countable resources, the State’s responsibilities include, but are not limited to:

1. Scope of Resource Evaluation – The resources of the person seeking Medicaid and each member of the FRU when deeming applies are evaluated at the time of initial application, when a beneficiary reports, or the agency receives, information about a change in an eligibility factor, including in conjunction with the annual renewal of Medicaid eligibility and when applying for Medicaid LTSS or moving across eligibility pathways.

2. Factors Affecting the Evaluation of Resources – The following factors must be considered when evaluating resources:

a. Availability. The extent to which a resource can be legally accessed, and used for income support and maintenance, affects how resources are evaluated and counted. Availability is often affected when more than one person has an ownership interest in the same resource.

b. Liquidity. The ease of converting a resource into cash – sometimes referred to as a liquid asset – is considered when determining how it is treated for financial eligibility purposes.

c. Equity value. Equity value of a resource is considered when determining the amount of a resource that counts. In general, equity value means the price an item is expected reasonably to sell for on the local open market minus any encumbrances.

d. Countable v. Excluded Resources. A resource is may be counted or excluded when determining financial eligibility. The agency must consider whether a

resource is counted or subject to a general or coverage group-specific exclusion and then assure any applicable exclusions are considered as follows –

(1) Countable Resource: A resource, whether real or personal property, that is available to the applicant or beneficiary and thus counts toward a resource limit. Resource deeming applies unless otherwise specific when determining eligibility for IHCC groups providing Community Medicaid;

(2) Excluded Resource: A resource that is not counted toward the resource limit because of a specific provision in federal or state laws or regulations. Some resources are excluded categorically under federal law or regulations; other resources are excluded regardless of value for some IHCC coverage groups but at a set amount for other groups (e.g., there is no limit on the value of a home for Community Medicaid but a cap based on equity value for LTSS); and still other resources are excluded only to the extent they do not exceed a specific threshold amount (e.g. life insurance face value limit).

3. Deemed Resources – non-LTSS only – The resources of members of the FRU must also be evaluated and any that are countable attributed to the applicant(s) in the deeming process in accordance with Section 210-RICR-40-05-1.11.3. For Medicaid LTSS, there is no deeming and the evaluation of resources is always based on the applicant or individual - that is, an FRU and Medicaid eligibility unit size of one – unless both spouses are seeking coverage.

4. Determination of Resource Eligibility – Resource eligibility is determined by comparing the countable resources of the FRU to the resource limits for the applicable IHCC group adjusted for the Medicaid eligibility group size.

3.5.4 BENEFICIARY'S RESPONSIBILITIES

A. Applicants and beneficiaries are responsible for: providing accurate information about their resources in the application process and submitting any necessary documentation and/or signed authorizations that may be necessary for verification purposes.

3.5.5 TYPES OF RESOURCES AND RELATED EXCLUSIONS

A. The SSI-methodology generally divides resources into non-liquid and liquid resources. Except for cash, any kind of property may be either liquid or non-liquid. A third distinction has been added below for resources of both kinds managed by a third-party, such as trusts.

1. Non-Liquid Resources –A non-liquid resource is property that is not cash, including real and personal property that cannot be converted to cash within twenty (20) business days. Real property, life estates, life insurance and burial funds, described below, are some of the more common kinds of non-liquid resources. Certain other noncash resources, though they may occasionally be liquid, are nearly always non-liquid including, but not limited to, household goods and personal effects, vehicles, livestock, and machinery. Types of non-liquid resources evaluated when determining eligibility for IHCC groups are as follows:

a. Home and Adjoining Land (real property). A home is a residential property which includes the shelter where a person lives, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, do not affect the exemption of the property. A home in which the applicant or the spouse of an applicant has an ownership interest is excluded as resource,

regardless of its value, for EAD or MN Community Medicaid. A home is also excluded for LTSS, but only up to the equity value limits established in Sections 0380 to 0382. Factors affecting application of the exclusion include --

(1) Principal Place of Residence. The excluded home must serve as the owner's principal place of residence. A home serves as the principal place of residence if the person or spouse with an ownership interest, sibling with an equity interest and/or dependent (minor child or relative with a disability) resides in the home for at least six (6) months and one day (183 days) in any given year.

(2) Multiple Residences. Although an applicant may own residential properties either alone or in conjunction with others, only one is considered a home and 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 person and his/her spouse/dependent child make conflicting claims over which residential property is subject to the home exclusion the following decision rules apply:

If the applicant and applicant's spouse live in separate residential properties in Rhode Island in which they share ownership, the home exclusion applies to the residential property where the person lived at the time the application for Medicaid health coverage was received by the State.

If each spouse lives in a separate residential property in Rhode Island, in which they share ownership, and both spouses apply for Medicaid, the home exclusion applies to the property where the spouse who applied first resides.

If both spouses apply on the same day, the spouses must agree in writing which home is to be excluded. If no agreement can be reached, the home exclusion is applied to the residential property with the greatest value.

(3) Out-of-State Residences. To be eligible for Medicaid, a person must be a Rhode Island resident and, as such, have intent to stay in the state permanently or for an indefinite period. Accordingly, an applicant who declares an out-of-state residential property as a home to return to is not considered a Rhode Island resident for the purposes of determining Medicaid eligibility. The out-of-state residence is considered a countable resource.

(4) Multi-State Residences – When a person owns residential properties both in and out-of-state, the home exclusion is applied to the residential property located in Rhode Island. The value of any 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 any Rhode Island residential property.

(5) Out-of-State property owner – If the person does not own residential 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 person's spouse or dependent child.

(6) Sale of the Home – The home exclusion remains in effect if the Medicaid beneficiary or spouse with an ownership interest is making an effort to sell the home.

(7) Proceeds from the Sale – Once a home has been sold, the proceeds are excluded for six (6) months from the date they are received. Unless obligated or used for the purchase, repair or construction of another domicile or another excluded resource, the proceeds become countable on the FOM in the month after the exclusion expires.

(8) Temporary Absences – A home exclusion is unaffected by temporary absences due to placement in a health facility or institutional setting, including a correctional facility, provided that the owner has not placed the home in a revocable trust and the owner and:

Intends to return to the home even if the likelihood of return is apparently nil;

Has a spouse or dependent residing in the home; or

Has a health condition that prevented the owner from living there before.

b. Business/Trade Property (real property). Real estate used in business or a trade is excluded regardless of its equity value and whether it produces income.

c. Income Producing Real Estate (real property). Up to $6,000 of the equity value in non- business real estate (excluding the home), mortgages, deeds of trust or other promissory notes may be excluded. For the exclusion to apply, the property must produce an annual income of six (6) percent of the net market value or current face value of the property.

d. Vehicle (personal property). Any motorized mode of transportation that moves persons or articles from place to place. This includes automobiles, trucks, motorcycles, tractors, snowmobiles, recreational vehicles, campers, and motorized boats. One vehicle that is used as the primary source of transportation for the applicant or beneficiary is excluded, regardless of its value. The equity value above $4,500 of any other vehicles owned by members of the FRU is counted.

e. Life estate (real property). Life estate means a legal arrangement entitling the owner of the life estate (sometimes referred to as the “life tenant”) to possess, rent, and otherwise profit from real or personal property during their lifetime. The amount of a life estate that is countable depends on when it was established, whether the applicant(s) have the legal right to sell the home, and the portion of the proceeds of the sale, if allowed, is available The owner of a life estate sometimes may have the right to sell the life estate but does not normally have future rights to the property. Life estates are only excluded in full when the owner retains the power to sell or mortgage the home. If the owner does not retain this right, see Chapter 0382.

f. Burial Funds (personal property) -- Any funds clearly designated for burial expenses including burial spaces and related items and services. May take the form of contracts, revocable or irrevocable trusts, or other agreements, accounts, or instruments with a cash value. The following applying when determining the amount of burial expenses that may be excluded under one of the following:

(1) Burial fund exclusion (BFE). The BFE allows an individual to exclude up to $1,500 of resources for services include preparing the body for burial and services that are not performed at the burial site; the exclusion for a couple is $3,000; and for a person seeking MN eligibility is $4,000. These resources must be clearly designated for the person or their spouse's burial, cremation, or other burial-related services; they cannot be commingled with other resources intended for burial. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial. The BFE is reduced by the face value of any whole life insurance policy excluded under this section as well as any amounts for such services covered in a revocable burial contract.

(2) Burial space exclusion (BSE). The BSE allows burial space items to be excluded without limiting their value. Burial space items include the burial site, a repository for bodily remains, services performed at the burial site, and items related to the burial site. Only burial space items may be excluded under the BSE. Burial services are never excluded under the BSE.

(3) Irrevocable burial contracts. If a burial contract is irrevocable, the funds deposited into the agreement are unavailable and cannot be withdrawn by the person or the funeral provider until the time of need. Irrevocable burial contracts include those funded by life insurance, those funded by annuities, and those in which the person directly pays the funeral provider. Interest earned on these contracts may be separately designated as revocable or irrevocable. If the interest is designated as irrevocable, it is unavailable. If the interest is designated as revocable, it is a counted resource. The maximum amount of an exclusion for an irrevocable contract is $15,000.

(4) Revocable burial contracts. If an agreement is revocable, the funds deposited into the agreement are available and can be withdrawn at any time. A revocable burial contract may be an excludable resource depending on what burial costs it is intended to cover and whether any portion of the allocated funds can be excluded due to the BSE or BFE. When a revocable burial contract is a countable resource, either the amount the owner would receive if the contract was revoked, or the current market value if it is a saleable contract, is counted less the BFE amount if not otherwise applied – that is, $1,500 for an individual, $3,000 for a couple, or $4,000 for a person seeking MN eligibility.

g. Personal Effects and Household Goods (personal property). Personal effects are items goods such as clothing, heirlooms, jewelry and accessories. Household goods include home furnishings (e.g., furniture, rugs, and decorations) and recreational items (e.g., televisions, table or digital games, musical instruments and equipment). Such items are excluded.

h. Life Insurance Policy. A contract between the policy holder and an insurer in which the insurer agrees to pay a designated beneficiary a sum of money in exchange for a premium, upon the death of the insured person – in this case the applicant/beneficiary (often the policy holder). Whole life insurance is permanent and builds cash value over the insured person's lifetime because it has an added investment component along with its death benefit. The value of a whole life insurance policy is only counted if the person, or the person's spouse (couple) is the owner. Policies on the life of a person or applicant's spouse owned by

another member of the FRU are not considered even when deeming applies (non-LTSS). Whether a policy is counted as resource depends on two factors:

(1) Cash surrender value. Cash surrender value is the amount which the insurer will pay (usually to the owner) upon cancellation of the policy before death of the insured or before maturity of the policy.

(2) Face value. Face value is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provision.

(3) Counting rule. If the total face value of all life insurance policies on any person is at or below $1,500, or $4,000 for MN only, no part of the cash surrender value of the life insurance is included when determining countable resources. If the face value is above these amounts, the cash surrender value is a countable resource. Note: term insurance and burial insurance are not taken into account.

2. Liquid Resources –A liquid resource is cash or other property that can be converted to cash within twenty (20) business days. Accounts in financial institutions; retirement funds; stocks, bonds, mutual funds, and money market funds; annuities; mortgages and promissory notes; and home equity conversion plans, described below, are some of the more common kinds of liquid resources.

a. Annuities. A contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity; it may also be a private contract between two parties. There are two phases to an annuity, each of which affects how it is treated as resource: An accumulation phase and a payout phase. Annuities also vary significantly by type, how beneficiaries are treated, and how they accumulate and pay out money (e.g., lump sum v. scheduled, usually on a monthly basis.). All these factors influence whether the value of the annuity is counted or excluded. In addition, the State considers whether the annuity is a liquid resource, and ownership. Since annuities are trust-like instruments, terminology similar to trusts is used when it describes the availability of cash from annuities. The amount of any penalties paid when cashing-in an annuity is deducted from the amount of the payout. In general, exclusions are as follows:

(1) Annuity that can be surrendered, cashed in or assigned. An annuity that can be surrendered, cashed in or assigned by the owner is presumed to be a revocable annuity. A revocable annuity is considered a countable resource when the person seeking Medicaid is the owner. An annuity is presumed to be revocable when the annuity contract is silent on revocability.

(2) Annuity owned by someone other than the applicant or spouse. An annuity is an unavailable resource when the owner of the annuity is not the person or the person’s spouse or either spouse has abandoned all rights of ownership. However, as indicated in Section 210-RICR-40-00-3.3, if payments from the annuity are being made to the person seeking Medicaid (or spouse), those payments may be counted as income and considered for both income eligibility and deeming purposes.

(3) Treatment by Phase. An annuity owned by a person seeking Medicaid is a countable resource in its accumulation phase because it can be liquidated for a lump sum or sold. An annuity in its pay-out phase is considered an excluded resource if the person only has the right to

liquidate the annuity for the present value of all future payments and this commuted value is less than its equity value.

b. Cash and Accounts in Financial Institutions. Cash on hand is a countable resource. In addition, accounts held in financial institutions – checking and draft accounts, savings and share accounts, money market account, and certificates of deposit – are all countable resources for both the person seeking Medicaid and members of the FRU for deeming purposes. In instances in which an account is jointly held, the value is apportioned equally among owners unless there is a title or deed to the contrary. In cases in which there is ownership in common or in entirety, the provisions in Section 210-RICR-40-00-3.6.2(A)(4).

c. Investments. Stocks, bonds, mutual funds and other investment instruments are evaluated in terms of sole or joint ownership in the same manner as cash and then as follows:

(1) Savings Bonds. For U.S. Savings Bonds, the value of the bond is the amount that is paid out if the bond is cashed. The value of the bond is a countable resource, unless the bond cannot be cashed for a legal reason other than the standard 12-month waiting period.

(2) Bonds and Securities. The cash value of bonds/securities is the bid price. The bid price is a countable resource unless it was not paid for in full at the time of purchase – i.e., bought on the margin. Any debt owed is deducted from the value when calculating the amount of the resource that is countable.

(3) Stocks. The value of a stock is the closing price if it is publicly traded. The value of stocks is a countable resource.

d. Loans. A contract or written statement clearly indicating a borrower's indebtedness, the personal or real property used to secure the borrowed amount (collateral), if any, and the terms of repayment.

e. Mortgages. A debt instrument, secured by the collateral of specific piece of real estate property, that a borrower is obliged to pay back without paying the entire purchase price upfront by making a predetermined set of payments. A borrower is considered an owner for the purposes of determining Medicaid eligibility before the debt is paid-off as long as payments are being made. The countable value of a mortgage is the remaining balance on the contract; or the gross price for which it can be sold or discounted on the open market minus any legal debts, claims, or liens against the property, unless proof is provided that there is a legal bar to sale or a reliable third-party provides proof demonstrating a lower value.

f. Promissory notes. A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered or the owner of the agreement (the seller), a promissory note is a liquid resource. The property itself is not a resource because the seller cannot legally convert it to cash while it is encumbered by the agreement. If payments received by the seller consist of both principal and interest, only the interest portion is income. The principal portion is the conversion of a resource and is not income. The value of a promissory note is an available resource unless the person provides evidence of a legal bar to the sale of the promissory note.

g. Retirement funds. Any resource set aside by a person to be used for self-support upon their withdrawal from active life, service, or business. Retirement funds include, but are not limited to, certain IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and retirement annuities. The value of a retirement fund is the amount of money that can currently be withdrawn from the fund, less any penalties for withdrawal. Retirement funds are excluded when owned by either the person seeking Medicaid or a spouse and termination of employment is required to obtain a payout from the fund; the person applying is not eligible for periodic payments and does not have the option of withdrawing a lump sum; or either spouse is drawing down on the fund at a rate consistent with their life expectancy. In addition, there is no deeming of retirement funds to a person by a NAPP spouse or child.

h. Education funds. Resources set aside to pay for qualified education expenses such as 529 accounts and Coverdell Educational Savings Accounts. The full amount of such funds is typically excluded even if the beneficiary is a member of the FRU.

i. Health savings accounts (HSAs) Accounts used to set aside funds to meet medical expenses. Unless the individual can demonstrate that the funds in their HSA are not available to them, the HSA is a countable resource.

3. Resources managed by a third party –Resources, liquid and non-liquid, managed by a third party include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a person managed by a third party (e.g., trustee, guardian, conservator, or agent under a power of attorney) are considered available to that person as long as he or she can direct the third party to dispose of the resource or the third party has the legal authority to dispose of the resource on the person's behalf without the person's direction.

a. Guardianship funds. A person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a person with disabilities. Guardianship funds are presumed to be available for the support and maintenance of the protected person and, as such, are a countable resource if he or she is seeking Medicaid That person may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.

b. Power of attorney. Funds managed by an agent under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

c. Representative payee. A person, agency, or institution selected by a court or the SSA to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the benefit of that person, to notify the payer of any event that will affect the amount of benefits the person receives or circumstances that would affect the performance of the representative payee's responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.

d. Trust. A property interest that usually takes the form of fund comprised of a variety of liquid and non-liquid resources – e.g., cash, stocks, bonds, personal effects, life insurance, business interests, and real estate – that is held by a person or entity (called a "trustee") who is legally responsible for ensuring the

property owned by trust is used to benefit another person (the “trust beneficiary). The person who transfers the resources to the trust is known as the “grantor.” In some instances, the grantor is also named as a trust beneficiary or “grantee.” The treatment of a trust for Medicaid eligibility purposes depends on its type, whether the property it holds is accessible, and who is the grantor, grantee and/or trustee. Trusts – In general, the treatment of trusts depends on the specific type and whether they revocable or irrevocable by the grantor – i.e., the person who established the trust. For LTSS eligibility purposes, the evaluation of trusts considers whether there have been any impermissible transfers. Section 0382 identifies the types of trusts and how they are treated. For Community Medicaid purposes, the following rules apply:

(1) Revocable trusts. If the trust can be revoked by the grantor under RI law, the principal and interest are treated as a resource.

(2) Irrevocable trusts. If the trust cannot be revoked by the grantor – portions of principal that could be paid to the beneficiary are a countable resource.

3.6 Factors Considered in the Treatment of Resources

3.6.1 SCOPE AND PURPOSE

A. There are several common features in process for evaluating resources when using the SSI methodology that apply across IHCC groups, whether using a full or simplified review. The purpose of this section is to set forth these features and identify any exceptions where appropriate.

3.6.2 PROCESS RULES

A. The following process rules apply generally in the evaluation of resources across IHCC groups.

1. First of the Month Rule –Countable resources are determined as of the first of the month (FOM). This determination is based on the resources the person owns, their value, and whether or not they are excluded as of the first of the month.

2. Resource Changes – 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 may occur include:

   a. Changes in value of existing resources. The value of an existing resource may increase or decrease.

   b. Disposition or acquisition of resources. A person 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).

   c. Change in exclusion status of existing resources. A person may replace an excluded resource with one that is not excluded (e.g., sell an excluded vehicle 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 – RSDI – benefits) may expire.

   d. Change in resource form. The sale or transfer of a resource is treated as a change in the form of the resource rather than in countable income.

3. Resource Reduction – If countable resources exceed the limit as of the first moment of a month, the applicant is not eligible for that month, unless the resources are reduced by expenditures on certain allowable expenses.

    a. Community Medicaid. When a person seeking Community Medicaid has resources in excess of the general limits for a particular IHCC group, the Integrated Eligibility System evaluates eligibility for other forms of coverage and, if no other forms of eligibility are available, a notice is issued which explains the opportunity for resource reduction. In such instances, eligibility may be established by incurring and paying for a health care or other allowable expenses that equals or exceeds the amount of the excess resources. The expense and proof of payment must be provided within thirty (30) days of the notice of ineligibility.

    b. Medicaid LTSS. For persons applying for Medicaid-funded LTSS, income and/or resource reduction is generally part of the application review process and is referred to as the pre-eligibility evaluation of medical expenses (PEME). See Section 210-RICR-50-00-1.

    c. Allowable expenses. In general, allowable expenses for resource reduction include:

        (1) Health care services that are not covered under the Medicaid State Plan and the State's Section 1115 demonstration waiver and are not reimbursable by a third-party such as Medicare, or some form of insurance. Such expenses must occur in a month of eligibility, including periods of retroactive eligibility when applicable. Certain LTSS home health care services are allowable expenses for Community Medicaid applicants when delivered by certified providers but only up to the amount Medicaid pays for the same or similar services on a fee-for-service basis. Additional rules apply for Medicaid LTSS.

        (2) Tax payments based on assessments by the federal Internal Revenue Service, the Rhode Island Department of Revenue or, other State or municipal taxing authority.

        (3) Fees for court-appointed guardians or conservators including, but not limited to, court filing fees, the cost of a Probate Bond, court-approved guardianship/ conservatorship fees, and court-approved legal fees.

        (4) Legal fees associated with disposing or gaining access to resources.

4. Evaluation Factors - The methods for evaluating resources vary depending on the standard of review, as indicated above, as well the type of resources. In general, each type of resource has its own unique deductions, exclusions, and methods for determining its countable value. Unless a resource is excluded, the ownership interest in a resource is evaluated in accordance with the following:

    a. Countable value. The countable value of a resource is the equity value. The equity value is the current fair market value minus any legal debt or encumbrances on the item. To be considered a debt against the resource, the debt must be legally recognized as binding on the resource's owner. The current fair market value is the amount an item can be sold for on the open market.

    b. Jointly Owned Resources. When two or more parties share rights to sell, transfer, or dispose of part or all of personal or real property, the ownership share held by each person must be evaluated. This rule applies to resources such as joint

checking or savings accounts and real estate held in common. In instances in which the document creating the joint interests, such as a deed to real estate or a bank account signature card, specifies the shares of the parties, the fair market value of the entire resource is divided between the joint owners according to the shares specified. Attribution of jointly owned resources is otherwise determined as indicated below:

(1) Tenancy in common. Applies to all jointly owned resources which do not specify the ownership portion if each party – as in cases of joint tenancy or tenancy in its entirety – and, as result, the ownership portion may be unequal. When the person seeking Medicaid and/or spouse has a tenancy in common with someone outside the household, the total value of non-liquid resources is divided among the total number of owners in direct proportion to the ownership interest held by each. By contrast, when a liquid resources such as an account in a financial institution is held in common, the entire equity value of funds in the account is considered available to its owner.

(2) Joint tenancy. Occurs when each of two or more persons has an equal undivided interest in the whole resource. When a person owns a resource as a joint tenant, the entire equity value of the resource is considered available to that person. When the instrument creates an unequal interest between the joint tenants, only the portion available to the member of the FRU is counted.

(3) Tenancy in its entirety. The value of any resource owned in its entirety by a person – e.g., joint savings account – is considered available to its owner and is included as such for deeming in Community Medicaid and the allocation of resources for Medicaid LTSS.

c. Counting Order. If excluded funds are combined with countable resources, it is assumed the countable resources are spent first.

d. Prudent-person standard. The prudent-person standard is used when determining whether a lower fair market value for a resource is reasonable. For example, for property sold at an auction, the current fair market value is considered to be the highest bid unless there is evidence that the transaction constitutes a resource transfer rather than a sale.

5. Legal Factors Affecting Availability – A court restriction may make all or part of the resource unavailable. Other legal restrictions on resources may be included in: liens, domestic orders, divorce decrees, child support orders, probate matters, tax intercepts and garnishments, and/or bankruptcy proceedings.

6. Identifiability – Some resources must be identifiable to be excluded and, as such must be distinguishable from other resources. A resources is identifiable if:

a. The funds are kept physically apart from other funds, such as in a separate bank account.

b. The funds are not kept physically apart from other funds, but can be identified using a complete history of account transactions dating back to the initial date of deposit based on the records of the account holder.

c. When a withdrawal is made from a commingled account, the non-excluded funds are assumed to be withdrawn first, leaving as much of the excluded funds in the account as possible.

d. The excluded funds remaining in the account can only be increased by deposits of subsequently received excluded funds and excluded interest. If interest on the excluded funds is excluded, the percent of an interest payment to be excluded is the same as the percent of funds in the account that is excluded at the time the interest is posted. The excluded interest is then added to the excluded funds in the account.

e. The requirements related to identifiability vary for Community Medicaid and Medicaid LTSS.

3.6.3 MANDATORY RESOURCE EXCLUSIONS

A. Resource exclusions may be mandated under the SSI methodology or by federal laws other than the Social Security Act as well as by the State and various other program requirements.

1. Exclusions Required by Federal Law – Federal law establishes that certain resources are excluded when determining Medicaid eligibility using the SSI methodology across all IHCC coverage groups. A list of mandated federal exclusions based on how they are treated if identifiable is located in Section 210-RICR-40-00-3.7.

2. Required by State law or regulation – Rhode Islanders are permitted a state tax deduction for funds committed to the State-administered 529 education account. Funds contributed to such an account are excluded, except for the amount of the RI tax deduction, as long as they are set aside for qualified educational expenses.

3.6.4 SPECIAL AND LIMITED-TIME EXCLUSIONS

A. There are a number of special and time-limited exclusions that apply across the IHCC groups as well. Additional LTSS-specific time-limited exclusions are located in MCAR Section 0382 to 0384. Applicable general time-limited exclusions are as follows:

1. Retroactive Social Security and SSI/SSP – Retroactive payments of federal SSI, SSP (the state only supplement to SSI), or RSDI benefits are excluded for nine (9) months beginning on the FOM after the month of receipt. These payments are also excluded as resources during the month of receipt.

2. Funds for Replacing Excluded Resources – Cash and interest earned on that cash are excluded when received from any source, including casualty insurance, when it is for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged. The exclusion is allowed for nine (9) months from the month of receipt of such funds and may be extended for an additional nine months for good cause.

3. Earned Income Tax Credit – State and federal earned income tax credit refunds and advance payments are excluded as resources for one year beginning the month after receipt.

4. Health and Human Services Payments – Cash received for health and human services is excluded for the calendar month following the month of receipt. The month following the month of receipt, the cash counts as a resource if it has been retained.

5. Victim's Compensation Payments – State-administered victims' compensation payments are excluded for twelve (12) months after the month of receipt.

6. Relocation Payments – State and local government relocation payments are excluded for twelve (12) months after the month of receipt.

7. Expenses from Last Illness and Burial – Payments, gifts, and inheritances occasioned by the death of another person are excluded provided that they are used for expenses resulting from the last illness and burial of the deceased and by the end of the calendar month following the month of receipt.

8. Long-term Care Insurance Partnership – Amounts equal to the amount paid monthly in benefits from the time of application for long-term care insurance are disregarded as a resource when determining Medicaid eligibility under the Federal Deficit Reduction Act of 2005. For purposes of LTSS eligibility, the same amount is excluded when determining the amount to be recovered from a beneficiary's estate.

9. Dedicated home repair and modification funds – Up to an additional $4,000 may be set aside for a limited period – not to exceed one year – in a separate dedicated account for the purposes of home repairs/modifications that enable a Medicaid LTSS beneficiary to continue to receive home-based care. Funds may only be used for such expenses when they are not covered by a third-party, including Medicare, Medicaid and any federally or state-funded housing or assistance authority, and must be spent on repairs and modifications necessary to ensure a beneficiary is able to safely continue to obtain care in his or her own home. The set-aside must be approved by a Medicaid LTSS specialist based on documentation that the repairs/modifications are required for the person's health and safety and the cost estimates are deemed reasonable – i.e., estimates from a properly qualified contractor. Documentation that repairs are needed may be provided by a health practitioner or contractor. Any funds remaining in the account at the eligibility renewal after the account was established or used for purposes other than qualified home repairs or modifications are counted as a resource on the first day of the month following the renewal date.

3.6.5 DETERMINATION OF RESOURCE ELIGIBILITY

A. Once the appropriate exclusions have been applied and the value of each type of resource is determined, the value of all countable resources (including deemed resources) are added together to determine the total countable resources for the Medicaid eligibility group for the family size involved. If the resources of the Medicaid eligibility unit fall below or are equal to the applicable eligibility resource standard, the resource test is passed. If an excess resource amount remains after all exclusions have been applied, the applicant/beneficiary has not passed the resource test and must either reduce resources in accordance with the applicable provisions in subsection 210-RICR-40-00-3.6.2(A)(3) or give away excess resources subject to the transfer of resources rule for Medicaid LTSS coverage as provided for in MCAR Section 0384.

3.7 Federally Mandated Exclusions

A. The following is a list of federally mandated exclusions based on whether or not they are identifiable:

Federally Mandated Resource Exclusions
Identifiable and Excluded Indefinitely (unless otherwise indicated)
Agent Orange Settlement Fund payments

Federally Mandated Resource Exclusions
Blood Product Settlement payments
Corporation for National and Community Service (CNCS) payments. Payments to volunteers, including the following payments authorized under the Domestic Volunteer Services Act, are excluded: AmeriCorps Urban Crime Prevention Program Special Volunteer Programs under Title I Demonstration Programs under Title II Senior Corp: Retired Senior Volunteer Program (RSVP) Foster Grandparent Program Senior Companions
Individual Development Accounts (IDA)
Japanese and Aleutian Restitution payments
Jensen Settlement Agreement payments. Payments received by class members are excluded. Funds received under this agreement from countable resources at the time of application and at each renewal are deducted.
Low Income Home Energy Assistance Program (LIHEAP) payments
Nazi Persecution payments
Radiation Exposure Compensation Trust Fund (RECTF) payments
Real estate taxes, homeowner's insurance and funds set aside for upkeep expenses of the property. Up to one year's expenses are excluded. Funds must be kept in a separate account.
Relocation Assistance payments, federal
Ricky Ray Hemophilia Relief Fund payments
Student financial aid received under Title IV of the Higher Education Act or Student financial aid received from the Bureau of Indian Affairs (BIA) Non-Title IV and non-BIA grants, scholarships, fellowships and other non-loan financial aid, if used or set aside to pay educational expenses until the month following the last month the student is enrolled in classes. Distributions from a Coverdell Educational Savings Accounts (ESA) if the funds are used for educational expenses.

Federally Mandated Resource Exclusions
Excluded for the designated beneficiary of the account for nine months following the month of receipt of a distribution. Excluded for anyone who is not a beneficiary who contributes money to the account beginning the month after the month the funds are transferred into the account. Excluded, due to being a conversion of a resource, for a contributor who is the designated beneficiary beginning with the month after the month the cash is transferred into the account. Veteran's Affairs (VA) benefits designated as educational assistance both under graduate and graduate students until the month following the last month the student is enrolled in classes. Plan to Achieve Self Support (PASS) student financial aid. Training expenses paid by the Trade Adjustment Reform Act of 2002 Qualified Tuition Programs (QTP), also known as a 529 Plans, for the designated beneficiary (the student or future student) who is not the owner of the account and does not have any rights to the funds in the account. The account is counted as resource for the owner.
Tribal payments and interests. The following tribal resources are excluded. Tribal trust or restricted lands, individual interest Tribal per capita payments from a tribal trust Tribal land settlements and judgments
Uniform Gift to Minors Act/Uniform Transfers to Minors Act (UGMA/UTMA) The full value of resources established under the UGMA/UTMA is excluded. An adult designated to receive, maintain and manage custodial property on behalf of a minor beneficiary is not the owner of UGMA/UTMA resources because the adult cannot legally use any of the funds for his or her support and maintenance. When the UGMA/UTMA property is transferred to a beneficiary at the end of the custodianship (usually at the age of 18 or 21 depending on state law) the property becomes available to the beneficiary. It is counted as income in the month of transfer and as a resource in the following month.
Veterans' Children with Certain Birth Defects payments
Vietnamese Commando Compensation Act payments
Excluded Resources Regardless of Identifiability **(unless otherwise noted)**
Adoption Assistance payments are excluded in the month of receipt and thereafter.
Accrued Interest on resources is excluded if any excess is properly reduced at eligibility redetermination.

Federally Mandated Resource Exclusions
Alaska Native Claims Settlement Act (ANCSA) payments
Appeal Payments are excluded as resources in the month received and for three months after the month of receipt.
Clinical trial participation payments excluded by SSI. The first $2,000 a person receives during a calendar year is excluded.
Cobell Settlement for American Indians for a period of 12 months beginning with the month of receipt. This exclusion applies to all household members.
Crime victim payments
Disaster assistance, federal payments
Disaster assistance, state payments
Filipino Veterans Equity Compensation (FVEC) payments
Foster Care payments
Gifts to Children with Life Threatening Conditions from 501(c)(3) tax-exempt corporation. These are not considered resources of a parent and apply only to children who are under age 18. Cash gifts up to $2,000 in any calendar year are excluded. The amount of total cash payments that exceed $2,000 each year are counted as a resource. Multiple cash gifts in the same calendar year are added together and up to $2,000 of the total is excluded, even if none of the cash gifts exceeds $2,000 individually.
Homestead real property
Household goods and personal effects
James Zadroga 9/11 Health and Compensation Act of 2010
Kinship payments
Proceeds from the Sale of a Homestead are excluded if a person: Plans to use the proceeds to buy another homestead, and Does so within three full calendar months of receiving the funds
Reimbursements for replacement of lost, damaged or stolen excluded resources are excluded for the month of receipt and nine months thereafter. The funds are excluded for up to nine more months if the person tries to replace the resources during that time, but cannot do so for good reason.
Representative Payee Misuse payments. If a person’s Supplemental Security Income (SSI), Retirement, Survivors and Disability Insurance (RSDI) benefits, or Veterans Benefits for the Elderly is reissued because an individual representative payee misuses benefits, the reissuance is excluded as a resource for nine months if retained after the month of receipt.

Federally Mandated Resource Exclusions
Retroactive RSDI and SSI benefits are excluded for the nine (9) calendar months following the month in which the person receives the benefits. Any accrued interest on that account is counted as income in the month received and as a resource in the following months.
State Annuities for Certain Veterans
Relocation payments, State and local
Tax credits, rebates, and refunds are excluded for 12 months after the month of receipt
Term life insurance

210-RICR-40-05-1

Title 210 - Executive Office of Health and Human Services

Chapter 40 Medicaid Integrated Health Care Coverage

SUBCHAPTER 05 – IHCC COMMUNITY MEDICAID

Part 1 – Community Medicaid

1.1 OVERVIEW

A. The IHCC groups established in this section provide the principal Medicaid non-LTSS eligibility pathways for elders and adults with disabilities who have SSI, an SSI characteristic, and/or meet special program specific requirements. The medically needy (MN) eligibility pathway for all populations seeking non-LTSS Medicaid coverage is also included in this section. The State uses the term "Community Medicaid" to distinguish IHCC group members from Medicaid LTSS beneficiaries eligible using SSI financial eligibility requirements.

1.2 AUTHORITY

A. Legal authority for the IHCC groups is established in RI General Laws, the Medicaid State Plan, the State's Section 1115 demonstration waiver and various provisions of Title XIX of the Social Security Act and Code of Federal Regulations (CFR). State law establishing the IHCC group that expands eligibility to low-income elders and adults with disabilities (referred hereinafter as "EAD") with income up to and including one hundred percent (100%) of the Federal Poverty Level (FPL) is located in R.I.G.L.§ 40-8.5. Many of the core eligibility requirements associated with this group, including those pertaining to MN eligibility, pre-date both this law's enactment and federal approval of the State's 1115 waiver as extended in 2014 and, are dispersed in various other provisions of Chapter 40-8 rather than in a single statute.

1.3 SCOPE AND PURPOSE

A. This purpose of this rule is to establish and describe the Community Medicaid IHCC groups and the requirements for determining Medicaid eligibility, effective on and after the effective date of this rule. The summary table below shows each of these groups and the agency authorized to determine eligibility or the basis for eligibility:

Community Medicaid Eligibility Pathways	
IHCC Group	**Agency Responsible for Determining Eligibility**
Low-income Elders and Adults with Disabilities (EAD)	EOHHS
SSI Recipients	SSA
SSP Recipients	SSA and EOHHS
Pickle Amendment	EOHHS

Community Medicaid Eligibility Pathways	
IHCC Group	**Agency Responsible for Determining Eligibility**
Section 1619 (a) Employed Adults with Disabilities	SSA
Section 1619(b) Medicaid While Working	SSA
Protected Surviving Spouses	EOHHS
Adult Children with Disabilities	EOHHS
Divorced/Surviving Spouses with Disabilities	SSA
SSP Recipients, 12/73	EOHHS
Divorced/Surviving Spouses with Disabilities – Actuarial Changes	SSA
Breast and Cervical Cancer Screening and Treatment	DOH
Refugee Medicaid Assistance (RMA)	EOHHS
Sherlock Plan	EOHHS

1.4 DEFINITIONS

A. For the purposes of this section, the following definitions apply:

1. “Adult Dependent Child” means an unmarried person 18 years of age or older who has a disabling impairment that began before age 22 that is collecting disability related benefits from the U.S. Social Security Administration (SSA).

2. “Applicant” means the person seeking initial or continuing eligibility for Medicaid.

3. “Community Medicaid Eligibility Standards” means the income and resource standards used as the basis for determining initial and continuing Medicaid eligibility for each coverage group included in this section.

4. "Deemed income" means income attributed to another person whether or not the income is actually available to the person to whom it is deemed.

5. "Deemor" means a person whose income and/or resources are subject to deeming. Such individuals include non-applicant parents and spouses and sponsors of non-citizens.

6. “Non-Applicant or NAPP” means a person whose finances are considered for deeming purposes although is not seeking or is unqualified for Medicaid.

7. "Parent" means a natural or adoptive father or mother living in the same household as the eligible child.

1.5 Eligibility for Elders and Adults with Disabilities

1.5.1 SCOPE AND PURPOSE

A. This section identifies the chief eligibility pathways for persons 65 and older and 19 to 64 who are living with a disabling impairment - adults with disabilities.

1.5.2 EAD ELIGIBILITY PATHWAY – LOW-INCOME ELDERS AND ADULTS WITH DISABILITIES

A. Under Section 1396a of the Social Security Act, states have the option under the Medicaid State Plan of expanding eligibility to elders and adults with disabilities up to and inclusive of one-hundred percent (100%) of the FPL. Rhode Island chose this option in 1999 and now refers to this categorically eligible expansion group by the acronym “EAD.” The EAD coverage group has higher income and resource limits than the SSI program and serves, therefore, as the State’s chief general eligibility pathway for anyone with an SSI characteristic who does not qualify for SSI benefits. Coverage group features are as follows:

1. Eligibility Criteria – To qualify for Medicaid coverage through the EAD eligibility pathway, a person must meet the general eligibility requirements related to residency, citizenship and cooperation set forth in Section 210-RICR-40-05-1.9 and the following:

   a. Characteristic Requirements. A person must be without SSI and meet the characteristic requirements with respect to:

      (1) Age. Sixty-five (65) and older; or

      (2) Disability. Determined by the State’s Medicaid Assessment and Review Team (MART) to meet the applicable SSI disability standards; or

      (3) Blindness. Federal regulations preclude states that have expanded SSI-based eligibility to income above the SSI standard (at or below 75%) to treat blindness as a distinct eligibility characteristic. Accordingly, applicants who are blind and are ineligible for SSI or an SSI Protected Status are subject to a MART disability determination.

   b. Financial Requirements. The person must meet income and resource standards for EAD eligibility based on the SSI methodology as follows:

      (1) Income. Total countable income must be at or below 100% of the FPL for the family size involved; and

      (2) Resources. Total countable resources must not exceed $4,000 for an individual and $6,000 for a couple.

2. Determination Process -- The application review process evaluates all persons seeking Medicaid for eligibility through a MACC group using the MAGI standard. Anyone who self-reports a disabling impairment or who is sixty-five or older is then evaluated for Community Medicaid eligibility through the pathways set forth in this section. Federal regulations at 42 CFR 435.404 require EOHHS to provide anyone determined eligible through multiple pathways to choose the coverage group that best suits their needs.

3. Continuing Eligibility -- With implementation of the State's IES, EOHHS is instituting a modified passive renewal process. Beneficiaries are required to review and update a pre-populated form containing information obtained in their accounts and updated monthly or quarterly through electronic data matches about eligibility factors subject to change. Detailed provisions pertaining to the passive renewal process are set forth in Section 1402.02.

4. Agency Responsibilities -- The EOHHS is responsible for overseeing the evaluation of applications for EAD eligibility, enrollment, and processing renewals. In addition, prior to ending Medicaid health coverage, the EOHHS must ensure that a review is conducted to determine whether eligibility exists through any other eligibility pathway. Other responsibilities are set forth in greater detail, as indicated, in other sections of this rule.

1.5.3 MEDICALLY NEEDY (MN) ELIGIBILITY PATHWAY

A. Medically needy eligibility is available to certain IHCC group members who do not need LTSS. (Different rules apply for LTSS eligibility as indicated in MCAR 0390.) Under the RI Medicaid State Plan, MN coverage is an option for elders and adults with disabilities, parents/caretakers, children and pregnant women. Adults19-64 in the MACC group do not qualify for MN coverage, and must therefore reapply through the Community Medicaid MN pathway. There is also a MN pathway for Refugee Medicaid Assistance as indicated in Section 210-RICR-40-05-1.7.3. See Section 210-RICR-40-05-2 for provisions related to the Community Medicaid MN pathway.

1.5.4 SSI AND SSP RECIPIENTS AND SSI PROTECTED STATUS

A. Federal law requires the states to provide Medicaid health coverage to SSI and SSP recipients. There are certain circumstances in which SSI recipients who lose or otherwise no longer qualify for full cash assistance benefits are afforded "protected status" which allows them to retain their Medicaid eligibility. In such instances, the person is treated as if he or she is an SSI recipient for Medicaid eligibility purposes. The Medicaid SSI, SSP and protected status coverage groups are described below:

1. SSI Recipients – There is no distinct State-based eligibility pathway for SSI recipients. Medicaid eligibility is automatic upon approval of SSI. The SSA determines eligibility for SSI and notifies the State of the SSI recipient's eligibility through an electronic data exchange. The State is responsible for enrollment and the provision of Medicaid health coverage until SSI eligibility ceases unless protected status is available. The EOHHS is responsible for determining whether EAD coverage is available through an alternative Medicaid eligibility pathway for SSI recipients without protected status who have or are about to lose SSI.

2. State Supplement Payment (SSP) Recipients – Persons who are eligible to receive the optional state-funded supplemental payment are automatically eligible for Medicaid health coverage under the Medicaid State Plan.

    a. Eligibility criteria. To qualify, a person must be an SSI recipient, a former SSI recipient with Medicaid protected status, or a person who meets the criteria for EAD or LTSS and resides in one of several pre-approved SSP living arrangements as specified in R.I.G.L. 40-6-27.2.

    b. Determination process. The SSA determines eligibility for SSP for SSI recipients. As the State agency that shares responsibility with the SSA for administering the SSI program in Rhode Island, the Rhode Island Department of Human Services (DHS) requires non-SSI recipients to qualify for SSP on the basis of the EAD or applicable LTSS eligibility criteria. Eligibility criteria for all other SSP categories are located in the DHS Code of Administrative Rules in the section entitled: Supplemental Security Income (SSI) and State Supplemental Payment Program

and are available on the RI Secretary of State's website at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DHS/8080.pdf.

c. Continuing eligibility. Renewal of Medicaid for SSP recipients is conducted in accordance with the requirements for SSI or EAD, depending on the basis of eligibility, and the applicable requirements related to living arrangement. The amount of the payment, which depends on a characteristic, living arrangement and certain other factors, is not considered in determining countable income for continuing Medicaid eligibility purposes. Medicaid eligibility based solely on SSP ceases when a recipient no longer qualifies for the payment unless there is another basis for coverage.

d. Agency responsibilities. The SSA determines initial eligibility for SSP using the SSI methodology and any additional criteria required by the State. DHS determines eligibility for non-SSI recipients through the State's IES. The EOHHS and DHS share responsibility for certifying that a beneficiary qualifies for SSP cash assistance in Category D (assisted living) and Category F (community supportive living arrangements) based on living arrangement. A need for a Medicaid LTSS is an eligibility condition for Category F.

e. Applicant/beneficiary responsibilities. SSP beneficiaries must meet all specified application and general eligibility requirements and provide the evidence required to certify payment based on living arrangement.

3. Pickle Amendment Eligibility Pathway – Since enacted in 1977, Section 503 of Public Law 94-566, known as the "Pickle Amendment," protected Medicaid eligibility for certain persons who receive Social Security or Retirement, Survivor, or Disability Insurance (RSDI) benefits. The Pickle Amendment requires the State to apply certain income disregards using a specific federal formula, which essentially deems the person an SSI recipient for Medicaid eligibility purposes.

a. Eligibility Criteria. Pickle Amendment coverage is available for a person who meets all other SSI eligibility criteria and:

(1) Was simultaneously entitled to receive both Social Security RSDI and SSI in some month after April 1977;

(2) Receives income that would qualify him or her for SSI after deducting all RSDI cost-of-living adjustments (COLA) received since the last month in which the person was eligible for both RSDI and SSI; and

(3) Is currently ineligible for SSI and eligible for and receiving RSDI.

b. Determination process. When determining Pickle eligibility, the current SSI federal benefit rate plus any SSP payment is compared to the person's other countable income plus the amount of the RSDI benefit at the time SSI/SSP eligibility was lost. The COLA at the time Pickle eligibility is determined is disregarded in this calculation as are any COLAs for years prior up to and including the year SSI payments ceased, as long as the date the increase occurred is after April 1977. The result of this calculation is the "Protected Benefit Amount" (PBA) and is used as the basis for determining continuing Pickle Amendment eligibility. Income of any financially responsible family members is factored into the PBA calculation. All other general eligibility criteria apply. However, a MART determination of disability is not required.

c. Continuing eligibility. Persons eligible under the Pickle Amendment are subject to EAD passive renewal requirements. The COLA disregards continue to apply as

long as income permits. As the SSI benefit rises from year to year, it may increase to an amount that exceeds the RSDI and the countable income amount at the time SSI eligibility ceased. At this point, the State discontinues Pickle Amendment eligibility and determines whether eligibility through an alternative pathway is available.

d. Agency responsibilities. SSA informs the State annually about potential "Pickles" at cost-of-living adjustment (COLA) time. The EOHHS is responsible for applying the COLA disregards when determining EAD eligibility of anyone who may qualify for Medicaid in this group. If found ineligible on this basis, the State also evaluates whether Medicaid is available through any other pathway.

e. Applicant/beneficiary responsibilities. Potential members of this coverage group must provide any additional information that may be required to determine eligibility and comply with the applicable general requirements for SSI-based eligibility set forth in Section 210-RICR-40-05-1.9.

f. Table of RSDI Cost-of-Living Adjustments. For a history of automatic cost-of-living adjustments, see: https://www.ssa.gov/news/cola/automatic-cola.htm

4. Employed Persons with Disabilities (Section 1619(a)) Working persons with disabilities who have gross earnings at or above the SSI income standard may qualify for continuing payments, and thus Medicaid health coverage, providing they meet all SSI non-disability requirements. The following must be met for Section 1619 (a) coverage:

   a. Eligibility Criteria. To qualify, the person receiving SSI based on disability must have gross earnings at or above the SSI income standard and:

      (1) Maintain disability status while working;

      (2) Meet all other SSI eligibility criteria;

      (3) Have been eligible for and received a regular SSI payment based on disability for a previous month within the current SSI eligibility period.

   b. Determination process. As long as the beneficiary meets the criteria for 1619 (a), no income or resource standards apply e.g., income can be above the EAD limits set forth in section 210-RICR-40-05-1.5.2.

   c. Continuing Eligibility. Medicaid health care coverage for members of this group is automatic and continues until ended by the SSA for any reason for which it may be granted.

   d. Agency responsibilities. The SSA determines initial and continuing eligibility and notifies the EOHHS on a monthly basis of beneficiaries who qualify for 1619(a) coverage. The EOHHS is responsible for determining whether beneficiaries who no longer qualify are eligible through an alternative eligibility pathway.

5. Medicaid While Working (1619(b) – Section 1619 (b) of the Social Security Act provides Medicaid to employed persons with disabilities who no longer qualify for Section 1916 (a), but need coverage to continue working. This pathway preserves Medicaid eligibility when a working person's total countable income, both earned and unearned, including deemed income, is too high for an SSI cash payment. Unlike Section 1619 (a) coverage, Section 1619(b) provides "Medicaid While Working" protection when SSI cash benefits are no longer available. Medicaid health coverage is preserved for both members of a couple under 1619(b) if each is working, and their total combined income would result in the loss of SSI cash benefits, even if the income of one would not alone trigger non-payment

status. However, a non-working spouse has no protection under 1619(b) and loses Medicaid when the earned income of his or her spouse exceeds the limits for SSI cash benefits. . For Community Medicaid health coverage through this pathway, the following apply:

a. Eligibility Criteria. A person must have received an SSI cash payment based on disability, including under Section 1619(a), for at least one month in the most recent SSI benefit period, and –

(1) Continue to meet the disability criteria for SSI payments except for earnings;

(2) Have insufficient earnings to replace the SSI/SSP cash benefit, Medicaid health coverage, and/or personal care or attendant services that would be available if they did not have such earnings; and

(3) Need Medicaid health coverage to continue to work or obtain employment.

b. Determination process. As long as the beneficiary meets the eligibility criteria for Medicaid While Working, and income remains below the 1619(b) threshold for Rhode Island, which changes annually and can be obtained on the Social Security Administration's website, no income or resource standards apply.

c. Continuing Eligibility. Medicaid coverage for members of this group is automatic and continues until ended by the SSA for any reason for which it may be granted or income exceeds the threshold for Rhode Island.

d. Agency responsibilities. The SSA determines initial and continuing eligibility and notifies the EOHHS on a monthly basis of beneficiaries who qualify in this coverage group. The EOHHS is responsible for determining whether beneficiaries who no longer qualify for Medicaid through an alternative eligibility pathway.

6. Protected Surviving Spouses – In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress permanently revised eligibility standards set in Section 1634 (b) of the Social Security Act to protect access to Medicaid health coverage for divorced and surviving spouses who lose SSI eligibility as a result of RSDI benefits.

a. Eligibility criteria. To qualify, a person must be between the ages of 50 and 65 and meet all other eligibility criteria for SSI except for income and the following:

(1) Were it not for RSDI benefits, the person would continue to be eligible for SSI and/or SSP;

(2) Received an SSI payment the month before RSDI payments began; and

(3) Must not eligible for Medicare Part A (hospital coverage insurance).

b. Determination process. For the purposes of Medicaid eligibility, the State must disregard the RSDI benefit and consider a person who meets these criteria a deemed SSI recipient until they become eligible for Medicare Part A.

c. Continuing eligibility. Medicaid eligibility in this coverage group ends on the first day of the month the beneficiary becomes eligible for Medicare Part A.

d. Agency responsibilities. The SSA notifies the EOHHS that an SSI recipient losing eligibility may qualify for Medicaid through this pathway. Notification is also provided to the State of the date in which Medicare Part A becomes available. The State then determines whether coverage is available through EAD or another alternative eligibility pathway. The RSDI disregard, the basis for protected status, is no longer included in the determination of countable income when the person is being evaluated for these other forms of Medicaid health coverage.

7. Adult Dependent Child with Disabilities – Section 1634 of the Social Security Act provides protection of Medicaid eligibility status for certain adult children with disabilities who lose SSI due to income from a parent's RSDI benefits or Social Security Disability (SSD) benefits from the adult child's own work record. For the purposes of this coverage, "adult child" includes an adopted child, or, in some cases, a stepchild, grandchild, or step grandchild who is unmarried and is age 18 or older. When determining EAD eligibility for members of this group, the parent's RSDI or child's SSD benefit is disregarded to preserve continuing Medicaid eligibility.

   a. Eligibility criteria. To qualify for this eligibility pathway, a person must be:

      (1) At least 18 years of age;

      (2) Living with a disabling impairment that began prior to the age of twenty-two (22);

      (3) An SSI recipient based on blindness or that disabling impairment; and

      (4) No longer be qualified for SSI due to income resulting only from either the RSDI benefits associated with the retirement, death or disability of a parent or an SSD benefit paid to an adult child with disabilities.

   b. Determination process. RSDI or SSD benefits paid to the beneficiary are disregarded when calculating countable income. . SSI rules for the treatment of income otherwise apply. Protected eligibility is granted if the RSDI or the SSD benefit is the ONLY source of additional income.

   c. Continuing eligibility. Protected status as a result of the RSDI or SSD disregard continues to apply as long as the beneficiary meets the disability/blindness criteria, there are no additional sources of increased countable income, and resources remain within the applicable limits.

   d. Agency responsibilities. SSA notifies the State when a recipient loses SSI on this basis and qualifies for the disregards for eligibility through this pathway. The EOHHS is responsible for determining whether other relevant criteria for continuation of protected status and application of the disregard is warranted. Beneficiaries who lose protected status must be evaluated for alternate forms of Medicaid eligibility before their coverage is terminated.

8. Divorced or Surviving Spouses with Disabilities – This coverage group consists of surviving and divorced spouses who have been determined disabled and lose SSI and/or SSP due to receipt of the RSDI Disabled Widow Benefits (DWB). For Medicaid purposes, these persons are deemed to be SSI recipients until they are entitled to receive Medicare. The SSA is responsible for informing the State of persons who are eligible for continuing eligibility on this basis.

9. State Supplemental Recipients, 12/73 – This coverage group consists of Medicaid beneficiaries eligible under the Medicaid State Plan on the basis of SSI in December

1973 and their spouses who continue to live with them and are essential to their well-being. Medicaid eligibility of the spouse continues as long as the SSI recipient remains eligible under the 1973 eligibility requirements. The SSA notifies the State of persons who are deemed eligible in this group.

10. Surviving Spouses with Disabilities Affected by Actuarial Changes – The Social Security Amendments of 1983 eliminated an actuarial reduction formula applied to the RSDI benefits of surviving spouses with disabilities who became entitled to RSDI benefits before age 60. To offset the loss of Medicaid eligibility that occurred as a result, the Consolidated Omnibus Budget Reconciliation (COBRA) of 1985 restored Medicaid eligibility for any surviving spouses with disabilities who lost coverage and filed an application for Medicaid before July 1, 1988. SSA notifies the State of any SSI recipients who may qualify for Medicaid coverage via this eligibility pathway. Eligibility continues until such time as coverage through another Medicaid eligibility pathway becomes available or the beneficiary's countable income exceeds the total of the SSI benefit rate and the RSDI payment at the time protected status was initially conferred.

1.6 The Medicare Premium Payment Program (MPPP)

1.6.1 SCOPE AND PURPOSE

A. The Medicare Premium Payment Program (MPPP) helps low-income elders 65 and older and adults with disabilities pay all or some of the costs of Medicare Part A and Part B premiums, deductibles and co-payments.

1. Basis of Eligibility -- A person's income and resources, as calculated using the SSI methodology, determine which type of Medicare premium assistance is available. Members of this coverage group are known as "dual eligible", as they qualify for both Medicare and Medicaid, as defined below:

   a. Dual eligible beneficiaries who qualify for the MPPP, but not full Medicaid health coverage are referred to as "partial dual eligible" beneficiaries;

   b. Dual eligible beneficiaries who meet the all the eligibility requirements for an IHCC or MACC group and are enrolled in Medicare Parts A and B are known as "full dual eligible beneficiaries."

   c. Dual eligible beneficiaries who receive Medicaid health coverage through the MN pathway, and meet the income requirements for the MPPP, are referred to a partial dual eligible plus beneficiaries.

2. Medicare Coverage and the MPPP -- Medicare provides the following types of coverage:

   a. Part A. Pays for hospital services and limited skilled nursing services. Medicare Part A is provided at no-cost to a person who: is insured under Social Security or Railroad Retirement Systems (e.g., paid into the system for 40 quarters of work) and 65 years of age; has reached the 25th month of a permanent and total disability; or received continuing kidney dialysis or had a kidney transplant. Under an agreement with the SSA, the State is authorized to purchase Part A through the MPPP for persons who are elderly or living with a disability who do not qualify for no-cost Part A coverage.

   b. Medicare Part B. Pays for physician services, durable medical equipment and other outpatient services. Medicare Part B is available to persons who pay a monthly premium and are 65 years of age or older without regard to whether they are insured in the Social Security or Railroad Retirement Systems as well anyone

who has reached the 25th month of a permanent and total disability. Initial enrollment is a seven-month period that starts three (3) months before a person first qualifies for Medicare and extends three months past the 65th birthday or, if failing to enroll during this period, through an open enrollment period held each year from January through the end of March. The State pays the Part B premium for Medicare beneficiaries eligible through all of the MPPP eligibility pathways listed below.

c. Medicare Part C. Medicare managed care ("Advantage" plans) provide Medicare Part A, Part B and Part D (prescription drug coverage) for beneficiaries who qualify.

d. Medicare Part D. Pays for prescription drug coverage for enrolled Medicare beneficiaries. Costs for beneficiaries vary. Low-income Medicare beneficiaries who qualify for the federal government's Extra Help[2] program, which provides assistance in paying the costs for Part D, are automatically eligible for the MPPP. The SSA provides electronic notification to the states of Medicare beneficiaries who are eligible for the MPPP on this basis.

e. Medicaid wraps around Medicare's coverage by providing financial assistance to beneficiaries in the form of payment of Medicare premiums and cost-sharing, as well as coverage of some benefits not included in the Medicare program. Not all dual eligible beneficiaries receive the same level of Medicaid benefits, as indicated below.

1.6.2 MPPP ELIGIBILITY PATHWAYS

A. The specific eligibility requirements and benefits coverage groups included in the MPPP pathway are as follows:

1. Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only) – Financial assistance in this group is provided to beneficiaries who are eligible for or enrolled in Medicare Part A, have countable income of 100% of FPL or less and resources that do not exceed the amounts set annually by the federal government (see subsection 210-RICR-40-05-1.6 below). For partial dual eligible QMBs:

   a. Medicaid makes a direct payment to the federal government for the Part A premium (if any), the Part B premium, and provides payments for Medicare co-insurance and deductibles as long as the total amount paid by Medicare does not exceed the amount Medicaid allows for the service.

   b. Eligibility begins on the first day of the month after the application is filed and all eligibility requirements are met.

   c. Eligibility is renewable in twelve (12) month periods.

   d. Deeming rules do not apply.

   e. There is no retroactive coverage.

2. QMBs with Medicaid health coverage (QMB Plus) – Persons who qualify through this pathway must be entitled to Medicare Part A, have countable income at or below 100% of the FPL, and resources at $4,000 individual or $6,000 couple. Beneficiaries eligible

---

2 See: https://www.medicare.gov/your-medicare-costs/help-paying-costs/extra-help/level-of-extra-help.html

through this pathway are full dual eligible beneficiaries and receive premium assistance and Medicaid health coverage. Includes MN Medicaid beneficiaries. Access to Medicaid retroactive coverage, continuing eligibility, and the full scope of Medicaid essential benefits is available.

3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) – These individuals are entitled to Medicare Part A, have countable income of greater than 100% FPL, but less than 120% FPL, resources within the federally defined limits, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

    a. Medicaid pays the Medicare Part B premium to SSA

    b. Eligibility begins on the first day of the month in which the application is filed and all eligibility requirements are met.

    c. Eligibility is authorized for a twelve (12) month period and is renewable on that basis.

    d. Deeming rules do not apply.

    e. Retroactive coverage may be available.

4. SLMBs with Medicaid health coverage (SLMB Plus) – To be eligible through this pathway, a person must be entitled to Medicare Part A, have countable income of greater than 100% FPL but less than 120% FPL, and resources of no more than $4,000 for an individual or $6,000 couple. A person qualifies for Medicaid through this pathway only if MN requirements are met. In addition to full Medicaid essential benefits, the MPPP also pays the beneficiary's Medicare Part B premiums, coinsurance, deductibles and copayments.

5. Medicaid pays the SSA. Community Medicaid EAD general eligibility requirements govern access to Medicaid retroactive coverage, continuing eligibility, and scope of coverage.

6. Qualified Disabled and Working Individuals (QDWIs) – This pathway covers beneficiaries who lost their Medicare Part A benefits due to their return to work. They must be eligible to purchase Medicare Part A benefits, have countable income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility (EAD limits of $4,000 for an individual or $6,000 for a couple), and must not be otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

    a. Medicaid makes a direct payment to the SSA for the Part A premium;

    b. Eligibility begins the month in which all requirements are met, including enrollment in Part A, and continues for a year unless or until changes in employment result in resumption of Medicare without MPPP assistance.

7. Qualifying Individuals-1 (QI-1) – To qualify for eligibility through this pathway, beneficiaries must be entitled to Medicare Part A, have countable income of at least 120% FPL, but less than 135% FPL, resources that do not exceed the amounts set by the federal government (see subsection 210-RICR-40-05-1.6 below), and be otherwise ineligible for Medicaid. Medicaid pays Medicare Part B premiums only. Federal matching funds for members of this group is 100 percent and, as such, the availability of financial assistance through QI-1 eligibility is contingent on federal appropriations. For members of this group:

a. Medicaid makes a direct payment to the SSA for the Part B premium.

b. Eligibility begins the month in which the application is filed and all requirements are met and ends on December 31st of the year in which the application is filed.

c. Cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty Guideline update is published.

d. Deeming applies.

e. Retroactive coverage is available.

8. MN and QMB (+) and SLMB (+) – Participation in the MPPP may adversely affect the income eligibility of a person seeking initial or continuing Medicaid health coverage through the MN pathway. As the State pays some or all Medicare costs for MPPP participants, these allowable health expenses cannot be counted toward a MN spenddown. This, in turn, may make it difficult to obtain Medicaid health coverage for high costs services that are covered only in part or not at all by Medicare. MPPP enrollment may also affect other forms of Medicaid eligibility if it changes the way income or resources are counted. An agency eligibility specialist should be consulted by an applicant or beneficiary who is concerned that enrolling in the MPPP will affect access to Medicaid health coverage.

1.6.3 MPPP APPLICATION PROCESS

A. There are multiple application pathways for pursuing MPPP eligibility.

1. MPPP -- Persons seeking MPPP coverage may apply through the State or the SSA. If applying through the State's IES, a person has the option of applying for the MPPP only or Medicaid health coverage and the MPPP.

2. LIS and Social Security Administration (SSA) – An application for the LIS program is available on line at: https://secure.ssa.gov/i1020/start or by calling 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm. The State uses information provided by the SSA for determining LIS eligibility to initiate an application for the MPPP, when appropriate.

1.6.4 MPPP ELIGIBILITY AND CONTINUING ELIGIBILITY

A. Persons seeking MPPP assistance are subject to the SSI-methodology for determining financial eligibility, though the income and resources standards specific to the MPPP coverage group, as indicated in subsection 210-RICR-40-05-1.6 below, are applied. A disability determination is not required for MPPP financial help only. With the implementation of the State's IES, continuing eligibility is determined using a modified passive renewal process (See Section 210-RICR-40-00-2.7).

1.6.5 MPPP SUMMARY

A. The following provides a summary of the MPPP eligibility pathways by coverage group that shows current year financial eligibility limits and the benefits provided:

MPPP Eligibility Pathways – 2017			
Coverage Group	**Full or Partial Eligible**	**Income and Resource Limits** **Individual/Couple**	**Benefits**
QMB	Partial Dual	100% FPL[3] $7,390/$11,090	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part A premiums (if needed) Medicare Part B premiums Certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)
QMB +	Full Dual	100% FPL $4,000 / $6,000	All of the above AND Medicaid health coverage
SLMB	Partial Dual	101-125% FPL $ $7,390/$11,090	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums
SLMB +	Full Dual	101-120% FPL $4,000 / $6,000	Same as above AND: Certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program) Full Medicaid Coverage

3 All MPPP applicants receive a $20 income disregard.

MPPP Eligibility Pathways – 2017			
Coverage Group	**Full or Partial Eligible**	**Income and Resource Limits** **Individual/Couple**	**Benefits**
QI	Partial Dual	121-135% FPL $7,390/$11,090	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums
QWDI	Partial Dual	$4,105/$5,499	Lost Medicare Part A benefits because of return to work but eligible to purchase Medicare Part A and qualify for Medicaid payment of: Medicare Part A premiums

1.7 Special Coverage Groups

1.7.1 OVERVIEW

A. There are certain IHCC groups that are exempt from various income and/or resource requirements because they provide coverage to people with unique characteristics and/or health needs.

1.7.2 BREAST AND CERVICAL CANCER

A. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), amended Title XIX to include an optional Medicaid coverage group for uninsured women who are screened and need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix. The RI Department of Health (DOH), Women's Cancer Screening Program, is responsible for administering the screening required for Medicaid eligibility through this pathway.

1. Eligibility Criteria – To qualify, an applicant must be under age sixty-five (65) and receive screening for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program administered by DOH and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix. In addition, an applicant must not be Medicaid eligible in another coverage group or have access to or be enrolled in a health insurance plan that provides essential benefits, as defined in federal regulations at 42 CFR 447.56. All general requirements for Medicaid must also be met. There is no resource limit. Retroactive eligibility is available for eligible members of this coverage group and no disability determination is required.

2. Determination process – Members of this coverage group are not required to meet EAD income and resource limits or those established for other Medicaid eligibility pathways. Under the State's Section 1115 waiver, income eligibility for members of this coverage group is set at two-hundred and fifty (250%) of the FPL. In addition, presumptive eligibility is also available to women who meet the screening requirements, prior to a full determination of Medicaid eligibility, if the woman is a resident of the State.

3. Continuing eligibility – A redetermination of Medicaid eligibility must be made periodically to determine whether the beneficiary continues to meet all eligibility requirements. Eligibility ends when the beneficiary:

   a. Attains age sixty-five (65);

   b. Acquires qualified health insurance/creditable coverage;

   c. No longer requires treatment for breast or cervical cancer;

   d. Fails to complete a scheduled redetermination;

   e. Is no longer a RI resident; OR

   f. Otherwise does not meet the eligibility requirements for the program.

4. Agency responsibilities – The DOH administers the screening and application segments of the program. EOHHS conducts redeterminations and renewals and is responsible for providing timely notice and the right to appeal when any change in eligibility occurs.

5. Applicant/beneficiary responsibilities – Beneficiaries are responsible for providing timely and accurate information about the status of their condition/treatment prior to the date of redetermination or at intervals specified.

1.7.3 REFUGEE MEDICAL ASSISTANCE (RMA) - MN OPTION

A. Refugee Medical Assistance (RMA) is a 100 percent federally funded program for individuals and families operating under the auspices of the U.S. Department of Health and Human Services, Office of Refugee Resettlement (ORR). RMA is an eligibility pathway for individuals and families who are otherwise ineligible for Medicaid. Until enactment of the ACA, all persons seeking RMA were evaluated using the SSI methodology, through the MN eligibility pathway. The ORR has waived these requirements and directed that, prior to a determination for RMA, states should evaluate all participants in its programs for Medicaid and commercial coverage , using the MAGI methodology (MACC groups under Chapter 1300 and HSRI) and SSI-related coverage (Community Medicaid under this Chapter) before pursuing RMA through the MN pathway.

   1. Eligibility Criteria – Any member of the federal resettlement program for refugees who has income at or below 200 percent of the FPL and is otherwise ineligible for Medicaid or an HSRI plan providing financial help, may apply for RMA using the MN process. This included adults 19 to 64 who have no other Medicaid MN eligibility option and certain persons in need of LTSS. The criteria set forth in 210-RICR-40-20.9 for Community Medicaid apply for establishing the spenddown period and allowable expenses except there are no resource requirements and deeming is not permitted.

   2. Determination Process – All persons seeking Medicaid coverage who have refugee status are evaluated for MACC group eligibility first using the MAGI before being evaluated for IHCC group coverage using the SSI methodology or special eligibility requirements in this section. This includes the MN pathways identified in this chapter for elders, adults with disabilities, children, parents/caretakers, and pregnant women. If determined ineligible through these pathways, the person is evaluated for coverage through HSRI and then MN eligibility pathway through RMA. The RMA MN eligibility pathway requires a beneficiary to spenddown to the MNIL for elders and adults with disabilities, adjusted for family size.

   3. Continuing Eligibility – Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months residing 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 federal government.

a. Coverage Limit. Coverage and 100 percent federal matching funds continue until the end of the eighth month or the date in which the person no longer meets the immigration status requirement, whichever comes first. Prior to ending eligibility for Medicaid through this pathway, a review of other possible forms of Medicaid eligibility is conducted by the State.

b. No Five Year Bar. Federal law exempts refugees from the five (5) year bar for qualified non-citizens established under the U.S. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Section 401. Once the (8) eight-month RMA period ends, states are required to continue Medicaid eligibility under any other coverage group for which a refugee may qualify providing all other requirements are met. (See MCAR, Section 0340 for more immigration information.) Renewals for continuing coverage are conducted in accordance with the applicable coverage group requirements including six month budget periods through the MN pathway.

4. Agency responsibilities – Beneficiaries eligible under this section are required to meet the spenddown requirements set forth in Section 210-RICR-40-05-2. The agency is responsible for ensuring that the spenddown period coincides with the eligibility period. In addition, the EOHHS must evaluate each applicant/beneficiary in this group for MAGI-based Medicaid and HSRI eligibility prior to granting MN eligibility. Federal payment for eight months is provided regardless of pathway.

5. Applicant/beneficiary responsibilities – Beneficiaries are responsible for meeting the spenddown requirements set forth in Section 210-RICR-40-05-2.

1.7.4 SHERLOCK PLAN

A. The Sherlock Plan Medicaid for Working People with Disabilities Program is an SSI-related IHCC group comprised of working adults with disabilities pursuant to the Balanced Budget Act of 1997 (42 USC section 1396a(a)(10)(ii)(XIII)). Eligibility for the Sherlock Plan is included in Section 1373 which focuses on Medicaid eligibility for adults with disabilities who are working.

1.7.5 EMERGENCY MEDICAID

A. Medicaid health coverage is available to non-citizens in emergency situations without regard to immigration status.

1. Eligibility Criteria – To qualify for emergency Medicaid, a non-citizen must meet all of the eligibility requirements for a MACC or an IHCC group, except for immigration status. Persons seeking emergency Medicaid are evaluated as follows:

a. Persons under age 65. All persons in this group are evaluated for the MACC groups identified in Chapter 1300 using the MAGI, at the income limit applicable for the population to which they belong – e.g., child, adult or parent/caretaker, pregnant woman. There is no resource limit and no determination of disability.

b. Elder 65 and older. Non-citizens in this category are evaluated using the IHCC Community Medicaid EAD eligibility requirements and income standard. Resource limits apply, but there is no determination of disability.

c. Medically Needy. Persons who are ineligible under (a) or (b) in this subsection because their income is too high, may seek coverage through the IHCC pathway

as MN in accordance with Section 210-RICR-40-05-1.5.3 and Section 210-RICR-40-05-2 in detail.

d. In addition, the person must require treatment for an emergency health condition in accordance with the prudent layperson standard -- as defined in the federal Balanced Budget Act of 1997 -- as specified below and obtain such services from a certified Medicaid provider. Such an emergency health condition is:

(1) A health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

2. Determination Process – Emergency service providers – typically an acute care facility such as a hospital – provide assistance with completing any required forms upon determining, in conjunction with the presumptive eligibility process specified in MCAR, Section 1318, that emergency Medicaid coverage may be required. In situations in which eligibility for emergency Medicaid cannot be determined or ascertained in this process, an agency eligibility specialist is contacted to provide the non-citizen with assistance in applying for coverage and assuring payment is made for any of the Medicaid-covered emergency services rendered. MN eligibility is available, as a last resort, for non-citizens who have income above the applicable eligibility limits for other coverage groups if the costs incurred for emergency services are sufficient for a spenddown. Payments to providers are typically made post-treatment.

3. Continuing Eligibility – Emergency Medicaid coverage is limited to the period in which the emergency health condition is treated. Under applicable federal regulations, such coverage does not include any follow-up services deemed medically necessary to prevent the need in the future for emergency services for the same illness, disease or condition in an acute care facility.

4. Agency responsibilities – The EOHHS is responsible for assisting in the application process and making timely payment for services provided under this subsection, including for any services billed separately by licensed providers and professionals as long as the costs were incurred during the emergency health period for the condition specified.

5. Applicant/beneficiary responsibilities – Applicants must provide timely and accurate information on all eligibility factors unrelated to immigration status required for making a determination for Medicaid health coverage.

1.8 COMMUNITY MEDICAID -- LTSS PREVENTIVE SERVICES

1.8.1 AUTHORITY

A. Under the terms of the State's Section 1115 demonstration waiver, Community Medicaid beneficiaries who do not yet need Medicaid LTSS but are at risk for the nursing facility institutional level of care have access to LTSS preventive services. Beneficiaries who meet the needs-based criteria for these LTSS preventive services are eligible for a limited range of home and community-based services and supports along with the full range of primary care essential benefits they are entitled to receive. The goal of preventive services is to delay or avert LTSS institutionalization or more extensive and intensive home and community-based care.

1.8.2 SCOPE OF SERVICES

A. Depending on a beneficiary's needs, the following LTSS preventive services may be available to Community Medicaid beneficiaries:

1. Limited Certified Nursing Assistant/ Homemaker Services – These services include general household tasks (e.g., meal preparation and routine household care) and are available when a beneficiary can no longer perform them on their own and there is no other person available to provide assistance. Limited personal care may also be available.

    a. Maximum hours available: 6 hours per week for a single beneficiary or 10 hours per week for a household with two or more beneficiaries.

2. Minor Environmental Modifications – Minor modifications may be available to a beneficiary to facilitate independence and the ability to live at home or in the community safely. Such modifications may include: grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, simple devices, such as: eating utensils, a transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles.

1.8.3 CLINICAL REVIEW

A. To qualify, the Office of Medicaid Review (OMR) must determine that one or more LTSS preventive services will improve or maintain the ability of a beneficiary to perform Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) and/or delay or mitigate the need for intensive home and community-based or institutionally based care. Detailed information about the clinical standards and review process is provided in MCAR, Section 210-RICR-50-00.

1.8.4 LIMITS

A. To qualify for preventive level services, there must be no other form of coverage for the services provided and no other person or agency responsible or capable for doing so.

1.8.5 CONTINUING NEED

A. The need for LTSS preventive services is reassessed annually in conjunction with the renewal process. Preventive services continue until the beneficiary reports that the risk for LTSS has been mitigated or a follow-up clinical evaluation conducted by the OMR finds that such services need to be changed or terminated. Beneficiaries are notified of the date of a clinical review at least ninety (90) days in advance.

1.9 Community Medicaid General Eligibility Requirements

1.9.1 SCOPE AND PURPOSE

A. All applicants for Medicaid in the IHCC groups must meet general eligibility requirements in addition to those related to income, resources, and clinical need.

1.9.2 CHARACTERISTIC REQUIREMENTS

A. Unless specifically exempt, a person applying for Community Medicaid when eligibility is determined by the state must establish their categorical relationship to SSI by qualifying on the basis of one of the following characteristics:

1. Age – A person qualifying on the basis of age must be at least sixty-five (65) years of age in or before the month in which eligibility begins.

    a. Verification: An applicant's age is verified electronically with information about date of birth from the SSA and/or the RI Department of Health, Division of Vital Statistics. If data matches are unsuccessful, an applicant is required to provide paper documentation of date of birth to support a self-attestation of age.

2. Disability – Determined to meet the SSI disability criteria applied by the MART, or the SSA for SSI cash benefits or RSDI or SSD. Note: An applicant must be determined disabled due to blindness by the MART or by an entity of the SSA. If income is at or below SSI income standard, a disability determination for blindness is NOT required.

1.9.3 NON-FINANCIAL CRITERIA

A. Applicants must also meet all of the following non-financial eligibility criteria for Medicaid:

1. Social Security number – Each person applying for Medicaid must have a Social Security Number (SSN) as a condition of eligibility for the program.

    a. 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 are required to provide a SSN, however. An SSN of a non-applicant may be requested to verify income. Refusal of a non-applicant to provide an SSN cannot be used as a basis for denying eligibility to an applicant who has provided an SSN. If an SSN is unavailable, other proof of income must be accepted.

    b. Limits on Use. Applicants must also be informed that their SSN will be utilized only in the administration of the Medicaid program, including in verifying income and eligibility.

    c. Verification. SSN is verified through an electronic data-match with the SSA. Applicants must provide documentation of SSN if the data match fails. Paper documentation indicating that an application for an SSN has been made is required for applicants who do not have an SSN at the time of application.

2. Residency –A person must be a resident of Rhode Island to be eligible for Medicaid. The state of residence of a person is determined according to the following:

    a. SSP. For persons receiving an SSP payment, the state of residence is the state paying the supplement. Exception: Persons involved in work of a transient nature or who have moved to the state to seek employment may claim Rhode Island as their state of residence and be granted Medicaid in Rhode Island if they meet all other eligibility criteria. These persons may be granted Rhode Island Medicaid even though they continue to receive a state supplemental payment from another state.

    b. Persons under 21. Residency is determined as follows for minors:

        (1) A person who is blind or living with a disabling impairment under the age of 21 who is not residing in an institution, the state of residence is the state in which the person is living.

        (2) Any person residing in a health care or treatment facility who is under the age of 21, or who is 21 or older and became incapable of indicating intent prior to the age of 21, the state of residence is that of –

The parents or legal guardian, if one has been appointed, or

The parent applying for Medicaid on behalf of the person if the parents live in different states, or

The person or party who has filed the application on behalf of the applicant if the applicant has been abandoned by his or her parents and does not have a legal guardian.

c. Persons 21 and older. For adults age 21 or older, residence is determined as follows:

(1) If not living in an institution, the state of residence is the one in which the person is living –

With intent to remain permanently or for an indefinite period of time;

While incapable of stating intent; or

After entering with a job commitment or in pursuit of employment whether or not currently employed.

(2) A person age 21 or older who is residing in a health institution and became incapable of stating intent at or after age 21, residence is in the state in which the person is physically present, unless another state arranged for placement in a Rhode Island institution.

(3) For any other person age 21 or older living in an institutional setting, residence is in the state where the person is living with the intention to remain permanently or for an indefinite period, unless another state has made a placement. A person living in a health care institution cannot be considered a Rhode Island resident if he or she owns a home in another state and has an intent to return there even if the likelihood of return is apparently nil.

d. Absence Due to Military Assignment. A blind or impaired child who travels out of the State for an indefinite period with a parent in the armed forces is no longer eligible for Medicaid or SSP even if SSI benefits continue.

e. Temporary Absence. Temporary absences from Rhode Island for any of the following purposes do not interrupt or end Rhode Island residence:

(1) Obtaining necessary health care;

(2) Visiting;

(3) Obtaining education or training under a program of the RI Office of Rehabilitation Services (ORS), Work Incentive or higher education program, or

(4) Residing in an LTSS facility in another state, if arranged by an agent of the State of Rhode Island, unless the person or his/her parents or guardian, as applicable, stated an intent to abandon Rhode Island residence and to reside outside Rhode Island upon discharge from LTSS.

f. Placement in Rhode Island Institutions. When an agent of another state arranges for a person's placement in a Rhode Island institution, the person remains a resident of the state which made the placement, irrespective of the person's intent.

g. Incapable of Stating Intent. Persons are incapable of stating intent regarding residence if they are judged to be legally incapable of doing so or there is medical documentation or other documentation acceptable for such purposes that supports a finding that they are incapable of stating intent.

h. Residence as Payment Requirement. A person must be a resident of Rhode Island at the time a medical service is rendered in order for Rhode Island Medicaid to pay for that service. The service does not, however, have to be rendered in Rhode Island.

i. Specific Prohibitions. Under federal law, the State may not deny Medicaid eligibility to an applicant for any of the following reasons:

(1) Failure to reside in the State for a specified period; or

(2) Failure of a person receiving care in an institutional setting to establish residence in the State before entering the institution if otherwise satisfying the residency rules set forth in this section; or

(3) Temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for purposes of Medicaid; or

(4) Failure to have a permanent or fixed address. Homeless persons may designate a mailing address.

j. Verification – At the time of initial application for Medicaid, self-attestation of Rhode Island residency is accepted and/or verified electronically and the intent to remain is accepted unless required for the evaluation of resources or income that has been earned by the applicant in another state.

3. Living Arrangements – A person's living arrangement is a factor when determining eligibility for programs and payment amounts that may directly or indirectly affect access to Medicaid for certain Medicaid services. In addition, incarceration is also a factor that affects eligibility status and access to Medicaid coverage.

a. Financial eligibility. The financial responsibility of relatives varies depending upon the type of living arrangement. Thus, when determining financial eligibility, the living arrangements of individuals and couples matter as follows:

(1) Living in own home such as a house, apartment, or mobile home or someone else's household. Affects Medicaid MACC household composition and RIte Share participation and thus is a factor considered in the process noted in Section 210-RICR-40-00-2.6.2;

(2) Residing in a community-based group care or board and care facility such as assisted living, supportive home for persons with developmental disabilities or behavioral health needs. Determines Medicaid eligibility group size and cap on room and board charges and allowances and contributions to cost of care;

(3) Residing in a health care or treatment institution such as a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, residential care facility for adults or children requiring treatment or rehabilitation services. An institution is, for these purposes, an establishment that furnishes food, shelter and some health treatment, services, and/or supports to four (4) or more persons unrelated to the proprietor. Determines Medicaid eligibility group size and countable income;

(4) Persons who are homeless are considered to be living in their own homes if they reside in a shelter or move from one temporary living arrangement to another for more than six (6) months during a calendar year.

b. SSP. Eligibility for and the amount of the optional state supplemental payment is affected by the following living arrangements which, in turn, may determine a Medicaid beneficiary's choice of care settings:

(1) Residence in a hospital or nursing facility for the whole month and Medicaid pays for over one-half of the cost of care;

(2) Medicaid LTSS beneficiary living in either an appropriately certified residence/home participating in the Medicaid Community Supportive Living Program established under R.I.G.L. § 40-8.13-12, or Medicaid certified assisted living residence authorized in accordance with R.I.G.L.§ 40-6-27;

(3) Medicaid beneficiary who is SSI or EAD eligible (non-LTSS) and is residing in an assisted living residence;

(4) Medicaid beneficiary under 21 residing in a hospital or nursing facility for the entire month and private insurance and/or Medicaid together pay over one-half the cost of care; or

(5) Medicaid beneficiary of an age or IHCC group residing in a public or private health care treatment facility and Medicaid is paying for more than half the cost of care. If residing in the facility for the whole month, the SSP payment is limited to $50.

c. Verification – For both Medicaid eligibility (a) and SSP (b), self-attestation of living arrangement is accepted during initial application for persons living in their own homes or in someone else's household. Documentation certifying that a person is or will be residing in a community-based residence that qualifies for one of the special SSP payments is required. Proof of living in a health care or treatment institution must be provided when no other source of verification is available. Notification to EOHHS and DHS of change in living arrangement from a community-based to an institutional setting or the reverse is mandatory and must be made within ten (10) days of the date the change occurs for all applicants and beneficiaries.

d. Correctional Facility. While living in a correctional facility, including a juvenile facility, Medicaid health coverage for otherwise IHCC eligible persons is suspended except for in-patient and emergency services provided outside of the facility. Residence in a correctional facility begins on the date of incarceration and continues until the date the person is released from the correctional facility. A person transferred from a correctional facility to a hospital for part or all of the sentencing period is considered to be still living in the correctional facility for

general eligibility purposes, unless the exemption for Medicaid coverage of in-patient and emergency care applies.

e. Verification. Self-attestation of incarceration is accepted initially and then verified through information exchanges with the RI Department of Corrections (DOC). In addition, electronic data matches with DOC records are conducted on a regular basis in conjunction with the post-eligibility verification process.

4. Citizenship and Immigration Status – Immigration and citizenship status affect Community Medicaid eligibility as follows:

a. Citizen or Qualified Non-citizen. An applicant for coverage in one of the IHCC groups must be a United States citizen or a lawfully present "qualified" non-citizen immigrant who has been in the U.S. for five (5) years or more. Lawfully present qualified non-citizens include persons in the U.S. as legal permanent residents (LPR), with humanitarian statuses or as a result of such circumstances (e.g., refugees, asylum applicants, temporary protected status), valid non-immigrant visas, and legal status conferred by other federal laws (temporary resident, LIFE Act, Family Unity Act, etc.). There are exceptions in federal law and, more generally, under the Rhode Island Medicaid Program which permit qualified non-citizens who might otherwise be subject to the bar to obtain Medicaid health coverage. These exceptions are located in MCAR, Section 0340. General exceptions specific to Rhode Island are as follows:

(1) Pregnant women are eligible if they meet all other requirements regardless of immigration status.

(2) Lawfully present children who meet all other requirements are eligible during the five-year bar under the State's Children's Health Insurance Program (CHIP) State Plan. Eligibility under CHIP also extends to lawfully present children in the U.S. on non-immigrant visas who are treated as qualified non-citizens exempt from the five (5) year bar.

b. Non-qualified Non-citizen. With the exception of pregnant women, adult "non-qualified" non-citizens are not eligible for Medicaid. Non-qualified non-citizens are persons from other nations who are not considered to be immigrants under current federal law, including those in the United States on a time-limited visa (such as visitors or person in the U.S. on official business) and those who are present in the country without proper documentation (includes people with no or expired status). Non-qualified non-citizens may obtain Medicaid health coverage in emergency situations only, as indicated in Section 210-RICR-40-05-1.7.5. Non-emergency services may be obtained through Federally Qualified Community Health Centers.

Note: Lawfully present adult non-citizens may be eligible for commercial coverage, with financial assistance, through HSRI. Further information is available at: www. healthsourceri.org.

c. Verification: Members the Medicaid eligibility who are applying for coverage must provide their immigration and citizenship status. Non-applicants in the FRU are exempt from the requirement. Any information provided by an applicant on paper or electronically must be used only for verifying status. Acceptable documentation, when required, is set forth Section 0304 as well and Section 1305.12.

5. Other Forms of Cooperation – Rhode Island's Medicaid State Plan states that as a condition of eligibility for Medicaid, applicants must at the time of application:

a. Agree to cooperate in identifying and providing information to assist the State in pursuing any third party who may be liable to pay for care and services;

b. Agree to cooperate with the State in obtaining medical support and payments (e.g., signing papers necessary to pursue payments from absent parents);

c. Agree to apply for eligibility for any other forms of public assistance which may be available upon receiving notification from the EOHHS in accordance with MCAR, Section 0380.20;

d. Enroll in a RIte Share-approved employer-sponsored health insurance plan if cost-effective to do so, in accordance with MCAR, Section 1312; and

e. Agree to cooperate in establishing the paternity of a child born out of wedlock for whom the applicant can legally assign rights.

1.9.4 GOOD CAUSE FOR FAILING TO COOPERATE

A. A Medicaid applicant or beneficiary must have the opportunity to claim good cause for refusing to cooperate. Good cause may be claimed by contacting an 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 persons supporting the claim.

1. A determination of good cause is based on the evidence establishing or supporting the claim and/or an investigation by EOHHS agency staff of the circumstances used as justification for the claim of good cause for non-cooperation.

2. 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.

B. 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 set forth in MCAR, Section 0110 or its successor regulation.

1.10 State-Administered Community Medicaid Disability Determinations

1.10.1 SCOPE AND PURPOSE

A. Disability determinations are made by the State's Medicaid Assessment and Review Team (MART) in accordance with the applicable requirements of the (SSA based on information supplied by the applicant and by reports obtained from treating physicians and other health care professionals. Anyone who is blind and is seeking IHCC group Community Medicaid who does not qualify for SSI or has never received a determination of disability on that basis by a government agency, is subject to an evaluation by the MART.

1.10.2 DISABILITY STANDARDS FOR COMMUNITY MEDICAID

A. For the purposes of IHCC groups providing Community Medicaid, the standards for determining whether a person has a disability centers on:

1. Duration – The disabling impairment or chronic condition is expected to result in death or has lasted or can be expected to last for at least 12 consecutive months;

2. Substantial Gainful Activity – The impairment or condition adversely affects the person's ability to engage in substantial gainful activity or SGA. For these purposes, SGA is work activity that involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if a person does less, gets paid less or has less responsibility than during prior employment. Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

3. Application of Standards – The disability determination standards that apply for Community Medicaid vary by age:

    a. Persons age 18 or older. Disability determinations for applicants in this age group are made by the MART using the SSI criteria and standards. The determination is based on an assessment of whether the person seeking coverage is unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment, or combination of impairments, expected to result in death, or last or could be expected to last for a continuous period of not fewer than twelve (12) months. To meet this definition, there must be a severe impairment, which makes the person unable to do his or her previous work or any other substantial gainful activity existing in the national economy. To determine whether a person is able to do any other work, the MART considers residual functional capacity, age, education, and work experience.

    b. Children under age 19 – MN Only. The MART is not usually responsible for making disability determinations for persons under 19. In general, these disability determinations are made formally by the SSA in conjunction with SSI eligibility, evaluations conducted by professionals for educational or child welfare services or through a qualified Medicaid provider. The SGA standard does not apply; however. The child must have a physical, mental, or behavioral health impairment, or combination of impairments, resulting in marked and severe functional limitations, expected to result in death or that have lasted or are expected to last for at least twelve (12) consecutive months. The MART may make such disability determinations for MN applicants under age 19 using the applicable SSI standards.

    c. Disability based on Blindness. Applicants seeking eligibility for a disability based on blindness who do not qualify for SSI because their income is too high must meet the duration and SGA standard and have central visual acuity of 20/200 or less, even with glasses, or a limited visual field of 20 degrees or less in the better eye with the use of a correcting lens.

    d. Working Persons with Disabilities --No LTSS. Applicants who have disabilities but who are working are exempt from the SGA step of the sequential evaluation of the disability determination. This exemption applies if the person otherwise meets the requirements set forth for coverage under the Sherlock Plan in Section 1373 or other related provisions for adults with disabilities.

1.10.3 MART FIVE STEP DETERMINATION PROCESS

A. This subsection explains the five-step sequential review process the MART uses when determining whether an applicant who is age 19 or older meets the SSI disability criteria. When using the review process, the MART considers all the evidence in an applicant's case record in a series of sequential steps. Upon making a determination of disability at any step in the sequence, the review process stops and the MART does not proceed to the next step. If no determination is

made, the MART proceeds from one-step to the next in order until a decision is made. The steps are as follows:

1. Step One -- At the first step, the MART must consider the work activity of the person applying, if any. If the applicant is engaging in substantial gainful activity, he or she will be determined ineligible except in instances in which the provisions in Section 1373 or related provisions apply, pertaining to Medicaid eligibility for working persons with disabilities.

2. Step Two – Upon proceeding to the second step, the MART must consider the medical severity of a person's impairment(s). If the person does not have a severe medically determinable physical or mental impairment that meets the duration requirement set forth in the SSI disability rules, or a combination of impairments that is severe and meets the duration requirement, the person will be found not disabled.

3. Step Three -- At the third step, the MART must also consider the medical severity of the person's impairment(s). If the person has at least one impairment that meets or equals one of the listings in the SSI rules at 20 CFR 404 (appendix 1 to subpart P) (located at: https://www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm) and meets the duration requirement, the MART determines the person to be disabled for Medicaid eligibility purposes.

4. Fourth Step – The fourth step entails MART consideration of the required assessment of the person's residual functional capacity and past relevant work. If the person continues to perform past relevant work, the MART will the find the person not disabled.

5. Fifth Step -- At the fifth and last step, the MART considers the assessment of the person's residual functional capacity, age, education, and work experience to determine if the person is able to make an adjustment to other work. If a person is found to be able to make an adjustment to other work, the MART determines the person is not disabled. If the person is not able to make such an adjustment to other work, the MART will find the person to be disabled.

1.10.4 REFERRAL TO THE MART

A. All adults over age nineteen (19) applying for Medicaid are evaluated by the Integrated Eligibility System using the MAGI standard before consideration using the SSI-methodology. The application includes questions about a person's need for care, previous or pending disability determinations and the need for retroactive Medicaid, which provides coverage for certain health expenses incurred in the three (3) months prior to making application.

1. Referral to the MART – Applicants who indicate on the Medicaid application that they have been determined to have a disabling condition by a government agency and/or are seeking retroactive eligibility are referred to the MART for a disability review if they:

   a. Are not currently an SSI or RSDI recipient and do not qualify for MAGI-based coverage due to Medicare eligibility or enrollment and/or are seeking retroactive eligibility; or

   b. Qualify for such MAGI coverage but would prefer to be evaluated for IHCC through a pathway for Community Medicaid.

2. Limits on Referral –In accordance with federal regulations at 20 CFR 435.541, when a person is seeking Medicaid on the basis of a disability, the following limitations apply:

   a. The MART may not make a determination of disability when the only application for benefits has been filed with the SSA.

b. The MART may not make an independent determination of disability if the SSA has made such a determination on the same issues presented in the Medicaid application within the 90-day time limit allowed by federal regulations.

c. A determination of disability made by the SSA is binding. Accordingly, the MART, as a unit of the Medicaid Single State Agency, must refer to the SSA all applicants alleging new information or evidence affecting previous determinations of ineligibility based on disability for reconsideration or reopening of the determination except in cases specified in 20 CFR 435.541 (c)(4).

3. These limits on referrals to the MART do not apply if the person is seeking Medicaid as a non-cash recipient with income above the SSI standard through the EAD pathway and the person has not applied for SSI cash benefits; has applied and has been found ineligible for SSI for a reason other than disability; or the SSA has not made a determination on a disability related application within ninety (90) days from the date the application for Medicaid was filed with the SSA.

1.10.5 CONTINUING ELIGIBILITY FOR EAD ADULTS WITH DISABILITIES

A. Continuing eligibility for beneficiaries eligible due to a disability is multifaceted.

1. Medicaid Renewal -- Beneficiaries eligible through the EAD pathway on the basis of a disabling impairment are renewed on an annual basis in accordance with the provisions of Section 210-RICR-40-00-2.7, subject to periodic reviews by the MART.

2. MART Periodic Reviews --These reviews must focus on whether there has been any medical improvement in a beneficiary's impairment since the comparison point decision and, if so, whether the improvement is related to the beneficiary's ability to work. For these purposes:

a. Comparison Point Decision (CPD). The most recent favorable decision which is the latest final determination or decision involving a consideration of the medical evidence and whether a person is disabled or continues to be disabled.

b. Medical Improvement. Any decrease in the medical severity of the impairment that was presented at the CPD as measured by changes in symptoms, signs and/or laboratory findings associated with the impairment.

3. The MART must conduct these reviews in accordance with federal SSI regulations at 20 CFR 404.1594 and the schedule for conducting reviews identified at 20 CFR 416.990. This schedule indicates the reviews must generally be conducted as follows:

a. Impairment expected to improve – 6 to 18 months from date of CPD;

b. Impairment not considered permanent, but medical improvement cannot be accurately predicted – once every three (3) years from CPD;

c. Impairment is considered permanent – at least once every seven (7) years, but not more often than once every five (5) years from CDP;

d. Immediately, for the reasons set forth in subsection (b) of the federal rule including, but not limited to: the beneficiary returns to work or is reported by government agency or other source to be able to begin working or no longer disabled, electronic data sources indicating earnings increased substantially, or a self-reported recovery from the impairment.

4. Limitations - - A periodic review is not required for any beneficiary with a disability determined by the SSA and/or authorized to work under the Sherlock Plan or any other eligibility pathway for adults with disabilities who are working as identified in this chapter.

5. The eligibility of Medicaid beneficiaries who are 65 and older are renewed on an annual basis in accordance with the provisions located in Section 1402.02.

1.10.6 AGENCY AND APPLICANT RESPONSIBILITIES

A. The applicant must provide the health care authorizations and information necessary to make a timely and accurate determination of disability. The MART is responsible for assuring that determinations are made in accordance with the federal Medicaid regulations at 42 CFR 435.541 and the disability criteria established by the SSA. The criteria used by the MART are located at: www.eohhs.ri.gov/ Federal requirements used by the SSA are located at https://www.ssa.gov/disability/professionals/bluebook/ and may be obtained in hard copy by contacting the Social Security Administration, One Empire Plaza, 6th Floor, Providence, RI 02903 or 1-877-402-0808 (TYY 401-273-6648).

1.11 Financial Eligibility Determination

1.11.1 SCOPE AND PURPOSE

A. To determine a person's eligibility using the SSI methodology, a comparison is made between the countable income and resources of the applicant's FRU and the income limits applicable to the Medicaid eligibility IHCC group. Once these groups have been established, financial eligibility is determined in accordance with the provisions for the SSI treatment of income and resources set forth in Sections 210-RICR-40-00-3 to 210-RICR-40-00-3.5, and/or the special eligibility requirements in Section 210-RICR-40-05-1.7. This section focuses on the financial eligibility determination process for the Community Medicaid pathways in which the State is responsible for initial and continuing eligibility.

1.11.2 THE MEDICAID ELIGIBILITY GROUP

A. The Medicaid eligibility group for Community Medicaid when determined by the state is as follows:

1. Single Adults –A single adult requesting Community Medicaid, including Medicaid LTSS, is treated as an "individual" – that is- Medicaid eligibility group of one.

2. Groups for Adults with Spouses –When two spouses are living together, both the person requesting Medicaid and the applicant's spouse are considered members of applicant's Medicaid eligibility group – a "couple" or group of two (2) – unless one of the exceptions specified below applies. . This is true whether or not the spouse is also requesting Medicaid.

a. Living together. A couple is also considered living together in any of the following circumstances:

(1) Until the first day of the month following the calendar month of death or marriage separation, that is, when one spouse dies or the couple separates;

(2) When the number of days one spouse is expected to receive LTSS in an institution or home and community-based setting is fewer than thirty (30) days; and

(3) When the resources of the couple are reassessed and allocated at the point in which the need for continuous LTSS is determined and an application for Medicaid coverage of LTSS is made as indicated in MCAR Sections 0382 and 0384.

b. Exceptions. Adult applicants with spouses are treated as an "individual" for eligibility purposes in the following circumstances:

(1) When one spouse in a couple is receiving long-term care and applying for Medicaid LTSS, the applicant for Community Medicaid is treated as an "individual" – group of one – for the determination of initial and ongoing income eligibility and resource reviews. The couple, whether or not still married, is treated as no longer living together as of the first day of the calendar month that the spouse receiving LTSS became eligible for Medicaid. This remains true even if the other spouse receiving Community Medicaid begins receiving Medicaid LTSS in a subsequent month.

(2) When both spouses receive Community Medicaid and are residing in a residential care setting serving four (4) persons or more, each spouse is treated as an individual without regard to whether they live together. This applies to Community Medicaid beneficiaries who do not qualify for LTSS while residing in licensed assisted living residences, behavioral health community residences, adult supportive care homes, and supportive living arrangements for adults with developmental disabilities.

c. Dependent child in the household. The Medicaid eligibility group increases in size for any dependent child under age nineteen (19) who is not receiving SSI.

3. Child (Applicable for MN Eligibility Only) –The Medicaid eligibility group for a dependent child up to age nineteen (19) applying for MN coverage using the SSI methodology is a group of one. Once reaching age 19, the rules related to a single adult apply.

4. Parent-Child –When a parent and dependent child living together are both seeking Medicaid in IHCC groups in which the SSI methodology applies, they are treated as two Medicaid groups of one, if the parent is not living with a spouse. If the parent is living with a spouse, the parents are treated as a Medicaid group of two and the child as a Medicaid group of one. When a parent/caretaker is seeking MN eligibility, any MAGI-eligible members of the household are excluded from the eligibility group.

1.11.3 FORMATION OF THE FRU

A. The financial responsibility group (FRU) consists of the persons whose income and resources are considered available to the applicant or beneficiary in the eligibility determination. The FRU is relevant for deeming purposes for non-LTSS Medicaid and in determining eligibility for certain IHCC Community Medicaid coverage groups. The following subsections set forth the rules for determining membership in the FRU and the portion of income considered available to the person seeking Medicaid.–

1. FRU Composition for Citizens – The FRU for citizens and sponsored non-citizens differs due to deeming requirements. For citizens, the FRU consists of the person seeking Medicaid and, as appropriate, a spouse, parent, and/or dependent child. Other members of the household are not included in the FRU even if they make financial contributions.

a. FRU Single Adults. The FRU for an adult requesting SSI- related Medicaid, including Medicaid LTSS, is the same as the adult's Medicaid eligibility group.

b. FRU Child. The financial responsibility group for a dependent child includes the child and any parents living with the child, until the child reaches the age of nineteen (19) or twenty-one (21) if the child has a disabling impairment. A child's income is never deemed to parent. If the child is under age 19 and seeking Medicaid LTSS through the Katie Beckett eligibility pathway, the income and resources of the child's parents are deemed unavailable and the FRU is composed of the child only.

c. FRU Couples. Except in instances in which a member of a couple is a Medicaid LTSS applicant or beneficiary, spouses are considered financially responsible for one another during the financial eligibility determination process. The FRU includes the applicant and spouse, even when the spouse is not applying for Medicaid (NAPP spouse, hereinafter). The child's income is never deemed to a parent or a sibling.

2. FRU for Sponsored Non-citizens – The FRU for a non-citizen admitted to the United States on or after August 22, 1996 based on a sponsorship under section 204 of the Immigration and Nationalization Act (INA) includes the income and resources of the sponsor and the sponsor's spouse, if the spouse is living with the sponsor, when all four of the following conditions are met:

a. The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to conform to the requirements of Section 213A(b) of INA;

b. The non-citizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;

c. The non-citizen is not battered; and

d. The non-citizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

e. The financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the SSA. See: http://policy.ssa.gov/poms.nsf/lnx/0300301315

1.11.4 GENERAL RULES FOR COUNTING INCOME – COMMUNITY MEDICAID

A. For Community Medicaid, the determination of income eligibility using the SSI methodology follows a set sequence of calculations related to the application of exclusions and disregards as set forth in Section 210-RICR-40-00-3.3. Unearned income exclusions and disregards are applied first.

1. Order of Unearned Income Exclusions and Disregards – Unearned income is countable as income in the earliest month it is received by the person; credited to a person's account; or set aside for the person's use. The order for applying exclusions and disregards is as follows:

a. Federal law. Exclusions mandated in federal law or regulations as set forth in Section 210-RICR-40-00-3.4 are applied first unless indicated otherwise.

b. Medicaid. The following types of unearned income are excluded or disregarded in the order indicated:

(1) Any refund of taxes;

(2) Assistance based on need which is provided under a program which uses income as a factor of eligibility and is wholly funded by the State or a local government. General Public Assistance (GPA) and the optional State Supplemental Payment (SSP) for SSI beneficiaries and SSI-lookalikes are examples of excluded payments in this category.

(3) Grants, scholarships, fellowships, or gifts used for paying educational expenses are excluded or countable depending upon their use:

Any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other necessary educational expenses at any educational institution, including vocational or technical education institutions, is excluded from income.

Any portion of such educational assistance that is not used to pay current tuition, fees or other necessary educational expenses but is set aside to be used for paying this type of educational expense at a future date is excluded from income in the month of receipt. If these funds are not spent after nine (9) months, they become a countable resource the first day of the tenth month following receipt.

Any portion of a grant, scholarship, fellowship, or gift that is not used or set aside for paying tuition, fees, or other necessary educational expenses is income in the month received and a resource the month after the month of receipt if retained.

(4) Food which a person or his/her spouse raises if it is consumed by the household;

(5) Assistance received under the Disaster Relief and Energy Assistance Act (as in effect on February 1, 2016) and assistance provided under any federal statute because of a presidentially declared disaster;

(6) The first sixty dollars of infrequent or irregular unearned income received in a calendar quarter;

(7) Alaska longevity bonus payments;

(8) Foster care payments that are not funded through Section IV-E;

(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of that burial fund;

(10) Support and maintenance assistance based on need:

Provided in-kind by a private nonprofit agency; or

Provided in cash or in-kind by a supplier of home heating oil or gas, or by a private or municipal utility company.

(11) One-third of child support payments made by a non-custodial absent parent, unless exempt in accordance with Section 210-RICR-40-00-3.3;

(12) Twenty dollar ($20.00) general income disregard. The disregard does not apply to program payments when income is used as an eligibility factor and the payment is wholly or partially funded by the federal government or by a non-governmental agency such as Catholic Charities or the Salvation Army.

(13) Unearned income used to fulfill an approved plan to achieve self-support (PASS);

(14) Federal housing assistance provided by:

An office or program of the U.S. Department of Housing and Urban Development (HUD); or

The U.S. Department of Agriculture's Rural Housing Service (RHS), formally known as the Farmers Home Administration (FHA);

(15) Any interest on excluded burial space purchase agreement if left to accumulate as part of the value of the agreement;

(16) The value of any commercial transportation ticket which is received as a gift and is not converted to cash;

(17) Payments from a State compensation fund for victims of crime;

(18) Relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 in accordance with 42 U.S.C.§ 301 (as in effect on February 1, 2016) provided to individuals displaced by any federal or federally- assisted project or state or local government or through a state-assisted or locally-assisted project involving the acquisition of real property;

(19) Combat fire pay received from the uniformed services;

(20) Interest on a dedicated account in a financial institution, the sole purpose of which is to receive and maintain past-due SSI benefits which are required or allowed to be paid into such an account, and the use of which is restricted by section 1631(a)(2)(F) of the Social Security Act;

(21) Gifts to children with life-threatening conditions from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 (as in effect on February 1, 2016), within the following limitations:

(22) In-kind gifts are not converted to cash;

(23) No more than the first two thousand dollars of any cash gifts within a calendar year may be excluded;

(24) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than section 1613(a) of the Social Security Act (as in effect on February 1, 2016);

(25) An annuity paid by a state, to a person and/or the person’s spouse, on the basis of the state's determination that the person is a veteran and is blind 65 or older and/or living with a disabling impairment.

2. Order of Earned Income Exclusions -- In general, earned income disregards and exclusions are applied in the following order –

   a. Federal law. Exclusions mandated in federal law or regulations as set forth in Section 210-RICR-40-00-3.4 are applied first, unless indicated otherwise.

   b. SSI Methodology. The following types of earned income are excluded or disregarded in order:

      (1) Earned income tax credit payments and child care tax credit payments;

      (2) The first $30 of infrequent or irregular earned income received in a calendar quarter;

      (3) Student earned income exclusion (SEIE) up to the monthly limit, and not more than the yearly limit as indicated in Section 210-RICR-40-00-3.1.7.

      (4) Any portion of the $20 monthly general income disregard which has not been excluded from unearned income in that same month;

      (5) The first $65 of earned income in a month;

      (6) Earned income of a person with disabilities used to pay impairment-related work expenses (IRWEs), as described in 20 C.F.R. 404.1576;

      (7) One-half of remaining earned income in a month;

      (8) Work expenses of a person who is blind;

      (9) Earned income used to fulfill an approved plan to achieve self-support (PASS).

3. Unused exclusions and disregards –When calculating countable income, the limitations below apply:

   a. Exclusions never reduce earned or unearned income below zero.

   b. Unused portions of a monthly disregard or exclusion cannot be carried over for use in subsequent months.

   c. Unused earned income disregards and exclusions are never applied to unearned income.

   d. Other than the $20 general income disregard, no unused unearned income exclusion may be applied to earned income.

   e. The $20 general and $65 earned income exclusions are applied only once to a couple, even when both members have income, since the couple's earned income is combined in determining Medicaid eligibility.

1.11.5 INCOME DEEMING

A. To deem income is to attribute one person’s countable income in the calculation of another person’s countable income. Income deeming requirements are based on the FRU rather than the Medicaid eligibility group rule. A person may be included in the Medicaid eligibility group without being included in the FRU – (e.g., the sibling of a child seeking MN eligibility –) and having their

income deemed to an applicant or non-applicant in the household. The general rules for determining countable income related to the application of earned and unearned income exclusions identified above in subsection 210-RICR-40-05-1.11.4 are applied. In addition:

1. The person seeking initial or continuing Medicaid eligibility is referred to as the "applicant"; members of the household who are not covered by or applying for Medicaid are referred to in this subsection as "non-applicants" or NAPPs.

2. Whose income is deemed to an applicant is determined separately for each member of the FRU.

3. Income based on need, in which income is a factor in determining eligibility, provided by any local, state or federal agency and any income which was taken into account in determining eligibility and which affected the amount of such assistance or payment is excluded in the income deeming process, unless specifically indicated otherwise. Includes: SSI; SSP; RI Works and GPA cash assistance; Veteran's Administration (VA) pensions; or in-kind support and maintenance.

B. Spouse-to-Spouse --Except as indicated in the situations noted below, the income of a NAPP spouse is deemed to an applicant if the spouses live together. If an applicant is not divorced but is legally separated from his or her spouse, and continues to live in the same household, the NAPP spouse's income is deemed. In the following situations, spouse-to-spouse income deeming does not apply:

1. The spouses do not live together.

2. The applicant is seeking coverage under the Sherlock Plan as a working adult with a disability in accordance with Section 1373.

a. Deeming. The amount of income that is deemed to the applicant spouse is calculated by subtracting from the NAPP spouse's gross income:

(1) An amount equal to the deeming standard for each dependent child in the household. The "deeming standard" is the difference between the Federal Benefit Rate (FBR) for a couple and the limit for a single person, as indicated in Section 210-RICR-40-00-3.1.7, less any countable income from that the child. The difference between is the living allowance for the NAPP child, as indicated herein.

(2) Any portion of the NAPP spouse's income paid in court-ordered child support for a child living in another household.

(3) Exclusions and disregards that apply when calculating countable income for the applicant spouse.

(4) If the NAPP spouse's remaining income after exclusions and disregards are applied is greater than the deeming standard, then the couple's income is calculated according to the general rules for determining countable income using SSI methodology. That income is then compared against the Medicaid eligibility group income limit for the family size involved – i.e., household size.

b. Treatment of deemed income. The deemed amount is counted as unearned income in determining the applicant's income eligibility for Medicaid.

C. Parent-to-Child -- Except in the situations noted below for MN eligibility, the income of a biological or adoptive parent is deemed to a child who is under age 18 and living with a parent as long as

the child has not been legally emancipated. When the father is not married to the child's mother, the father's income is only deemed to the child if they reside together and paternity has been established.

1. In the following situations, the income of a parent is NOT deemed to a child:

    a. The child is not eligible for SSI, but is participating in a foster care or adoption subsidy program administered by the State.

    b. The child is seeking LTSS through the Katie Beckett eligibility option in accordance with Section 210-RICR-50-00-1.

2. Deeming Rules: The amount of income deemed from parent to child requires a multi-step calculation of income that must be followed in the sequence below:

    a. The earned and unearned income of the parents of the applicant child is calculated allowing the standard exclusions EXCEPT for the standard $20 and $65 plus one-half disregards.

    b. The living allowance allocated to NAPP children is determined by multiplying their number by the deeming standard. Any children receiving SSI or RI Works cash assistance are not included in this calculation. The income of each NAPP child is deducted from this sum, if any.

    c. The total of the unearned income of the parents is calculated and then any remaining allowance for NAPP children in the household not met by their own income is subtracted.

    d. The earned income of the parents is totaled and any remaining living allowance for NAPP children is subtracted. If there is no remainder, there is no income to deem. If there is income remaining, deeming is applicable.

    e. Deemed income from parent to child is then calculated by: deducting the $20 income disregard from any remaining parental unearned income; subtracting $65, plus any of the remainder of the $20 disregard and one-half of the still remaining parental earned income. The remaining unearned and earned income is added and, from this total, so too is the individual FBR (for a one (1)-parent household) or the couple FBR (for a two (2)-parent household).

    f. The remaining income is deemed to be unearned income to the child. Note: If more than one child is applying, deemed income is divided equally.

D. Other Household Members -- When determining a person's initial or continuing eligibility, income is NOT deemed from a:

1. Child to a parent;

2. Sibling to another sibling, or other children under 21 living in the household;

3. Stepparent to a stepchild;

4. Grandparent to a grandchild; or

5. Relative caretaker to a child.

E. Sponsor Deeming -- Sponsor deeming rules apply to non-citizens who are sponsored by one or more individuals under a signed Affidavit of Support (USCIS I-1864), unless one of the following exceptions applies.

1. Exceptions to Sponsor Deeming. Sponsor deeming does not apply to sponsored non-citizens when:

   a. The non-citizen is under age 21.

   b. The non-citizen is pregnant. This exception ends when the sponsored pregnant woman's 60-day postpartum period ends. Sponsor deeming applies the month following the end of the postpartum period.

   c. The non-citizen has sponsorship deferred by USCIS when their immigration status is changed to "Battered Non-citizen."

   d. If the non-citizen needs placement in a facility and placement is jeopardized by the sponsor's failure or inability to provide support, or inability of the non-citizen to locate the sponsor.

2. General rules of sponsor deeming. Income of a sponsor and the sponsor's spouse is deemed to each non-citizen covered by the affidavit regardless of whether the sponsor actually contributes to the non-citizen's support and maintenance needs. Income is deemed even if the sponsor or the sponsor's spouse is receiving public assistance in Rhode Island or another state. The following types of income of the sponsoring individual/couple are deemed:

   a. Gross income, including any cash assistance received by the sponsor or the sponsor's spouse;

   b. Net self-employment income, minus self-employment expenses;

   c. If the sponsor is a member of the FRU, the sponsor's income is already deemed to the sponsored non-citizen spouse and family members in accordance with income deeming rules (1)-(3) above.

3. If the sponsor is not a member of the FRU or is a member of the Medicaid eligibility group whose income is not deemed under income deeming rules (1)-(3), the following apply:

   a. The total gross income of the sponsor and the sponsor's spouse is deemed to each sponsored non-citizen.

   b. The sponsor or the sponsor's spouse's income are considered available and are not excluded.

1.11.6 GENERAL RULES FOR COUNTING RESOURCES – COMMUNITY MEDICAID

A. The State uses a more simplified process for counting resources for Community Medicaid, as explained in Section 210-RICR-40-00-3.5.1, which permits attestations about the value of certain resources during the application process when determining financial eligibility. For Medicaid LTSS eligibility, full verification of resources and a transfer of asset review are required for IHCC group members prior to the determination of eligibility and authorization of services. There is no review of the transfer of assets for Community Medicaid.

1. Process – The process rules identified in Section 210-RICR-40-00-3.6.2 are used in evaluating resources to determine which are included in the calculation.

2. Application of Exclusions – Both federally mandated and program specific exclusions are applied for resources of a Community Medicaid applicant or beneficiary, the following items are excluded in the following order in the amounts indicated:

    a. The home and adjoining land;

    b. Household goods and personal effects;

    c. One automobile and the equity value of a second vehicle above $4,500;

    d. Property of a trade or business which is essential to the means of self-support;

    e. Non-business property which is essential to the means of self-support;

    f. Resources of person who is blind or living with a disabling impairment which are necessary to fulfill an approved PASS;

    g. Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;

    h. Whole life insurance owned by a person and/or spouse but only when the combined face value of all policies per person is at or below $1,500 for EAD or $4000 for medically needy;

    i. Restricted allotted Indian lands;

    j. Payments or benefits provided under a federal statute other than Title XVI (OASDI, including RSDI and SSD) of the Social Security Act where an exclusion is required by such statute as indicated in Section 210-RICR-40-00-3.6;

    k. Disaster relief assistance;

    l. Burial expense funds and set asides to the extent allowed up to $1,500 for EAD and $4,000 for persons who are MN;

    m. Title XVI (OASDI) or Title II (SSI) retroactive payments;

    n. Housing assistance;

    o. Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit;

    p. Payments received as compensation for expenses incurred or losses suffered as a result of a crime ;

    q. Relocation assistance from the State or a local government;

    r. Dedicated financial institution accounts;

    s. Gifts to children under age 18 with life-threatening conditions;

    t. Restitution of SSI, title VIII or RSDI benefits because of misuse by certain representative payees;

    u. Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses;

v. Payment of a refundable child tax credit, as provided; and

w. Any annuity paid by a state to a person (or his or her spouse) based on the State's determination that the person is a veteran (as defined in 38 U.S.C. 101) and blind, living with a disabling impairment, or aged.

1.11.7 RESOURCE DEEMING

A. To deem resources is to count one person's resources in the calculation of another person's countable resources. As with income deeming, resource deeming requirements apply to members of the FRU, which is not always the same as the Medicaid eligibility group. Only the resources of the applicant's spouse or the parent(s) of a child are considered for the purposes of deeming resources. The deeming process proceeds as follows:

1. Spouse- to-Spouse – In deeming resources from one spouse to the other, only the resources of the couple are considered.

   a. Living together. When an applicant and NAPP spouse live together, all resources are combined and the couple is permitted resources up to the amount allowed for the Medicaid eligibility group of two. The couple's resource limitation is not affected by whether the spouse of the applicant is applying for or receiving Medicaid or is a non-applicant.

   b. Living apart. When an applicant and spouse are no longer living together, each person is considered as an individual living alone beginning the month after separation and the individual resource limit applies. For the month of separation, the spouses are treated as couple, as long as they were living together at some point during the month.

2. Single individual –When an applicant is not living in a home with a spouse or parent(s), only the resources of the applicant are considered. The resource limits for an "individual" or Medicaid eligibility group of one apply.

3. Parent-to-child – In deeming resources from a parent to a child, the resources of a child consist of whatever resources the child has in his or her own right plus whatever resources are deemed to the child from his or her parent(s).

   a. In determining the amount of resources to be deemed to an applicant child, the resources of the child and of the parents are computed separately and both the child and the parents are each allowed all of the resource exclusions they would normally be eligible to receive in their own right. Only one home and one vehicle are completely excluded, however. The equity value of a second vehicle is counted in accordance with Section 1405.01.

   b. It does not matter whether a parent(s) is or is not eligible for Medicaid.

   c. After the exclusions are applied, only the countable resources over the resource exclusion of the parent(s) living in the home are deemed to the child when there is only one child.

   d. When there is more than one applicant/eligible child, the resources available for deeming are shared equally among the eligible children.

   e. None of the parents' resources are deemed to any other non-applicant/ineligible children.

f. A child is not eligible for Medicaid as MN if his or her own countable resources plus the value of the parents' resources deemed to the child exceed the resource limit for an individual– Medicaid Eligibility group of one – of $4,000.

210-RICR-40-05-2

Title 210 - Executive Office of Health and Human Services

Chapter 40 Medicaid Integrated Health Care Coverage

SUBCHAPTER 05 – COMMUNITY MEDICAID

Part 2 – Medically Needy Eligibility

2.1 SCOPE AND PURPOSES

A. A MN spenddown, previously referred to as the "Flexible Test of Income", is a cost-sharing approach that provides a Medicaid eligibility pathway for certain people who have income above the limit for their applicable coverage group if they have high health expenses. Under the State's Medicaid State Plan, members of these populations become eligible for Medicaid by "spending down" their income to a limit established by the state - - known as the MN income limit or MNIL by deducting certain health care expenses. The following populations may be MN eligible under this section:

1. Elders and adults with disabilities with income above 100 percent of the FPL;

2. Children with income above the MACC limit of 266% of the FPL (includes the 5% disregard);

3. Pregnant women with income above the MACC limit of 258% of the FPL (includes the 5% disregard);

4. Parents/caretakers with income above the MACC limit of 138% of the FPL (includes the 5% disregard);

5. Non-qualified non-citizens seeking coverage for emergency Medicaid if ineligible under all other pathways. (See section 210-RICR-40-05-1.7.5; and

6. Certain refugees, as defined in Section 210-RICR-40-05-1.7.3, who do not otherwise qualify for Medicaid health coverage or commercial insurance with financial help through HSRI.

B. This section describes the Community Medicaid (non-LTSS) MN eligibility pathway in general and establishes the provisions governing initial and continuing eligibility for persons in these populations seeking Medicaid health coverage through this option.

2.2 GENERAL PROVISIONS ELIGIBILITY CRITERIA

A. For the IHCC groups in this section, MN coverage is available to elders and persons with disabilities with high medical expenses who have income above the EAD income limit, but otherwise meet all of the general eligibility requirements for Medicaid set forth in Section 210-RICR-40-05-1.9.

1. Determination process – Applicants who do not meet the income limits for Medicaid in the IHCC groups are automatically evaluated for MN coverage. Members of the MACC groups must contact an agency eligibility specialist if seeking MN coverage. The MN cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility for Medicaid health coverage as MN is not established, however, until the applicant has presented proof of health expenses incurred

and paid or that remain outstanding for the eligibility period. Any health expenses for which a beneficiary continues to be liable dating back to the retroactive period are also considered.

2. Continuing eligibility – The date of eligibility is the actual day of the month the applicant incurs a health expense – not the billing date – which reduces income to the MNIL. Eligibility may be renewed on a continuing basis if the beneficiary is liable for health care expenses that exceed current income. Otherwise, a re-evaluation of eligibility, based on the cost of health costs currently being incurred is required.

3. Agency responsibilities – The EOHHS must inform applicants who have income above the applicable limit for the appropriate IHCC group that MN coverage is an option and provide information about allowable health expenses for spenddown purposes and the scope and limits of obtaining coverage through this eligibility pathway. In addition, applicants must be informed of the impact of obtaining MN Medicaid health coverage for other programs, including the Supplemental Nutrition Assistance Program (SNAP) and the MPPP.

4. Applicant/beneficiary responsibilities – Eligibility and renewal is contingent upon the applicant/beneficiary providing bills and receipts related to allowable health care expenses that are not paid through a third party. Therefore, the chief responsibility of the applicant/beneficiary is to maintain and present this information, unless submitted directly by a provider, to the state agency.

2.3 SPENDDOWN CALCULATION

A. For a person who has income above the income standard across applicable eligibility pathways, the spenddown standard for their eligibility coverage group is applied. For example, the appropriate spenddown standard for parents/caretakers is 138% of the FPL (ceiling for MACC eligibility when 5% disregard is applied) and 266% of the FPL for children (MACC ceiling including disregard). The appropriate spenddown standard for elders and adults with disabilities is the medically needy income limit adjusted for household size.

1. Spenddown Amount – The spenddown amount is calculated as follows:

    a. The beneficiary's anticipated monthly net income for each month of the eligibility period based on the criteria appropriate for the specific coverage group using the SSI methodology.

    b. Net income for all six (6) months.

2. FPL Comparison – The applicable six-month FPL standard is subtracted from the beneficiary's six-month net income. If the result is:

    a. Equal to or less than the FPL standard, the applicant is eligible for Medicaid without a spenddown, even if they exceed the monthly FPL standard in one or more months of the six-month period. No further calculation is necessary.

    b. Greater than the FPL standard continue, further calculations are required.

3. Six-month Spenddown Amount – The six-month spenddown amount is determined by subtracting the applicable six-month FPL spenddown standard from the total six-month net income. The result is the six-month spenddown amount.

4. Application of Allowable Expenses – Allowed health care expenses are applied to the six-month spenddown amount. If the applicant will incur bills to satisfy the spenddown after the date the application is processed, the final processing will be delayed until after the

applicant has received the health care services. Pre-approval of certain remedial (Medicaid LTSS) services is required if the MN beneficiary does not qualify for an LTSS preventive level of care.

2.4 SIX-MONTH SPENDDOWN RENEWAL

A. Upon renewal, a six-month spenddown is calculated in the same manner.

2.5 ALLOWABLE EXPENSES

A. Allowable health care expenses are those that are incurred by the beneficiary or other allowable family member(s) that are not subject to payment by a third party and may be:

1. Paid or unpaid health care bills incurred in the current eligibility period; and

2. Unpaid bills incurred prior to the current eligibility period.

B. The portion of a bill used to meet a previous spenddown cannot be used again in future spenddown calculations, unless the entire eligibility period was denied.

1. Allowable health care expenses – Such expense include, but are not limited to:

a. Physician /health care provider visits

b. Health insurance premiums, co-pays and deductibles

c. Dental visits

d. Chiropractic visits

e. Co-payments

f. Prescription drugs

g. Tests and X-rays

h. Hospital and nursing care

i. Home nursing care, such as personal care attendants, private duty nursing and home health aides

j. Eyeglasses

k. Hearing aids

l. Dentures

m. Medical supplies, such as wheelchairs

n. Therapy, such as speech, physical, or occupational therapy

o. Transportation for medical care, such as car, taxi, bus or ambulance

2. LTSS (remedial care) expenses – Costs related to LTSS level or remedial care, such as home nursing care/homemaker services, adult day and home stabilization may be applied to a spenddown when a beneficiary meets the LTSS preventive level of need. In

all other instances, Community Medicaid MN beneficiaries must obtain per-authorization from an agency eligibility specialist to count these costs toward a spenddown.

2.6 EXPENSE EXCEPTIONS

A. Certain health care expenses are not allowed to be deducted from income. Such expenses include, but are not limited to:

1. Premiums paid by Medicaid or paid by the MPPP as a health care expense. Applicants and beneficiaries should consider whether participation in the MPPP will adversely affect their ability to maintain MN eligibility and vice versa with the assistance of an eligibility specialist.

2. Health care expenses incurred before the first day of the six-month certification period are not eligible for Medicaid payment; the beneficiary remains responsible for those bills.

210-RICR-40-05-3

Title 210 - Executive Office of Health and Human Services

Chapter 40 Medicaid Integrated Health Care Coverage

SUBCHAPTER 05 – COMMUNITY MEDICAID

Part 3 – Retroactive Coverage

3.1 SCOPE AND PURPOSE

A. Medicaid coverage may start retroactively for up to three (3) months prior to the month of application for IHCC groups, unless explicitly excluded. To qualify, a person must have met the criteria for Medicaid eligibility during the retroactive period. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility. The provisions in this section do not apply to the MAGI-eligible individuals and families in the Medicaid Affordable Care Coverage (MACC) groups identified in MCAR, Chapter 1300, except when a person who is ineligible for coverage in one of these groups applies for MN IHCC in accordance with the provisions in Section 210-RICR-40-05-2.

3.2 GENERAL PROVISIONS

A. Medicaid beneficiaries in the IHCC groups may request retroactive eligibility for up to three months prior to the month of application.

1. Eligibility criteria – To obtain retroactive coverage, applicants must meet all eligibility criteria related to the applicable IHCC group 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.

    a. 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.

    b. Only the income and resources available to the applicant in the retroactive period are used to determine eligibility. No deeming is required.

    c. The following chart details beneficiaries' eligible retroactive benefits:

Persons Eligible	Eligible For Retro
IV-E and non IV-E Foster Children	Y
Adoption Subsidy Children Coverage Groups	Y
IHCC group members, excluding partial dual MPPP	Y
Non-citizens who are eligible for emergency Medicaid	Y
LTSS beneficiaries	Y

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

2. Limits – Current eligibility for Medicaid does NOT affect retroactive eligibility. A person denied Medicaid in the month of application may be eligible for retroactive coverage.

   a. An applicant need not be alive when an application for retroactive coverage is made. A family member or authorized representative may sign and submit an application on the deceased person's behalf.

   b. Retroactive eligibility is not available to persons who were not residents of Rhode Island in the retroactive period at the time the service was provided. Retroactive coverage applies only to unpaid medical bills for services provided within the scope of the Medicaid program. The bills must have been incurred during the three month retroactive period.

   Note: All services provided in the retroactive period and the costs incurred are subject to the same Title XIX utilization review standards as all other medical services of the Medicaid Program.

210-RICR-40-10-1

Title 210 - Executive Office of Health and Human Services

Chapter 40 Medicaid Integrated Health Care Coverage

SUBCHAPTER 10 – MANAGED CARE SERVICE DELIVERY OPTIONS FOR ELDERS AND ADULTS WITH DISABILITIES AND LONG-TERM CARE BENEFICIARIES

Part 1 – Managed Care Service Delivery Arrangements

1.1 OVERVIEW OF THIS RULE

A. 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.

B. 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	Reside in Tavares, Eleanor Slater, or out-of-state hospitals; or	Determined eligible for Medicaid as medically needy and not receiving LTSS;	Determined eligible for Medicaid as medically needy and not receiving LTSS	

B. Overview of Managed Care Programs for Adults with Disabilities and Elders

Program	Rhody Health Partners	Rhody Health Options		Medicare-Medicaid Plan	PACE
	Receive LTSS for more than 30 days	In hospice on the enrollment date	Reside in Tavares, Eleanor Slater, or an out-of-state hospital; or In hospice on the enrollment date	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	

1.2 DEFINITIONS

A. For the purpose of this rule, the following terms are defined as follows:

1. "Appeal" means a request to review an "adverse benefit determination" based on medical necessity, appropriateness, health care setting, and effectiveness.

2. "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.

3. "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.

4. "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.

5. "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.

6. "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.

7. "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.

8. "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.

9. "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.

10. "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.

11. “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.

12. “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.

13. “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.

14. “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.

15. “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.

16. “Medicaid Code of Administrative Rules (MCAR)” means the collection of administrative rules governing the Medicaid program in Rhode Island.

17. “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.

18. “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.

19. "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.

20. “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.

21. “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.

22. “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.

23. “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).

24. “Partial Dual Eligible Plus” means a Medicare beneficiary who is eligible for Medicaid Health Coverage as medically needy and the MPPP.

25. “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.

26. “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).

27. “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.

28. “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.

29. “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.

30. “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.

31. “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.

1.3 Rhody Health Partners (RHP)

1.3.1 AUTHORITY AND SCOPE

A. 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 210 RICR-40) 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. 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 see 210 RICR-40.

B. 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 Section 0360 and 210-RICR-40 and enrollment as established herein will remain in effect unless or until replaced.

C. 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.

1.3.2 EOHHS RESPONSIBILITIES

A. 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.

B. 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.

1.3.3 RHP ENROLLEES

A. Enrollment in an RHP plan typically occurs no more than thirty (30) days from the date of the determination of eligibility unless excluded.

B. 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 see 210 RICR-40.

5. 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.

1.3.4 RHP ENROLLMENT PROCESS

A. 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.

1.3.5 RHP MEMBER DISENROLLMENT

A. 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:

   a. Death;

   b. No longer Medicaid eligible;

   c. Eligibility error;

   d. Enrolled in Medicare or other third-party coverage;

   e. Placement in a long-term care institution – e.g., nursing facility – for more than thirty (30) consecutive days;

   f. Placement in Eleanor Slater, Tavares, or an out-of-state hospital;

   g. Incarceration; and

   h. 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:

   a. An adverse change in the member's health status;

   b. The member's utilization of medical services; or

   c. Uncooperative behavior resulting from the member's special needs.

3. 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.

1.3.6 GRIEVANCES, APPEALS AND HEARINGS

A. 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:

        (1) 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.

        (2) 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.

3. Regulations governing the appeals process are found in MCAR Section 0110.

1.4 RHP Benefit Package

A. 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	
Inpatient Hospital Care		(01)	Dental Services
Outpatient Hospital Services		(02)	Court-ordered Mental Health and Substance Abuse Services Ordered to a Non-network Facility or Provider
Physician Services		(03)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)
Family Planning Services		(04)	Nursing home Services in Excess of 30 Consecutive Days
Prescription Drugs		(05)	Residential Services for Beneficiaries with Intellectual and Developmental Disabilities
Non-Prescription Drugs		(06)	Home stabilization services
Laboratory Services			
Radiology Services			
Diagnostic Services			
Outpatient & Inpatient Mental Health and Substance Use Services			
Court-ordered Mental Health and Substance Abuse Services – Criminal Court			
Court-ordered Mental Health and Substance Abuse Treatment – Civil Court			
Home Health Services			
Emergency Room Service and Emergency Transportation Services			
Nursing Home Care and Skilled Nursing Facility Care			
Services of Other Practitioners			

RHP Benefits		
	(a) In-Plan	(b) Out-of-Plan
	Podiatry Services	
	Optometry Services	
	Oral Health	
	Hospice Services	
	Durable Medical Equipment	
	Group/Education Programs	
	Interpreter Services	
	Transplant Services	
	Adult Day Services	
	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those at High Risk for Acquiring HIV	
	AIDS Medical Case Management	
(	Opioid Treatment Provider Health Home	
	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.

1.5 - 1.25 Reserved

1.26 Integrated Care Initiative (ICI)

1.26.1 AUTHORITY AND OVERVIEW

A. 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.

1.26.2 EOHHS RESPONSIBILITIES

A. 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 0378, 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 0392).

   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.

1.26.3 SERVICE DELIVERY OPTIONS

A. 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 210-RICR-40-35.27 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 210-RICR-40-35.41 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 0399.05. Beneficiaries must be 55 years old or older to participate in this option. See 210-RICR-40-35.70 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.

5. 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:

    a. Navigating the health care system

    b. Care management, client advocacy, and health education

    c. Working with a person’s primary care provider

    d. Links to community resources.

6. 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.

1.27 Rhody Health Options (RHO)

1.27.1 RHO PARTICIPATION CRITERIA

A. 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 Section 210-RICR-40-10-1. 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:

    a. Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;

    b. MAGI-eligible adults in the MACC group for parents/caretakers; and

    c. 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.

3. 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.

4. 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.

5. 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.

1.27.2 RHO SERVICE DELIVERY OPTION

A. 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.

1.27.3 RHO ENROLLMENT

A. 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.

   a. Beneficiary Action. If the beneficiary makes an enrollment choice within the specified timeframe, EOHHS initiates enrollment accordingly.

   b. 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.

1.27.4 RHO DISENROLLMENT

A. EOHHS Initiated Disenrollment EOHHS – Reasons for EOHHS disenrollment from an RHO plan include but are not be limited to:

1. Death;

2. Loss of Medicaid eligibility;

3. Loss of Medicare eligibility (if previously fully dually eligible for Medicare and Medicaid and not receiving LTSS);

4. MNM beneficiary loss of LTSS eligibility;

5. Eligibility error;

6. Placement in Eleanor Slater Hospital, Tavares, or an out-of-state residential hospital;

7. Incarceration;

8. Change of state residence;

9. Enrollment in PACE;

10. Enrollment in the Medicare-Medicaid Plan; and

11. Opt-out to FFS.

B. 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:

1. An adverse change in the member's health status;

2. The member's utilization of medical services; or

3. Uncooperative behavior resulting from the member's special needs.

C. 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.

1.27.5 GRIEVANCES, APPEALS AND HEARINGS

A. 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:

(1) 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.

(2) 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.

1.28 RHO Benefit Package

A. 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	
Inpatient Hospital Care	(01)	Dental Services
Outpatient Hospital Services	(02)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)
Physical Therapy Evaluation and Services	(03)	Residential Services for Clients with Intellectual and Developmental Disabilities
Physician Services	(04)	Home Stabilization Services
Care Management Services		
Family Planning Services		
Prescription Drugs		
Non-Prescription Drugs		
Laboratory Services		
Radiology Services		
Diagnostic Services		
Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient		
Home Health Services		
Home Care Services		
Emergency Room Service and Emergency Transportation Services		
Nursing Home Care and Skilled Nursing Facility Care		
Services of Other Practitioners		

RHO Benefits	
(a) In-Plan	(b) Out-of-Plan
Podiatry Services	
Optometry Services	
Oral Health	
Hospice Services	
Crossover Claims	
Durable Medical Equipment	
Adult Day Health	
Nutrition Services	
Group/Individual Education Programs	
Interpreter Services	
Transplant Services	
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those that are at High Risk for Acquiring HIV	
AIDS Medical Case Management	
Court-ordered Mental Health and Substance Abuse Services – Criminal Court	
Court-Ordered Mental Health and Substance Abuse Treatment – Civil Court	
Preventive Services, including:	
Homemaker	
Minor Environmental Modifications	
Physical Therapy Evaluation and Services	
Respite	
Long Term Services and Supports, including:	
Homemaker	

RHO Benefits	
(a) In-Plan	(b) Out-of-Plan
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 Opioid Treatment Provider Health Home	

1.29 - 1.40 RESERVED

1.41 Medicare-Medicaid Plan (MMP)

1.41.1 OVERVIEW

A. 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.

1.41.2 MMP PARTICIPATION CRITERIA

A. 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:

    a. Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;

    b. MAGI-eligible adults in the MACC group for parents/caretakers;

    c. 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

    d. Persons with End Stage Renal Disease (ESRD) at the time of enrollment.

2. 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.

3. 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.

1.41.3 MMP SERVICE DELIVERY OPTION

A. 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.

1.41.4 MMP ENROLLMENT

A. 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:

   a. The MME beneficiary is enrolled in a Medicare Advantage plan that is not operated by the same MCO as the MMP;

   b. 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;

   c. 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

   d. 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.

1.41.5 ENROLLMENT INFORMATION

A. 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 210-RICR-40-35.26.2(A)(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.

B. 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 210-RICR-40-35.70).

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.

1.41.6 MMP MEMBER DISENROLLMENT

A. EOHHS Initiated Disenrollment – Reasons for EOHHS disenrollment from an MMP include but are not limited to:

1. Death;
2. No longer eligible for Medicaid;
3. Loss of Medicare Part A and/or Part B;
4. Enrollment into a Medicare Advantage (Part C) plan or Medicare Part D prescription drug plan;
5. Eligibility error;
6. Placement in Eleanor Slater Hospital, Tavares, or out-of-state residential hospital;
7. Incarceration;
8. Changed state of residence;
9. Enrollment in PACE; and
10. Opt-out to fee-for-service.

B. 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.

C. 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:

1. An adverse change in the member's health status;

2. The member's utilization of medical services;

3. Uncooperative or disruptive behavior resulting from the member's special needs;

4. The member exercising treatment decisions with which the MCO or the MCO's provider(s) disagree; or

5. Diminished or diminishing mental capacity of the member.

D. Beneficiaries who are involuntarily disenrolled based on a written request by the MMP receive their Medicaid benefits on a fee-for-service basis.

E. 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.

1.41.7 GRIEVANCES, APPEALS AND HEARINGS

A. 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.

d. 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.

1.41.8 MMP BENEFIT PACKAGE

A. 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		
(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		

MMP Medicaid Benefits		
(a) In-Plan		(b) Out-of-Plan
(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	

MMP Medicaid Benefits		
(a) In-Plan		(b) Out-of-Plan
(34)	Respite Long Term Services and Supports, including: 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	

MMP Medicaid Benefits	
(a) In-Plan	(b) Out-of-Plan
(35) Opioid Treatment Provider Health Home	

1.42 - 1.49 Reserved

1.50 Prescriptions: Generic Policy

A. 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:

1. Availability of suitable within-class generic substitutes or out-of-class alternatives.

2. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

3. Relative disruptions in care that may be brought on by changing treatment from one drug to another.

4. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

5. Relative clinical advantages and disadvantages of drugs within a therapeutic class.

6. Cost differentials between brand and generic alternatives.

7. Drugs that are required under federal and State regulations.

8. Demonstrated medical necessity and lack of efficacy on a case by case basis.

B. 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.

1.51 Home Stabilization Services Policy

A. Home stabilization services are available for beneficiaries eligible for enrollment in RHP, RHO, or an MMP as follows:

1.51.1 NO LTSS ELIGIBILITY

A. 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:

1. Beneficiary is considered homeless or at-risk of homelessness according to the HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009;

2. Beneficiary has history of homelessness as defined by HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009; or

3. 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

4. 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.

1.51.2 LTSS ELIGIBLE

A. Access to home stabilization services for LTSS beneficiaries is provided in accordance with the applicable provisions set forth in MCAR Section 0399.15, related to available services and supports.

1.52 Non-Emergency Transportation Policy

A. 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.

1.53 Interpretation Services Policy

A. 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.

1.54 Tracking, Follow-up, Outreach

A. 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.

1.55 Mainstreaming/Selective Contracting

A. 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.

1.56 - 1.69 Reserved

1.70 Program of All-Inclusive Care for the Elderly (PACE)

1.70.1 OVERVIEW

A. 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.

1.70.2 EOHHS RESPONSIBILITIES

A. EOHHS is responsible for the eligibility and enrollment functions set forth in 210-RICR-40-35.26.2, establishing PACE provider standards, and oversight and monitoring of all aspects of the PACE program.

1.70.3 PACE PROVIDER RESPONSIBILITIES

A. The PACE provider is responsible for:

1. Point of entry identification;

2. Submitting all necessary documentation for initial determinations and reevaluations of a level of need and referral to EOHHS for a determination of financial eligibility;

3. Verifying PACE enrollment prior to service delivery;

4. Verifying and collecting required beneficiary liability (cost-share amount);

5. Providing and coordinating all integrated services;

6. Reporting changes to the PACE-eligibility status of participants; and

7. 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.

1.70.4 PACE PARTICIPATION CRITERIA

A. To qualify as a Medicaid-eligible PACE participant, an individual must:

1. Be fifty-five (55) years of age or older;

2. Meet the criteria for a high or the highest need for a nursing facility level of care in accordance with MCAR Section 0399.10; and

3. 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.

B. Medicaid-eligible PACE participants may be, but are not required to be, enrolled in Medicare.

1.70.5 PACE DISENROLLMENT

A. Reasons for PACE Disenrollment – Reasons for disenrollment from PACE include but are not limited to:

1. Death;

2. Loss of Medicaid eligibility;

3. Eligibility error;

4. Placement in an out-of-state residential hospital;

5. Incarceration;

6. Change of state residence;

7. Loss of functional level of care; and

8. Voluntary opt-out to Medicaid FFS.

B. 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:

1. A statement that the PACE provider intends to disenroll the member;

2. The reason(s) for the intended disenrollment; and

3. A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

C. Disenrollment Requests Not Allowed. EOHHS does not permit disenrollment requests based on:

1. An adverse change in the member's health status;

2. The member's utilization of medical services; or

3. Uncooperative behavior resulting from the member's special needs.

D. 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.

E. 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).

F. 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.

1.70.6 DISENROLLMENT APPEAL

A. 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.

1.70.7 RE-ENROLLMENT AND TRANSITION OUT OF PACE

A. 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.

1.71 PACE Benefit Package

A. 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:

1. Multidisciplinary assessment and treatment planning;
2. Case Management services;
3. Personal Care;
4. Homemaking;
5. Rehabilitation;
6. Social Work;
7. Transportation;
8. Nutritional Counseling;
9. Recreational Therapy;
10. Minor Home Modifications; and
11. Specialized Medical Equipment and Supplies.

B. 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.

1.72 - 1.79 Reserved

1.80 Severability

A. 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.

1.81 CROSSWALK: MEDICAID CODE OF ADMINISTRATIVE RULES, SECTION #1400 "MEDICAID INTEGRATED HEALTH CARE COVERAGE" AND 210-RHODE ISLAND CODE OF REGULATIONS (RICR) CHAPTER 40-00-1

The purpose of this crosswalk is to align numbered sections of the Medicaid Code of Administrative Rules, Section #1400 entitled, "Medicaid Integrated Health Care Coverage" with the re-codified numbers appearing in Section 210-RICR-40-00 entitled, "Medicaid Integrated Health Care Coverage." Additionally, this crosswalk is intended to serve as a tool for the reader while Medicaid eligibility systems are being aligned.

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
1.	1400 Medicaid Integrated Health Care Coverage	210-RICR-40-00
2.	Overview	210-RICR-40-00-1
3.	1400 A. Overview of this Chapter	210-RICR-40-00-1.1
4.		210-RICR-40-00-1.1(A)
5.		210-RICR-40-00-1.1(A)(1)
6.		210-RICR-40-00-1.1(A)(2)
7.		210-RICR-40-00-1.1(A)(3)
8.	1400 B. Authority	210-RICR-40-00-1.2
9.		210-RICR-40-00-1.2(A)
10.	1400 C. Scope and Purpose	210-RICR-40-00-1.3
11.	Extension of Rhode Island's Section 1115 Demonstration Waiver	210-RICR-40-00-1.3(A)(1)
12.	ACA Implementation	210-RICR-40-00-1.3(A)(2)
13.	Integrated Eligibility System	210-RICR-40-00-1.3(A)(3)
14.	1400 D. Definitions	210-RICR-40-00-1.4
15.		210-RICR-40-00-1.4(A)
16.	Affordable Care Act	210-RICR-40-00-1.4(A)(1)
17.	Applicant	210-RICR-40-00-1.4(A)(2)
18.	Calendar Quarter	210-RICR-40-00-1.4(A)(3)
19.	Community Medicaid	210-RICR-40-00-1.4(A)(4)
20.	Executive Office of Health & Human Services	210-RICR-40-00-1.4(A)(5)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
21.	Dual Eligible Beneficiary	210-RICR-40-00-1.4(A)(6)
22.	Income Standard	210-RICR-40-00-1.4(A)(7)
23.	Long-Term Services and Supports	210-RICR-40-00-1.4(A)(8)
24.	Managed Care Arrangement	210-RICR-40-00-1.4(A)(9)
25.	Medicaid Affordable Care Coverage Groups	210-RICR-40-00-1.4(A)(10)
26.	Medicaid Code of Administrative Rules	210-RICR-40-00-1.4(A)(11)
27.	Primary Care Essential Benefits	210-RICR-40-00-1.4(A)(12)
28.	Primary Care Provider	210-RICR-40-00-1.4(A)(13)
29.	Resource Standard	210-RICR-40-00-1.4(A)(14)
30.	Wrap-around Coverage	210-RICR-40-00-1.4(A)(15)
31.	1400 E. IHCC Groups Subject to SSI Methodology	210-RICR-40-00-1.5
32.		210-RICR-40-00-1.5(A)
33.	(1) Elders and Adults with Disabilities	210-RICR-40-00-1.5(A)(1)
34.	(2) Medically Needy	210-RICR-40-00-1.5(A)(2)
35.	(3) Supplemental Security Income Recipients	210-RICR-40-00-1.5(A)(3)
36.	(4) State Supplemental Payment	210-RICR-40-00-1.5(A)(4)
37.	(5) SSI Protected Status Beneficiaries	210-RICR-40-00-1.5(A)(5)
38.	(6) Medicaid Premium Payment Program	210-RICR-40-00-1.5(A)(6)
39.	(7) Sherlock Plan for Working Adults with Disabilities	210-RICR-40-00-1.5(A)(7)
40.	(8) IHCC Medicaid LTSS	210-RICR-40-00-1.5(A)(8)
41.	1400 F. IHCC Special Coverage Groups	210-RICR-40-00-1.6
42.		210-RICR-40-00-1.6(A)
43.	(1) Low-income, uninsured women with breast or cervical cancer	210-RICR-40-00-1.6(A)(1)
44.	(2) Refugee Medicaid Assistance	210-RICR-40-00-1.6(A)(2)
45.	(3) Emergency Medicaid	210-RICR-40-00-1.6(A)(3)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
46.	1400 G. State's Integrated Eligibility System	210-RICR-40-00-1.7
47.		210-RICR-40-00-1.7(A)
48.	Coverage Group Options	210-RICR-40-00-1.7(A)(1)
49.	Streamlined Document Submission & Verification	210-RICR-40-00-1.7(A)(2)
50.	Modified Passive Eligibility Renewal	210-RICR-40-00-1.7(A)(3)
51.	1400 H. Medicaid Benefits	210-RICR-40-00-1.8
52.		210-RICR-40-00-1.8(A)
53.	(1) Premium Assistance and Financial Help	210-RICR-40-00-1.8(A)(1)
54.	(2) Health Care Services and Supports	210-RICR-40-00-1.8(A)(2)
55.	(a) Community Medicaid	210-RICR-40-00-1.8(A)(2)(a)
56.		210-RICR-40-00-1.8(A)(2)(a)(1)
57.		210-RICR-40-00-1.8(A)(2)(a)(2)
58.	(b) Medicaid LTSS	210-RICR-40-00-1.8(A)(2)(b)
59.	(3) Integrated Care	210-RICR-40-00-1.8(A)(3)
60.	(4) Retroactive Eligibility	210-RICR-40-00-1.8(A)(4)
61.	1400 I. Service Delivery Options	210-RICR-40-00-1.9
62.		210-RICR-40-00-1.9(A)
63.	Overview IHCC Group Service Delivery	210-RICR-40-00-1.9(B)
64.	**1402 Application & Review Process for IHCC Groups**	210-RICR-40-00-2
65.	1402 A. Scope & Purpose	210-RICR-40-00-2.1
66.		210-RICR-40-00-2.1(A)
67.	1402 B. Access Points	210-RICR-40-00-2.2
68.		210-RICR-40-00-2.2(A)
69.	(1) Self-service	210-RICR-40-00-2.2(A)(1)
70.	(2) Assisted Service	210-RICR-40-00-2.2(A)(2)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
71.		210-RICR-40-00-2.2(A)(3)
72.	1402 C. Application & Renewal Assistance	210-RICR-40-00-2.3
73.		210-RICR-40-00-2.3(A)
74.	(1) Eligibility and Renewal Help	210-RICR-40-00-2.3(A)(1)
75.	(2) Translation Services	210-RICR-40-00-2.3(A)(2)
76.	(3) Protection of Privacy	210-RICR-40-00-2.3(A)(3)
77.	(4) Timely Determinations	210-RICR-40-00-2.3(A)(4)
78.	(5) Appeals	210-RICR-40-00-2.3(A)(5)
79.	(6) Non-discrimination	210-RICR-40-00-2.3(A)(6)
80.	1402 D. Completing and Submitting the Application	210-RICR-40-00-2.4
81.		210-RICR-40-00-2.4(A)
82.	(1) Account Creation	210-RICR-40-00-2.4(A)(1)
83.	(a) Identity Proofing	210-RICR-40-00-2.4(A)(1)(a)
84.	(b) Account Matches	210-RICR-40-00-2.4(A)(1)(b)
85.	(2) Account Duration	210-RICR-40-00-2.4(A)(2)
86.	(3) Application Materials	210-RICR-40-00-2.4(A)(3)
87.	(a) MAGI-Based Eligibility	210-RICR-40-00-2.4(A)(3)(a)
88.	(b) SSI-Based Eligibility	210-RICR-40-00-2.4(A)(3)(b)
89.		210-RICR-40-00-2.4(A)(3)(b)(1)
90.		210-RICR-40-00-2.4(A)(3)(b)(2)
91.		210-RICR-40-00-2.4(A)(3)(b)(3)
92.		210-RICR-40-00-2.4(A)(3)(b)(4)
93.	(4) Application Filing Date	210-RICR-40-00-2.4(A)(4)
94.	(5) Application Completeness	210-RICR-40-00-2.4(A)(5)
95.	(6) Voluntary Withdrawal	210-RICR-40-00-2.4(A)(6)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
96.	(7) Self-attestation of Application Information	210-RICR-40-00-2.4(A)(7)
97.	(8) Privacy of Application Information	210-RICR-40-00-2.4(A)(8)
98.	(9) Eligibility Determination Timelines	210-RICR-40-00-2.4(A)(9)
99.	(10) MACC and IHCC Eligibility Determination Timelines	210-RICR-40-00-2.4(A)(10)
100.	1402 E. Beneficiary Responsibilities	210-RICR-40-00-2.5
101.		210-RICR-40-00-2.5(A)
102.	(1) Consent	210-RICR-40-00-2.5(A)(1)
103.	(2) Duty to Report	210-RICR-40-00-2.5(A)(2)
104.	(3) Cooperation	210-RICR-40-00-2.5(A)(3)
105.	(4) Voluntary Termination	210-RICR-40-00-2.5(A)(4)
106.	(5) Reliable Information	210-RICR-40-00-2.5(A)(5)
107.	(6) Change of Service Delivery Options	210-RICR-40-00-2.5(A)(6)
108.	(7) Alternative Forms of Benefits/Assistance	210-RICR-40-00-2.5(A)(7)
109.	1402.01 Application Review Process	210-RICR-40-00-2.6
110.	1402.01 A. Scope & Purpose	210-RICR-40-00-2.6.1
111.		210-RICR-40-00-2.6.1(A)
112.	1402.01 B. Conversion Process	210-RICR-40-00-2.6.2(A)
113.	(1) New Applicants	210-RICR-40-00-2.6.2(A)(1)
114.	(2) Existing Beneficiaries	210-RICR-40-00-2.6.2(A)(2)
115.	1402.01 C. General Rules	210-RICR-40-00-2.6.3
116.		210-RICR-40-00-2.6.3(A)
117.	(1) Limits on Choice	210-RICR-40-00-2.6.3 (A)(1)
118.	(a) Retroactive Coverage	210-RICR-40-00-2.6.3(A)(1)(a)
119.	(b) Other Health Coverage	210-RICR-40-00-2.6.3(A)(1)(b)
120.	(c) Former SSI Recipients	210-RICR-40-00-2.6.3(A)(1)(c)
121.	(d) Age	210-RICR-40-00-2.6.3 (A)(1)(d)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
122.	(e) LTSS Preventive Level Services	210-RICR-40-00-2.6.3(A)(1)(e)
123.	(f) Need for LTSS	210-RICR-40-00-2.6.3 (A)(1)(f)
124.	(g) Medically Needy Eligibility	210-RICR-40-00-2.6.3(A)(1)(g)
125.	(h) Medicare Premium Payment Program	210-RICR-40-00-2.6.3(A)(1)(h)
126.	(2) Eligibility Across Pathways	210-RICR-40-00-2.6.3(A)(2)
127.	(3) Continuing Eligibility Reviews Prior to Termination of Coverage	210-RICR-40-00-2.6.3(A)(3)
128.	1402.02 Renewal of Eligibility for IHCC Groups	210-RICR-40-00-2.7
129.	1402.02 A. Scope and Purpose	210-RICR-40-00-2.7.1
130.		210-RICR-40-00-2.7.1(A)
131.		210-RICR-40-00-2.7.1(B)
132.	1402.02 B. Agency Responsibilities	210-RICR-40-00-2.7.2
133.		210-RICR-40-00-2.7.2 (A)
134.	(1) Frequency	210-RICR-40-00-2.7.2 (A)(1)
135.	(2) Types of Information	210-RICR-40-00-2.7.2 (A)(2)
136.	(3) Notice	210-RICR-40-00-2.7.2 (A)(3)
137.	(a) Renewal Date	210-RICR-40-00-2.7.2(A)(3)(a)
138.	(b) Renewal Action	210-RICR-40-00-2.7.2(A)(3)(b)
139.	(4) Consent	210-RICR-40-00-2.7.2 (A)(4)
140.	(5) Modified Passive Renewal	210-RICR-40-00-2.7.2 (A)(5)
141.	(a) Initial Automated IES Renewal	210-RICR-40-00-2.7.2(A)(5)(a)
142.	(b) Continuing Renewals	210-RICR-40-00-2.7.2(A)(5)(b)
143.	1402.02 C. Beneficiary Responsibilities	210-RICR-40-00-2.7.3
144.	1403 Overview of the SSI Methodology	210-RICR-40-00-3
145.	1403 A. Scope and Purpose	210-RICR-40-00-3.1.1
146.		210-RICR-40-00-3.1.1(A)
147.		210-RICR-40-00-3.1.1(B)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
148.	1403 B. Organization of SSI Methodology Provisions in this Chapter	210-RICR-40-00-3.1.2
149.		210-RICR-40-00-3.1.2(A)
150.		210-RICR-40-00-3.1.2(A)(1)
151.		210-RICR-40-00-3.1.2(A)(2)
152.		210-RICR-40-00-3.1.2(A)(3)
153.		210-RICR-40-00-3.1.2(A)(4)
154.		210-RICR-40-00-3.1.2(A)(5)
155.		210-RICR-40-00-3.1.2(A)(6)
156.	1403 C. Definitions	210-RICR-40-00-3.1.3
157.		210-RICR-40-00-3.1.3(A)
158.	Child	210-RICR-40-00-3.1.3(A)(1)
159.	Couple	210-RICR-40-00-3.1.3(A)(2)
160.	Federal Benefit Rate	210-RICR-40-00-3.1.3(A)(3)
161.	Financial Responsibility Unit	210-RICR-40-00-3.1.3(A)(4)
162.	Medicaid Eligibility Group	210-RICR-40-00-3.1.3(A)(5)
163.	Medicaid Health Coverage	210-RICR-40-00-3.1.3(A)(6)
164.	Medically Necessary Service	210-RICR-40-00-3.1.3(A)(7)
165.	Medically Needy	210-RICR-40-00-3.1.3(A)(8)
166.	SSI Income Methodology	210-RICR-40-00-3.1.3(A)(9)
167.	1403 C. Key Elements of SSI Methodology	210-RICR-40-00-3.1.4
168.		210-RICR-40-00-3.1.4(A)
169.	Financial Determination	210-RICR-40-00-3.1.4(A)(1)
170.	Characteristic Requirements	210-RICR-40-00-3.1.4(A)(2)
171.	LTSS Need and Level of Care	210-RICR-40-00-3.1.4(A)(3)
172.	General and Group-Specific Eligibility Requirements	210-RICR-40-00-3.1.4(A)(4)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
173.	Clinical Reviews	210-RICR-40-00-3.1.4(A)(5)
174.		210-RICR-40-00-3.1.4(A)(5)(a)
175.		210-RICR-40-00-3.1.4(A)(5)(b)
176.		210-RICR-40-00-3.1.4(A)(5)(c)
177.		210-RICR-40-00-3.1.4(A)(5)(d)
178.		210-RICR-40-00-3.1.4(A)(5)(e)
179.		210-RICR-40-00-3.1.4(A)(5)(f)
180.	1403 D. Income	210-RICR-40-00-3.1.5
181.		210-RICR-40-00-3.1.5(A)
182.	(1) Earned Income	210-RICR-40-00-3.1.5(A)(1)
183.	(2) Unearned Income	210-RICR-40-00-3.1.5(A)(2)
184.		210-RICR-40-00-3.1.5(B)
185.	1403 E. Resources	210-RICR-40-00-3.1.6
186.		210-RICR-40-00-3.1.6(A)
187.	(1) Liquid Resources	210-RICR-40-00-3.1.6(A)(1)
188.	(2) Non-liquid Resources	210-RICR-40-00-3.1.6(A)(2)
189.	1403 F. Income and Resource Standards	210-RICR-40-00-3.1.7
190.		210-RICR-40-00-3.1.7(A)
191.	(1) Monthly Federal Benefit Rate	210-RICR-40-00-3.1.7(A)(1)
192.	(2) Optional State Supplemental Payment Limits	210-RICR-40-00-3.1.7(A)(2)
193.	(3) Medically Needy Monthly Income Standards	210-RICR-40-00-3.1.7(A)(3)
194.	(a) Community Medicaid	210-RICR-40-00-3.1.7(A)(3)(a)
195.		210-RICR-40-00-3.1.7(A)(3)(a)(1)
196.		210-RICR-40-00-3.1.7(A)(3)(a)(2)
197.	(b) LTSS	210-RICR-40-00-3.1.7(A)(3)(b)
198.	(c) MN Standards	210-RICR-40-00-3.1.7(A)(3)(c)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
199.	(4) Federal Poverty Level Income Guidelines	210-RICR-40-00-3.1.7(A)(4)
200.	(5) Resource Standards	210-RICR-40-00-3.1.7(A)(5)
201.	(6) Student Earned Income Exclusion	210-RICR-40-00-3.1.7(A)(6)
202.	(7) Spousal Impoverishment	210-RICR-40-00-3.1.7(A)(7)
203.	(8) Medically Needy Standards	210-RICR-40-00-3.1.7(A)(7)(a)
204.		210-RICR-40-00-3.1.7(A)(8)
205.	1404.00 SSI Methodology: Treatment of Income	210-RICR-40-00-3.2
206.	1404.00 A. Scope & Purpose	210-RICR-40-00-3.2.1
207.		210-RICR-40-00-3.2.1(A)
208.	1404.00 B. Definitions	210-RICR-40-00-3.2.2(A)
209.	Available Income	210-RICR-40-00-3.2.2(A)(1)
210.	Countable Income	210-RICR-40-00-3.2.2(A)(2)
211.	Deeming	210-RICR-40-00-3.2.2(A)(3)
212.	Infrequent Income	210-RICR-40-00-3.2.2(A)(4)
213.	PASS	210-RICR-40-00-3.2.2(A)(5)
214.	Non-applicant Person	210-RICR-40-00-3.2.2(A)(6)
215.	Unavailable Income	210-RICR-40-00-3.2.2(A)(7)
216.	1404.00 C. Agency Responsibilities	210-RICR-40-00-3.2.3
217.		210-RICR-40-00-3.2.3(A)
218.	(1) Evaluation of Income	210-RICR-40-00-3.2.3(A)(1)
219.	(2) Exclusions	210-RICR-40-00-3.2.3(A)(2)
220.	(3) Application of Disregards and Deductions	210-RICR-40-00-3.2.3(A)(3)
221.	(4) Deemed Income, Non-LTSS Only	210-RICR-40-00-3.2.3(A)(4)
222.	(5) Availability	210-RICR-40-00-3.2.3(A)(5)
223.	(6) Determination of Income Eligibility	210-RICR-40-00-3.2.3(A)(6)
224.	1404.00 D. Beneficiary Responsibilities	210-RICR-40-00-3.2.4

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
225.		210-RICR-40-00-3.2.4(A)
226.	1404.00 E. Types of Income	210-RICR-40-00-3.2.5
227.		210-RICR-40-00-3.2.5(A)
228.	(1) Not Income	210-RICR-40-00-3.2.5(A)(1)
229.		210-RICR-40-00-3.2.5(A)(1)(a)
230.		210-RICR-40-00-3.2.5(A)(1)(b)
231.		210-RICR-40-00-3.2.5(A)(1)(c)
232.		210-RICR-40-00-3.2.5(A)(1)(d)
233.		210-RICR-40-00-3.2.5(A)(1)(e)
234.		210-RICR-40-00-3.2.5(A)(1)(f)
235.		210-RICR-40-00-3.2.5(A)(1)(g)
236.		210-RICR-40-00-15.2.5(A)(1)(h)
237.		210-RICR-40-00-3.2.5(A)(1)(i)
238.		210-RICR-40-00-3.2.5(A)(1)(j)
239.	(2) Countable Earned Income	210-RICR-40-00-3.2.5(A)(2)
240.	(a) Employee Income	210-RICR-40-00-3.2.5(A)(2)(a)
241.		210-RICR-40-00-3.2.5(A)(2)(a)(1)
242.		210-RICR-40-00-3.2.5(A)(2)(a)(2)
243.		210-RICR-40-00-3.2.5(A)(2)(a)(3)
244.		210-RICR-40-00-3.2.5(A)(2)(a)(4)
245.		210-RICR-40-00-3.2.5(A)(2)(a)(5)
246.		210-RICR-40-00-3.2.5(A)(2)(a)(6)
247.	(b) Irregular or Infrequent Income	210-RICR-40-00-3.2.5(A)(2)(b)
248.	(c) Net Earnings from Self-Employment	210-RICR-40-00-3.2.5(A)(2)(c)
249.	(d) Net Rental Income	210-RICR-40-00-3.2.5(A)(2)(d)
250.	(e) In-Kind	210-RICR-40-00-3.2.5(A)(2)(e)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
251.	(f) Other Income	210-RICR-40-00-3.2.5(A)(2)(f)
252.	(3) Countable Unearned Income	210-RICR-40-00-3.2.5(A)(3)
253.	(a) Adoption Assistance Involving Title IV-E Funds	210-RICR-40-00-3.2.5(A)(3)(a)
254.	(b) Alimony, Spousal and Other Adult Support	210-RICR-40-00-3.2.5(A)(3)(b)
255.	(c) Annuities, Pensions, and Other Periodic Payments	210-RICR-40-00-3.2.5(A)(3)(c)
256.	(d) Child Support and Arrearage Payments	210-RICR-40-00-3.2.5(A)(3)(d)
257.	(e) Disability Payments	210-RICR-40-00-3.2.5(A)(3)(e)
258.	(f) Extended Income Support Payments through the Trade Adjustment Reform Act	210-RICR-40-00-3.2.5(A)(3)(f)
259.	(g) Foster Care Payments	210-RICR-40-00-3.2.5(A)(3)(g)
260.	(h) In-Kind	210-RICR-40-00-3.2.5(A)(3)(h)
261.	(i) Interest, Dividends, and Certain Royalties	210-RICR-40-00-3.2.5(A)(3)(i)
262.	(j) Irregular or Infrequent Lump Sum	210-RICR-40-00-3.2.5(A)(3)(j)
263.	(k) Net Rental Income	210-RICR-40-00-3.2.5(A)(3)(k)
264.	(l) Regular and Frequent Gift Income	210-RICR-40-00-3.2.5(A)(3)(l)
265.	(m) Retirement, Survivor's and Disability Insurance (RSDI)	210-RICR-40-00-3.2.5(A)(3)(m)
266.	(n) Retroactive RSDI	210-RICR-40-00-3.2.5(A)(3)(n)
267.	(o) Severance Pay	210-RICR-40-00-3.2.5(A)(3)(o)
268.	(p) Spousal Maintenance or Allowance	210-RICR-40-00-3.2.5(A)(3)(p)
269.	(q) Student Financial Aid	210-RICR-40-00-3.2.5(A)(3)(q)
270.		210-RICR-40-00-3.2.5(A)(3)(q)(1)
271.	(r) Distributions from a Coverdell Educational Savings Account	210-RICR-40-00-3.2.5(A)(3)(r)
272.	(s) Tribal per capita payments from casinos	210-RICR-40-00-3.2.5(A)(3)(s)
273.	(t) Unemployment Insurance, including Rhode Island Temporary Disability Insurance (TDI) Payments	210-RICR-40-00-3.2.5(A)(3)(t)
274.	(u) Veteran's Administration (VA) Benefits	210-RICR-40-00-3.2.5(A)(3)(u)
275.	1404.01 Factors Considered in Treatment Income	210-RICR-40-00-3.3

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
276.	1404.01 A. Scope & Purpose	210-RICR-40-00-3.3.1
277.		210-RICR-40-00-3.3.1(A)
278.	1404.01 B. Both Earned and Unearned Disregards & Exclusions	210-RICR-40-00-3.3.2
279.		210-RICR-40-00-3.3.2(A)
280.	(1) Infrequent/Irregular Income Disregards	210-RICR-40-00-3.3.2(A)(1)
281.		210-RICR-40-00-3.3.2(A)(1)(a)
282.		210-RICR-40-00-3.3.2(A)(1)(b)
283.		210-RICR-40-00-3.3.2(A)(1)(c)
284.	(2) $20/Month General Income Disregard	210-RICR-40-00-3.3.2(A)(2)
285.		210-RICR-40-00-3.3.2(A)(2)(a)
286.		210-RICR-40-00-3.3.2(A)(2)(b)
287.	(3) PASS Disregard	210-RICR-40-00-3.3.2(A)(3)
288.	(4) Federally Mandated Exclusions	210-RICR-40-00-3.3.2(A)(4)
289.	1404.01 C. Earned Income Disregards & Exclusions	210-RICR-40-00-3.3.3
290.		210-RICR-40-00-3.3.3(A)
291.	(1) $65 and ½ Earned Income Disregard	210-RICR-40-00-3.3.3(A)(1)
292.	(2) AmeriCorps	210-RICR-40-00-3.3.3(A)(2)
293.	(3) Child Care Tax Credit	210-RICR-40-00-3.3.3(A)(3)
294.	(4) Earned Income Tax Credit/Refund	210-RICR-40-00-3.3.3(A)(4)
295.	(5) Impairment-Related Work Expenses	210-RICR-40-00-3.3.3(A)(5)
296.		210-RICR-40-00-3.3.3(A)(5)(a)
297.		210-RICR-40-00-3.3.3(A)(5)(b)
298.		210-RICR-40-00-3.3.3(A)(5)(c)
299.		210-RICR-40-00-3.3.3(A)(5)(d)
300.		210-RICR-40-00-3.3.3(A)(5)(e)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
301.	(6) Student Child Earned Income Exclusions	210-RICR-40-00-3.3.3(A)(6)
302.	(7) Work-Related Expenses of Blind Persons	210-RICR-40-00-3.3.3(A)(7)
303.	1404.01 D. Unearned Income Disregards & Exclusions	210-RICR-40-00-3.3.4
304.		210-RICR-40-00-3.3.4(A)
305.	(1) Assistance Based on Need	210-RICR-40-00-3.3.4(A)(1)
306.	(2) Burial Funds	210-RICR-40-00-3.3.4(A)(2)
307.	(3) Child Support and Arrearage Payments	210-RICR-40-00-3.3.4(A)(3)
308.		210-RICR-40-00-3.3.4(A)(3)(a)
309.		210-RICR-40-00-3.3.4(A)(3)(b)
310.		210-RICR-40-00-3.3.4(A)(3)(c)
311.	(4) Death Benefits	210-RICR-40-00-3.3.4(A)(4)
312.		210-RICR-40-00-3.3.4(A)(4)(a)
313.		210-RICR-40-00-3.3.4(A)(4)(b)
314.		210-RICR-40-00-3.3.4(A)(4)(c)
315.		210-RICR-40-00-3.3.4(A)(4)(d)
316.		210-RICR-40-00-3.3.4(A)(4)(e)
317.		210-RICR-40-00-3.3.4(A)(4)(f)
318.		210-RICR-40-00-3.3.4(A)(4)(g)
319.	(5) Disaster Assistance	210-RICR-40-00-3.3.4(A)(5)
320.	(6) Federal Housing Assistance	210-RICR-40-00-3.3.4(A)(6)
321.		210-RICR-40-00-3.3.4(A)(6)(a)
322.		210-RICR-40-00-3.3.4(A)(6)(b)
323.		210-RICR-40-00-3.3.4(A)(6)(c)
324.		210-RICR-40-00-3.3.4(A)(6)(d)
325.		210-RICR-40-00-3.3.4(A)(6)(e)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
326.	(7) Food and Nutrition Assistance	210-RICR-40-00-3.3.4(A)(7)
327.	(8) Foster Care Payments	210-RICR-40-00-3.3.4(A)(8)
328.	(9) Gifts	210-RICR-40-00-3.3.4(A)(9)
329.	(10)Grants, Scholarships, Fellowship	210-RICR-40-00-3.3.4(A)(10)
330.	(11)Home Energy Assistance Payments	210-RICR-40-00-3.3.4(A)(11)
331.	(12)Refugee Cash Assistance	210-RICR-40-00-3.3.4(A)(12)
332.	(13)Relocation Assistance	210-RICR-40-00-3.3.4(A)(13)
333.	(14)Reparation Payments	210-RICR-40-00-3.3.4(A)(14)
334.		210-RICR-40-00-3.3.4(A)(14)(a)
335.		210-RICR-40-00-3.3.4(A)(14)(b)
336.		210-RICR-40-00-3.3.4(A)(14)(c)
337.		210-RICR-40-00-3.3.4(A)(14)(d)
338.	(15)RI Works Under a PASS	210-RICR-40-00-3.3.4(A)(15)
339.	(16)Student Loans	210-RICR-40-00-3.3.4(A)(16)
340.	1404.01 E. Lump Sum Income Disregards & Exclusions	210-RICR-40-00-3.3.5
341.		210-RICR-40-00-3.3.5(A)
342.		210-RICR-40-00-3.3.5(A)(1)
343.		210-RICR-40-00-3.3.5(A)(2)
344.	(1) General Treatment of Lump Sum Income	210-RICR-40-00-3.3.5(A)(3)
345.		210-RICR-40-00-3.3.5(A)(3)(a)
346.		210-RICR-40-00-3.3.5(A)(3)(b)
347.		210-RICR-40-00-3.3.5(A)(3)(c)
348.		210-RICR-40-00-3.3.5(A)(3)(d)
349.	(2) RSDI and SSI Payments	210-RICR-40-00-3.3.5(A)(4)
350.	(a) SSI/SSP Pathway	210-RICR-40-00-3.3.5(A)(4)(a)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
351.	(b) Community Medicaid, MPPP, & LTSS Pathways	210-RICR-40-00-3.3.5(A)(4)(b)
352.		210-RICR-40-00-3.3.5(A)(4)(b)(1)
353.		210-RICR-40-00-3.3.5(A)(4)(b)(2)
354.		210-RICR-40-00-3.3.5(A)(4)(b)(3)
355.	(3) Medicare Part B Reimbursements	210-RICR-40-00-3.3.5(A)(5)
356.	1404.01 F. Self-Employment Income	210-RICR-40-00-3.3.6
357.		210-RICR-40-00-3.3.6(A)
358.	(1) Treatment of self-employment income in general	210-RICR-40-00-3.3.6(A)(1)
359.	(2) Treatment of property related self-employment income	210-RICR-40-00-3.3.6(A)(2)
360.	(a) Rental Income	210-RICR-40-00-3.3.6(A)(2)(a)
361.	(b) Room/Board Income	210-RICR-40-00-3.3.6(A)(2)(b)
362.		210-RICR-40-00-3.3.6(A)(2)(b)(1)
363.		210-RICR-40-00-3.3.6(A)(2)(b)(2)
364.		210-RICR-40-00-3.3.6(A)(2)(b)(3)
365.		210-RICR-40-00-3.3.6(A)(2)(b)(4)
366.	(c) In-home Day Care	210-RICR-40-00-3.3.6(A)(2)(c)
367.	1404.01 G. In-Kind Income	210-RICR-40-00-3.3.7
368.		210-RICR-40-00-3.3.7(A)
369.	(1) Earned In-Kind	210-RICR-40-00-3.3.7(A)(1)
370.	(2) Unearned In-Kind	210-RICR-40-00-3.3.7(A)(2)
371.	(a) Assistance Household	210-RICR-40-00-3.3.7(A)(2)(a)
372.	(b) Living in Household of Another	210-RICR-40-00-3.3.7(A)(2)(b)
373.		210-RICR-40-00-3.3.7(A)(2)(b)(1)
374.		210-RICR-40-00-3.3.7(A)(2)(b)(2)
375.	(c) Living in Own Household	210-RICR-40-00-3.3.7(A)(2)(c)
376.	1404.01 H. Availability	210-RICR-40-00-3.3.8

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
377.		210-RICR-40-00-3.3.8(A)
378.	(1) Support Payments	210-RICR-40-00-3.3.8(A)(1)
379.	(2) Income Deductions	210-RICR-40-00-3.3.8(A)(2)
380.	(3) Loan Deductions	210-RICR-40-00-3.3.8(A)(3)
381.	(4) Garnishments and Liens	210-RICR-40-00-3.3.8(A)(4)
382.	1404.02 Federally Mandated Income Exclusions	210-RICR-40-00-3.4
383.	1405.00 SSI Methodology: Treatment of Resources	210-RICR-40-00-3.5
384.	1405.00 A. Scope & Purpose	210-RICR-40-00-3.5.1
385.		210-RICR-40-00-3.5.1(A)
386.	(1) Simplified Resource Review for Community Medicaid	210-RICR-40-00-3.5.1(A)(1)
387.	(2) Comprehensive Resource Review for LTSS	210-RICR-40-00-3.5.1(A)(2)
388.	(3) Coverage Groups Exempt	210-RICR-40-00-3.5.1(A)(3)
389.		210-RICR-40-00-3.5.1(A)(3)(a)
390.		210-RICR-40-00-3.5.1(A)(3)(b)
391.		210-RICR-40-00-3.5.1(A)(3)(c)
392.		210-RICR-40-00-3.5.1(A)(3)(d)
393.		210-RICR-40-00-3.5.1(A)(3)(e)
394.		210-RICR-40-00-3.5.1(A)(3)(f)
395.	1405.00 B. Definitions	210-RICR-40-00-3.5.2
396.		210-RICR-40-00-3.5.2(A)
397.	Annuity	210-RICR-40-00-3.5.2(A)(1)
398.	Available Resource	210-RICR-40-00-3.5.2(A)(2)
399.	Burial Expense Fund	210-RICR-40-00-3.5.2(A)(3)
400.	Equity Value	210-RICR-40-00-3.5.2(A)(4)
401.	Fair Market Value	210-RICR-40-00-3.5.2(A)(5)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
402.	Guardian	210-RICR-40-00-3.5.2(A)(6)
403.	Home	210-RICR-40-00-3.5.2(A)(7)
404.	Intent to Return	210-RICR-40-00-3.5.2(A)(8)
405.	Life Estate	210-RICR-40-00-3.5.2(A)(9)
406.	Liquid Resources	210-RICR-40-00-3.5.2(A)(10)
407.	Non-Liquid Resources	210-RICR-40-00-3.5.2(A)(11)
408.	Ownership Interest	210-RICR-40-00-3.5.2(A)(12)
409.	Principal Place of Residence	210-RICR-40-00-3.5.2(A)(13)
410.	Real Property	210-RICR-40-00-3.5.2(A)(14)
411.	Representative Payee	210-RICR-40-00-3.5.2(A)(15)
412.	Resource Transfer	210-RICR-40-00-3.5.2(A)(16)
413.	Temporary Absence	210-RICR-40-00-3.5.2(A)(17)
414.	Trust	210-RICR-40-00-3.5.2(A)(18)
415.	1405.00 C. Agency Responsibilities	210-RICR-40-00-3.5.3
416.		210-RICR-40-00-3.5.3(A)
417.	(1) Scope of Resource Evaluation	210-RICR-40-00-3.5.3(A)(1)
418.	Factors Affecting the Evaluation of Resources	210-RICR-40-00-3.5.3(A)(2)
419.		210-RICR-40-00-3.5.3(A)(2)(a)
420.		210-RICR-40-00-3.5.3(A)(2)(b)
421.		210-RICR-40-00-3.5.3(A)(2)(c)
422.		210-RICR-40-00-3.5.3(A)(2)(d)
423.		210-RICR-40-00-3.5.3(A)(2)(d)(1)
424.		210-RICR-40-00-3.5.3(A)(2)(d)(2)
425.	Deemed Resources Non-LTSS Only	210-RICR-40-00-3.5.3(A)(3)
426.	Determination of Resource Eligibility	210-RICR-40-00-3.5.3(A)(4)
427.	1405.00 D. Beneficiary's Responsibilities	210-RICR-40-00-3.5.4

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
428.		210-RICR-40-00-3.5.4(A)
429.	1405.00 E. Types of Resources and Related Exclusions	210-RICR-40-00-3.5.5
430.		210-RICR-40-00-3.5.5(A)
431.	(1) Non-Liquid Resources	210-RICR-40-00-3.5.5(A)(1)
432.	(a) Home and Adjoining Land	210-RICR-40-00-3.5.5(A)(1)(a)
433.	(01)Principal Place of Residence	210-RICR-40-00-3.5.5(A)(1)(a)(1)
434.	(02)Multiple Residences	210-RICR-40-00-3.5.5(A)(1)(a)(2)
435.	(03)Out-of-State Residences	210-RICR-40-00-3.5.5(A)(1)(a)(3)
436.	(04)Multi-state Residences	210-RICR-40-00-3.5.5(A)(1)(a)(4)
437.	(05)Out-of-State Property Owner	210-RICR-40-00-3.5.5(A)(1)(a)(5)
438.	(06)Sale of the Home	210-RICR-40-00-3.5.5(A)(1)(a)(6)
439.	(07)Proceeds from the Sale	210-RICR-40-00-3.5.5(A)(1)(a)(7)
440.	(08)Temporary Absences	210-RICR-40-00-3.5.5(A)(1)(a)(8)
441.	(b) Business/Trade Property	210-RICR-40-00-3.5.5(A)(1)(b)
442.	(c) Income Producing Real Estate	210-RICR-40-00-3.5.5(A)(1)(c)
443.	(d) Vehicle (Personal Property)	210-RICR-40-00-3.5.5(A)(1)(d)
444.	(e) Life Estate (Real Property)	210-RICR-40-00-3.5.5(A)(1)(e)
445.	(f) Burial Funds (Personal Property)	210-RICR-40-00-3.5.5(A)(1)(f)
446.	(01)Burial Fund Exclusion	210-RICR-40-00-3.5.5(A)(1)(f)(1)
447.	(02)Burial Space Exclusion	210-RICR-40-00-3.5.5(A)(1)(f)(2)
448.	(03)Irrevocable Burial Contracts	210-RICR-40-00-3.5.5(A)(1)(f)(3)
449.	(04)Revocable Burial Contracts	210-RICR-40-00-3.5.5(A)(1)(f)(4)
450.	(g) Personal Effects and Household Goods	210-RICR-40-00-3.5.5(A)(1)(g)
451.	(h) Life Insurance Policy	210-RICR-40-00-3.5.5(A)(1)(h)
452.	(01)Cash Surrender Value	210-RICR-40-00-3.5.5(A)(1)(h)(1)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
453.	(02) Face Value	210-RICR-40-00-3.5.5(A)(1)(h)(2)
454.	(03) Counting Rule	210-RICR-40-00-3.5.5(A)(1)(h)(3)
455.	(2) Liquid Resources	210-RICR-40-00-3.5.5(A)(2)
456.	(a) Annuities	210-RICR-40-00-3.5.5(A)(2)(a)
457.		210-RICR-40-00-3.5.5(A)(2)(a)(1)
458.		210-RICR-40-00-3.5.5(A)(2)(a)(2)
459.		210-RICR-40-00-3.5.5(A)(2)(a)(3)
460.	(b) Cash and Accounts in Financial Institutions	210-RICR-40-00-3.5.5(A)(2)(b)
461.	(c) Investments	210-RICR-40-00-3.5.5(A)(2)(c)
462.	Savings Bonds	210-RICR-40-00-3.5.5(A)(2)(c)(1)
463.	Bonds and Securities	210-RICR-40-00-3.5.5(A)(2)(c)(2)
464.	Stocks	210-RICR-40-00-3.5.5(A)(2)(c)(3)
465.	(d) Loans	210-RICR-40-00-3.5.5(A)(2)(d)
466.	(e) Mortgages	210-RICR-40-00-3.5.5(A)(2)(e)
467.	(f) Promissory Notes	210-RICR-40-00-3.5.5(A)(2)(f)
468.	(g) Retirement Funds	210-RICR-40-00-3.5.5(A)(2)(g)
469.	(h) Education Funds	210-RICR-40-00-3.5.5(A)(2)(h)
470.	(i) Health Savings Accounts	210-RICR-40-00-3.5.5(A)(2)(i)
471.	(3) Resources Managed by a Third Party	210-RICR-40-00-3.5.5(A)(3)
472.	(a) Guardianship Funds	210-RICR-40-00-3.5.5(A)(3)(a)
473.	(b) Power of Attorney	210-RICR-40-00-3.5.5(A)(3)(b)
474.	(c) Representative Payee	210-RICR-40-00-3.5.5(A)(3)(c)
475.	(d) Trust	210-RICR-40-00-3.5.5(A)(3)(d)
476.	(01) Revocable Trust	210-RICR-40-00-3.5.5(A)(3)(d)(1)
477.	(02) Irrevocable Trust	210-RICR-40-00-3.5.5(A)(3)(d)(2)
478.		210-RICR-40-00-3.5.5(A)(3)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
479.	1405.01 Factors Considered in Treatment of Resources	210-RICR-40-00-3.6
480.	1405.01 A. Scope & Purpose	210-RICR-40-00-3.6.1
481.		210-RICR-40-00-3.6.1(A)
482.	1405.01 B. Process Rules	210-RICR-40-00-3.6.2
483.		210-RICR-40-00-3.6.2(A)
484.	(1) First Moment of the Month Rule	210-RICR-40-00-3.6.2(A)(1)
485.	(2) Resource Changes	210-RICR-40-00-3.6.2(A)(2)
486.		210-RICR-40-00-3.6.2(A)(2)(a)
487.		210-RICR-40-00-3.6.2(A)(2)(b)
488.		210-RICR-40-00-3.6.2(A)(2)(c)
489.		210-RICR-40-00-3.6.2(A)(2)(d)
490.	(3) Resource Reduction	210-RICR-40-00-3.6.2(A)(3)
491.	(a) Community Medicaid	210-RICR-40-00-3.6.2(A)(3)(a)
492.	(b) Medicaid LTSS	210-RICR-40-00-3.6.2(A)(3)(b)
493.	(c) Allowable Expenses	210-RICR-40-00-3.6.2(A)(3)(c)
494.		210-RICR-40-00-3.6.2(A)(3)(c)(1)
495.		210-RICR-40-00-3.6.2(A)(3)(c)(2)
496.		210-RICR-40-00-3.6.2(A)(3)(c)(3)
497.		210-RICR-40-00-3.6.2(A)(3)(c)(4)
498.	(4) Evaluation Factors	210-RICR-40-00-3.6.2(A)(4)
499.	(a) Countable Value	210-RICR-40-00-3.6.2(A)(4)(a)
500.	(b) Jointly Owned Resources	210-RICR-40-00-3.6.2(A)(4)(b)
501.	(01)Tenancy in Common	210-RICR-40-00-3.6.2(A)(4)(b)(1)
502.	(02)Joint Tenancy	210-RICR-40-00-3.6.2(A)(4)(b)(2)
503.	(03)Tenancy in its Entirety	210-RICR-40-00-3.6.2(A)(4)(b)(3)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
504.	(c) Counting Order	210-RICR-40-00-3.6.2(A)(4)(c)
505.	(d) Prudent-person Standard	210-RICR-40-00-3.6.2(A)(4)(d)
506.	(5) Legal Factors Affecting Availability	210-RICR-40-00-3.6.2(A)(5)
507.	(6) Identifiability	210-RICR-40-00-3.6.2(A)(6)
508.		210-RICR-40-00-3.6.2(A)(6)(a)
509.		210-RICR-40-00-3.6.2(A)(6)(b)
510.		210-RICR-40-00-3.6.2(A)(6)(c)
511.		210-RICR-40-00-3.6.2(A)(6)(d)
512.		210-RICR-40-00-3.6.2(A)(6)(e)
513.	1405.01 C. Mandatory Resource Exclusions	210-RICR-40-00-3.6.3
514.		210-RICR-40-00-3.6.3(A)
515.	(1) Exclusions Required by Federal Law	210-RICR-40-00-3.6.3(A)(1)
516.	(2) Required by State Law or Regulation	210-RICR-40-00-3.6.3(A)(2)
517.	1405.01 D. Special & Time-Limited Exclusions	210-RICR-40-00-3.6.4
518.		210-RICR-40-00-3.6.4(A)
519.	(1) Retroactive Social Security and SSI/SSP	210-RICR-40-00-3.6.4(A)(1)
520.	(2) Funds for Replacing Excluded Resources	210-RICR-40-00-3.6.4(A)(2)
521.	(3) Earned Income Tax Credit	210-RICR-40-00-3.6.4(A)(3)
522.	(4) Health and Human Services Payments	210-RICR-40-00-3.6.4(A)(4)
523.	(5) Victim's Compensation Payments	210-RICR-40-00-3.6.4(A)(5)
524.	(6) Relocation Payments	210-RICR-40-00-3.6.4(A)(6)
525.	(7) Expenses from Last Illness and Burial	210-RICR-40-00-3.6.4(A)(7)
526.	(8) Long-term Care Insurance Partnership	210-RICR-40-00-3.6.4(A)(8)
527.	(9) Dedicated Home Repair and Modification Funds	210-RICR-40-00-3.6.4(A)(9)
528.	1405.01 C. Determination of Resource Eligibility	210-RICR-40-00-3.6.5
529.		210-RICR-40-00-3.6.5(A)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
530.	1405.02 Federally Mandated Exclusions	210-RICR-40-00-3.7
531.		210-RICR-40-00-3.7(A)
532.	1408.00 IHCC Community Medicaid	210-RICR-40-05-1
533.	1408.00 A. Overview	210-RICR-40-05-1.1
534.		210-RICR-40-05-1.1(A)
535.	1408.00 B. Authority	210-RICR-40-05-1.2
536.		210-RICR-40-05-1.2(A)
537.	1408.00 C. Scope & Purpose	210-RICR-40-05-1.3
538.		210-RICR-40-05-1.3(A)
539.	1408.00 D. Definitions	210-RICR-40-05-1.4
540.		210-RICR-40-05-1.4(A)
541.	Adult Dependent Child	210-RICR-40-05-1.4(A)(1)
542.	Applicant	210-RICR-40-05-1.4(A)(2)
543.	Community Medicaid Eligibility Standards	210-RICR-40-05-1.4(A)(3)
544.	Deemed Income	210-RICR-40-05-1.4(A)(4)
545.	Deemor	210-RICR-40-05-1.4(A)(5)
546.	Non-Applicant or NAPP	210-RICR-40-05-1.4(A)(6)
547.	Parent	210-RICR-40-05-1.4(A)(7)
548.	1408.01 Eligibility for Elders, Adults with Disabilities & Medically Needy	210-RICR-40-05-1.5
549.	1408.01 A. Scope & Purpose	210-RICR-40-05-1.5.1
550.		210-RICR-40-05-1.5.1(A)
551.	1408.01 B. EAD Pathway	210-RICR-40-05-1.5.2
552.		210-RICR-40-05-1.5.2(A)
553.	(1) Eligibility Criteria	210-RICR-40-05-1.5.2(A)(1)
554.	(a) Characteristic Requirements	210-RICR-40-05-1.5.2(A)(1)(a)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
555.	Age	210-RICR-40-05-1.5.2(A)(1)(a)(1)
556.	Disability	210-RICR-40-05-1.5.2(A)(1)(a)(2)
557.	Blindness	210-RICR-40-05-1.5.2(A)(1)(a)(3)
558.	(b) Financial Requirements	210-RICR-40-05-1.5.2(A)(1)(b)
559.	Income	210-RICR-40-05-1.5.2(A)(1)(b)(1)
560.	Resources	210-RICR-40-05-1.5.2(A)(1)(b)(2)
561.	(2) Determination Process	210-RICR-40-05-1.5.2(A)(2)
562.	(3) Continuing Eligibility	210-RICR-40-05-1.5.2(A)(3)
563.	(4) Agency Responsibilities	210-RICR-40-05-1.5.2(A)(4)
564.	1408.01 C. Medically Needy Eligibility Pathway	210-RICR-40-05-1.5.3
565.		210-RICR-40-05-1.5.3(A)
566.	1408.01 D. SSI & SSP and SSI Protected Status	210-RICR-40-05-1.5.4
567.		210-RICR-40-05-1.5.4(A)
568.	(1) SSI Recipients	210-RICR-40-05-1.5.4(A)(1)
569.	(2) State Supplemental Payment Recipients	210-RICR-40-05-1.5.4(A)(2)
570.	(a) Eligibility Criteria	210-RICR-40-05-1.5.4(A)(2)(a)
571.	(b) Determination Process	210-RICR-40-05-1.5.4(A)(2)(b)
572.	(c) Continuing Eligibility	210-RICR-40-05-1.5.4(A)(2)(c)
573.	(d) Agency Responsibilities	210-RICR-40-05-1.5.4(A)(2)(d)
574.	(e) Applicant/beneficiary Responsibilities	210-RICR-40-05-1.5.4(A)(2)(e)
575.	(3) Pickle Amendment Eligibility Pathway	210-RICR-40-05-1.5.4(A)(3)
576.	(a) Eligibility Criteria	210-RICR-40-05-1.5.4(A)(3)(a)
577.		210-RICR-40-05-1.5.4(A)(3)(a)(1)
578.		210-RICR-40-05-1.5.4(A)(3)(a)(2)
579.		210-RICR-40-05-1.5.4(A)(3)(a)(3)
580.	(b) Determination Process	210-RICR-40-05-1.5.4(A)(3)(b)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
581.	(c) Continuing Eligibility	210-RICR-40-05-1.5.4(A)(3)(c)
582.	(d) Agency Responsibilities	210-RICR-40-05-1.5.4(A)(3)(d)
583.	(e) Applicant/beneficiary Responsibilities	210-RICR-40-05-1.5.4(A)(3)(e)
584.	(f) Table of RSDI Cost-of-Living Adjustments	210-RICR-40-05-1.5.4(A)(3)(f)
585.	(4) Employed Persons with Disabilities (Section 1619a)	210-RICR-40-05-1.5.4(A)(4)
586.	(a) Eligibility Criteria	210-RICR-40- 05-1.5.4(A)(4)(a)
587.		210-RICR-40-05-1.5.4(A)(4)(a)(1)
588.		210-RICR-40-05-1.5.4(A)(4)(a)(2)
589.		210-RICR-40- 05-1.5.4(A)(4)(a)(3)
590.	(b) Determination Process	210-RICR-40- 05-1.5.4(A)(4)(b)
591.	(c) Continuing Eligibility	210-RICR-40-05-1.5.4(A)(4)(c)
592.	(d) Agency Responsibilities	210-RICR-40-05-1.5.4(A)(4)(d)
593.	(5) Medicaid While Working (1619b)	210-RICR-40-05-1.5.4(A)(5)
594.	(a) Eligibility Criteria	210-RICR-40-05-1.5.4(A)(5)(a)
595.		210-RICR-40-05-1.5.4(A)(5)(a)(1)
596.		210-RICR-40-05-1.5.4(A)(5)(a)(2)
597.		210-RICR-40-05-1.5.4(A)(5)(a)(3)
598.	(b) Determination Process	210-RICR-40- 05-1.5.4(A)(5)(b)
599.	(c) Continuing Eligibility	210-RICR-40-05-1.5.4(A)(5)(c)
600.	(d) Agency Responsibilities	210-RICR-40-05-1.5.4(A)(5)(d)
601.	(6) Protected Surviving Spouses	210-RICR-40-05-1.5.4(A)(6)
602.	(a) Eligibility Criteria	210-RICR-40-05-1.5.4(A)(6)(a)
603.		210-RICR-40-05-1.5.4(A)(6)(a)(1)
604.		210-RICR-40-05-1.5.4(A)(6)(a)(2)
605.		210-RICR-40-05-1.5.4(A)(6)(a)(3)
606.	(b) Determination Process	210-RICR-40-05-1.5.4(A)(6)(b)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
607.	(c) Continuing Eligibility	210-RICR-40-05-1.5.4(A)(6)(c)
608.	(d) Agency Responsibilities	210-RICR-40-05-1.5.4(A)(6)(d)
609.	(7) Adult Dependent Child with Disabilities	210-RICR-40-05-1.5.4(A)(7)
610.	(a) Eligibility Criteria	210-RICR-40-05-1.5.4(A)(7)(a)
611.		210-RICR-40-05-1.5.4(A)(7)(a)(1)
612.		210-RICR-40-05-1.5.4(A)(7)(a)(2)
613.		210-RICR-40-05-1.5.4(A)(7)(a)(3)
614.		210-RICR-40-05-1.5.4(A)(7)(a)(4)
615.	(b) Determination Process	210-RICR-40- 05-1.5.4(A)(7)(b)
616.	(c) Continuing Eligibility	210-RICR-40-05-1.5.4(A)(7)(c)
617.	(d) Agency Responsibilities	210-RICR-40-05-1.5.4(A)(7)(d)
618.	(8) Divorced or Surviving Spouses with Disabilities	210-RICR-40-05-1.5.4(A)(8)
619.	(9) State Supplemental Recipients, 12/73	210-RICR-40-05-1.5.4(A)(9)
620.	(10) Surviving Spouses with Disabilities Affected by Actuarial Changes	210-RICR-40-05-1.5.4(A)(10)
621.	1408.02 Medicare Premium Payment Program [MPPP]	210-RICR-40-05-1.6
622.	1408.02 A. Scope & Purpose	210-RICR-40-05-1.6.1
623.		210-RICR-40-05-1.6.1(A)
624.	(1) Basis of Eligibility	210-RICR-40-05-1.6.1(A)(1)
625.		210-RICR-40-05-1.6.1(A)(1)(a)
626.		210-RICR-40-05-1.6.1(A)(1)(b)
627.		210-RICR-40-05-1.6.1(A)(1)(c)
628.	(2) Medicare Coverage and the MPPP	210-RICR-40-05-1.6.1(A)(2)
629.		210-RICR-40-05-1.6.1(A)(2)(a)
630.		210-RICR-40-05-1.6.1(A)(2)(b)
631.		210-RICR-40-05-1.6.1(A)(2)(c)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
632.		210-RICR-40-05-1.6.1(A)(2)(d)
633.	1408.02 B. MPPP Eligibility Pathways	210-RICR-40-05-1.6.2
634.		210-RICR-40-05-1.6.2(A)
635.	(1) Qualified Medicare Beneficiaries without other Medicaid (QMB only)	210-RICR-40-05-1.6.2(A)(1)
636.		210-RICR-40-05-1.6.2(A)(1)(a)
637.		210-RICR-40-05-1.6.2(A)(1)(b)
638.		210-RICR-40-05-1.6.2(A)(1)(c)
639.		210-RICR-40-05-1.6.2(A)(1)(d)
640.		210-RICR-40-05-1.6.2(A)(1)(e)
641.	(2) QMBs with Medicaid Health Coverage (QMB Plus)	210-RICR-40-05-1.6.2(A)(2)
642.	(3) Specified Low-Income Medicare Beneficiaries without other Medicaid (SLMB only)	210-RICR-40-05-1.6.2(A)(3)
643.		210-RICR-40-05-1.6.2(A)(3)(a)
644.		210-RICR-40-05-1.6.2(A)(3)(b)
645.		210-RICR-40-05-1.6.2(A)(3)(c)
646.		210-RICR-40-05-1.6.2(A)(3)(d)
647.		210-RICR-40-05-1.6.2(A)(3)(e)
648.	(4) SLMBs with Medicaid Health Coverage (SLMB Plus)	210-RICR-40-05-1.6.2(A)(4)
649.		210-RICR-40-05-1.6.2(A)(5)
650.	(6) Qualified Disabled and Working Individuals (QDWIs)	210-RICR-40-05-1.6.2(A)(6)
651.		210-RICR-40-05-1.6.2(A)(6)(a)
652.		210-RICR-40-05-1.6.2(A)(6)(b)
653.	(7) Qualifying Individuals (QI-1)	210-RICR-40-05-1.6.2(A)(7)
654.		210-RICR-40-05-1.6.2(A)(7)(a)
655.		210-RICR-40-05-1.6.2(A)(7)(b)
656.		210-RICR-40-05-1.6.2(A)(7)(c)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
657.		210-RICR-40-05-1.6.2(A)(7)(d)
658.		210-RICR-40-05-1.6.2(A)(7)(e)
659.	(8) MN and QMB + and SLMB +	210-RICR-40-05-1.6.2(A)(8)
660.	1408.02 C. MPPP Application Process	210-RICR-40-05-1.6.3
661.		210-RICR-40-05-1.6.3(A)
662.	MPPP	210-RICR-40-05-1.6.3(A)(1)
663.	LIS and Social Security Administration (SSA)	210-RICR-40-05-1.6.3 (A)(2)
664.	1408.02 D. MPPP Eligibility and Continuing Eligibility	210-RICR-40-05-1.6.4
665.		210-RICR-40-05-1.6.4(A)
666.	1408.02 E. MPPP Summary	210-RICR-40-05-1.6.5
667.	MPPP Eligibility Pathways 2016	210-RICR-40-05-1.6.5(A)
668.	1408.03 Special Coverage Groups	210-RICR-40-05-1.7
669.	1408.03 A. Overview	210-RICR-40-05-1.7.1
670.		210-RICR-40-05-1.7.1(A)
671.	1408.03 B. Breast & Cervical Cancer	210-RICR-40-05-1.7.2
672.		210-RICR-40-05-1.7.2(A)
673.	(1) Eligibility Criteria	210-RICR-40-05-1.7.2(A)(1)
674.	(2) Determination Process	210-RICR-40-05-1.7.2(A)(2)
675.	(3) Continuing Eligibility	210-RICR-40-05-1.7.2(A)(3)
676.		210-RICR-40-05-1.7.2(A)(3)(a)
677.		210-RICR-40-05-1.7.2(A)(3)(b)
678.		210-RICR-40-05-1.7.2(A)(3)(c)
679.		210-RICR-40-05-1.7.2(A)(3)(d)
680.		210-RICR-40-05-1.7.2(A)(3)(e)
681.		210-RICR-40-05-1.7.2(A)(3)(f)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
682.	(4) Responsibilities	210-RICR-40-05-1.7.2(A)(4)
683.	(5) Applicant/beneficiary Responsibilities	210-RICR-40-05-1.7.2(A)(5)
684.	1408.03 C. Refugee Medical Assistance	210-RICR-40-05-1.7.3
685.		210-RICR-40-05-1.7.3(A)
686.	(1) Eligibility Criteria	210-RICR-40-05-1.7.3(A)(1)
687.	(2) Determination Process	210-RICR-40-05-1.7.3(A)(2)
688.	(3) Continuing Eligibility	210-RICR-40-05-1.7.3(A)(3)
689.	(a) Coverage Limit	210-RICR-40-05-1.7.3(A)(3)(a)
690.	(b) No Five Year Bar	210-RICR-40-05-1.7.3(A)(3)(b)
691.	(4) Agency Responsibilities	210-RICR-40-05-1.7.3(A)(4)
692.	(5) Applicant/beneficiary Responsibilities	210-RICR-40-05-1.7.3(A)(5)
693.	1408.03 D. Sherlock Plan	210-RICR-40-05-1.7.4
694.		210-RICR-40-05-1.7.4(A)
695.	1408.03 E. Emergency Medicaid	210-RICR-40-05-1.7.5
696.		210-RICR-40-05-1.7.5(A)
697.	(1) Eligibility Criteria	210-RICR-40-05-1.7.5(A)(1)
698.	(a) Persons under age 65	210-RICR-40-05-1.7.5(A)(1)(a)
699.	(b) Elders 65 and older	210-RICR-40-05-1.7.5(A)(1)(b)
700.	(c) Medically Needy	210-RICR-40-05-1.7.5(A)(1)(c)
701.		210-RICR-40-05-1.7.5(A)(1)(d)
702.		210-RICR-40-05-1.7.5(A)(1)(d)(1)
703.	(2) Determination Process	210-RICR-40-05-1.7.5(A)(2)
704.	(3) Continuing Eligibility	210-RICR-40-05-1.7.5(A)(3)
705.	(4) Agency Responsibilities	210-RICR-40-05-1.7.5(A)(4)
706.	(5) Applicant/beneficiary Responsibilities	210-RICR-40-05-1.7.5(A)(5)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
707.	1408.04 Community Medicaid – LTSS Preventive Services	210-RICR-40-05-1.8
708.	1408.04 A. Authority	210-RICR-40-05-1.8.1
709.		210-RICR-40-05-1.8.1(A)
710.	1408.04 B. Scope of Services	210-RICR-40-05-1.8.2
711.		210-RICR-40-05-1.8.2(A)
712.	(1) Limited Certified Nursing Assistant/Homemaker Services	210-RICR-40-05-1.8.2(A)(1)
713.		210-RICR-40-05-1.8.2(A)(1)(a)
714.	(2) Minor Environmental Modifications	210-RICR-40-05-1.8.2(A)(2)
715.	1408.04 C. Clinical Review	210-RICR-40-05-1.8.3
716.		210-RICR-40-05-1.8.3(A)
717.	1408.04 D. Limits	210-RICR-40-05-1.8.4
718.		210-RICR-40-05-1.8.4(A)
719.	1408.04 E. Continuing Need	210-RICR-40-05-1.8.5
720.		210-RICR-40-05-1.8.5(A)
721.	1408.05 Community Medicaid General Eligibility Requirements	210-RICR-40-05-1.9
722.	1408.05 A. Scope & Purpose	210-RICR-40-05-1.9.1
723.		210-RICR-40-05-1.9.1(A)
724.	1408.05 B. Characteristic Requirements	210-RICR-40-05-1.9.2
725.		210-RICR-40-05-1.9.2(A)
726.	(1) Age	210-RICR-40-05-1.9.2(A)(1)
727.	Verification	210-RICR-40-05-1.9.2(A)(1)(a)
728.	(2) Disability	210-RICR-40-05-1.9.2(A)(2)
729.	1408.05 C. Non-Financial Criteria	210-RICR-40-05-1.9.3
730.		210-RICR-40-05-1.9.3(A)
731.	(1) Social Security Number	210-RICR-40-05-1.9.3(A)(1)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
732.	(a) Condition of Eligibility	210-RICR-40-05-1.9.3(A)(1)(a)
733.	(b) Limits on Use	210-RICR-40-05-1.9.3(A)(1)(b)
734.	(c) Verification	210-RICR-40-05-1.9.3(A)(1)(c)
735.	(2) Residency	210-RICR-40-05-1.9.3(A)(2)
736.	(a) SSP	210-RICR-40-05-1.9.3(A)(2)(a)
737.	(b) Persons Under 21	210-RICR-40-05-1.9.3(A)(2)(b)
738.		210-RICR-40-05-1.9.3(A)(2)(b)(1)
739.		210-RICR-40-05-1.9.3(A)(2)(b)(2)
740.	(c) Persons 21 and Older	210-RICR-40-05-1.9.3(A)(2)(c)
741.		210-RICR-40-05-1.9.3(A)(2)(c)(1)
742.		210-RICR-40-05-1.9.3(A)(2)(c)(2)
743.		210-RICR-40-05-1.9.3(A)(2)(c)(3)
744.	(d) Absence due to Military Assignment	210-RICR-40-05-1.9.3(A)(2)(d)
745.	(e) Temporary Absence	210-RICR-40-05-1.9.3(A)(2)(e)
746.		210-RICR-40-05-1.9.3(A)(2)(e)(1)
747.		210-RICR-40-05-1.9.3(A)(2)(e)(2)
748.		210-RICR-40-05-1.9.3(A)(2)(e)(3)
749.		210-RICR-40-05-1.9.3(A)(2)(e)(4)
750.	(f) Placement in Rhode Island Institutions	210-RICR-40-05-1.9.3(A)(2)(f)
751.	(g) Incapable of Stating Intent	210-RICR-40-05-1.9.3(A)(2)(g)
752.	(h) Residence as Payment Requirement	210-RICR-40-05-1.9.3(A)(2)(h)
753.	(i) Specific Prohibitions	210-RICR-40-05-1.9.3(A)(2)(i)
754.		210-RICR-40-05-1.9.3(A)(2)(i)(1)
755.		210-RICR-40-05-1.9.3(A)(2)(i)(2)
756.		210-RICR-40-05-1.9.3(A)(2)(i)(3)
757.		210-RICR-40-05-1.9.3(A)(2)(i)(4)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
758.	(j) Verification	210-RICR-40-05-1.9.3(A)(2)(j)
759.	(3) Living Arrangements	210-RICR-40-05-1.9.3(A)(3)
760.	(a) Financial Eligibility	210-RICR-40-05-1.9.3(A)(3)(a)
761.		210-RICR-40-05-1.9.3(A)(3)(a)(1)
762.		210-RICR-40-05-1.9.3(A)(3)(a)(2)
763.		210-RICR-40-05-1.9.3(A)(3)(a)(3)
764.		210-RICR-40-05-1.9.3(A)(3)(a)(4)
765.	(b) SSP	210-RICR-40-05-1.9.3(A)(3)(b)
766.		210-RICR-40-05-1.9.3(A)(3)(b)(1)
767.		210-RICR-40-05-1.9.3(A)(3)(b)(2)
768.		210-RICR-40-05-1.9.3(A)(3)(b)(3)
769.		210-RICR-40-05-1.9.3(A)(3)(b)(4)
770.		210-RICR-40-05-1.9.3(A)(3)(b)(5)
771.	Verification	210-RICR-40-05-1.9.3(A)(3)(c)
772.	(c) Correctional Facility	210-RICR-40-05-1.9.3(A)(3)(d)
773.	Verification	210-RICR-40-05-1.9.3(A)(3)(e)
774.	(4) Citizenship and Immigration Status	210-RICR-40-05-1.9.3(A)(4)
775.	(a) Citizen or Qualified Non-Citizen	210-RICR-40-05-1.9.3(A)(4)(a)
776.		210-RICR-40-05-1.9.3(A)(4)(a)(1)
777.		210-RICR-40-05-1.9.3(A)(4)(a)(2)
778.	(b) Non-Qualified Non-Citizen	210-RICR-40-05-1.9.3(A)(4)(b)
779.	Verification	210-RICR-40-05-1.9.3(A)(4)(c)
780.	(5) Other Forms of Cooperation	210-RICR-40-05-1.9.3(A)(5)
781.		210-RICR-40-05-1.9.3(A)(5)(a)
782.		210-RICR-40-05-1.9.3(A)(5)(b)
783.		210-RICR-40-05-1.9.3(A)(5)(c)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
784.		210-RICR-40-05-1.9.3(A)(5)(d)
785.		210-RICR-40-05-1.9.3(A)(5)(e)
786.	1408.05 D. Good Cause for Non-Cooperation	210-RICR-40-05-1.9.4
787.		210-RICR-40-05-1.9.4(A)
788.		210-RICR-40-05-1.9.4(A)(1)
789.		210-RICR-40-05-1.9.4(A)(2)
790.		210-RICR-40-05-1.9.4 (B)
791.	1408.06 MART Disability Determinations	210-RICR-40-05-1.10
792.	1408.06 A. Scope & Purpose	210-RICR-40-05-1.10.1
793.		210-RICR-40-05-1.10.1(A)
794.	1408.06 B. Disability Standards for Community Medicaid	210-RICR-40-05-1.10.2
795.		210-RICR-40-05-1.10.2(A)
796.	(1) Duration	210-RICR-40-05-1.10.2(A)(1)
797.	(2) Substantial Gainful Activity	210-RICR-40-05-1.10.2(A)(2)
798.	(3) Application of Standards	210-RICR-40-05-1.10.2(A)(3)
799.	(a) Persons Age 18 or Older	210-RICR-40-05-1.10.2(A)(3)(a)
800.	(b) Children under Age 19 MN Only	210-RICR-40-05-1.10.2(A)(3)(b)
801.	(c) Disability Based on Blindness	210-RICR-40-05-1.10.2(A)(3)(c)
802.	(d) Working Persons with Disabilities No LTSS	210-RICR-40-05-1.10.2(A)(3)(d)
803.	1408.06 C. MART Five Step Determination Process	210-RICR-40-05-1.10.3
804.		210-RICR-40-05-1.10.3(A)
805.	(1) Step One	210-RICR-40-05-1.10.3(A)(1)
806.	(2) Step Two	210-RICR-40-05-1.10.3(A)(2)
807.	(3) Step Three	210-RICR-40-05-1.10.3(A)(3)
808.	(4) Fourth Step	210-RICR-40-05-1.10.3(A)(4)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
809.	(5) Fifth Step	210-RICR-40-05-1.10.3(A)(5)
810.	1408.06 D. Referral to MART	210-RICR-40-05-1.10.4
811.		210-RICR-40-05-1.10.4(A)
812.	(1) Referral to the MART	210-RICR-40-05-1.10.4(A)(1)
813.		210-RICR-40-05-1.10.4(A)(1)(a)
814.		210-RICR-40-05-1.10.4(A)(1)(b)
815.	(2) Limits on Referral	210-RICR-40-05-1.10.4(A)(2)
816.		210-RICR-40-05-1.10.4(A)(2)(a)
817.		210-RICR-40-05-1.10.4(A)(2)(b)
818.		210-RICR-40-05-1.10.4(A)(2)(c)
819.		210-RICR-40-05-1.10.4(A)(3)
820.	1408.06 E. Continuing Eligibility Responsibilities	210-RICR-40-05-1.10.5
821.		210-RICR-40-05-1.10.5(A)
822.	(1) Medicaid Renewal	210-RICR-40-05-1.10.5(A)(1)
823.	(2) MART Periodic Reviews	210-RICR-40-05-1.10.5(A)(2)
824.		210-RICR-40-05-1.10.5(A)(2)(a)
825.		210-RICR-40-05-1.10.5(A)(2)(b)
826.		210-RICR-40-05-1.10.5(A)(3)
827.		210-RICR-40-05-1.10.5(A)(3)(a)
828.		210-RICR-40-05-1.10.5(A)(3)(b)
829.		210-RICR-40-05-1.10.5(A)(3)(c)
830.		210-RICR-40-05-1.10.5(A)(3)(d)
831.	(3) Limitations	210-RICR-40-05-1.10.5(A)(4)
832.		210-RICR-40-05-1.10.5(A)(5)
833.	1408.06 F. Agency and Applicant Responsibilities	210-RICR-40-05-1.10.6

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
834.		210-RICR-40-05-1.10.6(A)
835.	1408.07 Financial Eligibility Determinations	210-RICR-40-05-1.11
836.	1408.07 A. Scope & Purpose	210-RICR-40-05-1.11.1
837.		210-RICR-40-05-1.11.1(A)
838.	1408.07 B. Medicaid Eligibility Groups	210-RICR-40-05-1.11.2
839.		210-RICR-40-05-1.11.2(A)
840.	(1) Single Adults	210-RICR-40-05-1.11.2(A)(1)
841.	(2) Groups for Adults with Spouses	210-RICR-40-05-1.11.2(A)(2)
842.	(a) Living Together	210-RICR-40-05-1.11.2(A)(2)(a)
843.		210-RICR-40-05-1.11.2(A)(2)(a)(1)
844.		210-RICR-40-05-1.11.2(A)(2)(a)(2)
845.		210-RICR-40-05-1.11.2(A)(2)(a)(3)
846.	(b) Exceptions	210-RICR-40-05-1.11.2(A)(2)(b)
847.		210-RICR-40-05-1.11.2(A)(2)(b)(1)
848.		210-RICR-40-05-1.11.2(A)(2)(b)(2)
849.	(c) Dependent Child in the Household	210-RICR-40-05-1.11.2(A)(2)(c)
850.	(2) Child (Applicable for MN Eligibility Only)	210-RICR-40-05-1.11.2(A)(3)
851.	(3)Parent - Child	210-RICR-40-05-1.11.2(A)(4)
852.	1408.07 C. Formation of FRU	210-RICR-40-05-1.11.3
853.		210-RICR-40-05-1.11.3(A)
854.	(1) FRU Composition for Citizens	210-RICR-40-05-1.11.3(A)(1)
855.	(a) FRU Single Adults	210-RICR-40-05-1.11.3(A)(1)(a)
856.	(b) FRU Child	210-RICR-40-05-1.11.3(A)(1)(b)
857.	(c) FRU Couples	210-RICR-40-05-1.11.3(A)(1)(c)
858.	(2) FRU for Sponsored Non-Citizens	210-RICR-40-05-1.11.3(A)(2)
859.		210-RICR-40-05-1.11.3(A)(2)(a)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
860.		210-RICR-40-05-1.11.3(A)(2)(b)
861.		210-RICR-40-05-1.11.3(A)(2)(c)
862.		210-RICR-40-05-1.11.3(A)(2)(d)
863.		210-RICR-40-05-1.11.3(A)(2)(e)
864.	1408.07 D. General Rules for Counting Income	210-RICR-40-05-1.11.4
865.		210-RICR-40-05-1.11.4(A)
866.	(1) Order of Unearned Income Exclusions and Disregards	210-RICR-40-05-1.11.4(A)(1)
867.	(a) Federal Law	210-RICR-40-05-1.11.4(A)(1)(a)
868.	(b) Medicaid	210-RICR-40-05-1.11.4(A)(1)(b)
869.		210-RICR-40-05-1.11.4(A)(1)(b)(1)
870.		210-RICR-40-05-1.11.4(A)(1)(b)(2)
871.		210-RICR-40-05-1.11.4(A)(1)(b)(3)
872.		210-RICR-40-05-1.11.4(A)(1)(b)(4)
873.		210-RICR-40-05-1.11.4(A)(1)(b)(5)
874.		210-RICR-40-05-1.11.4(A)(1)(b)(6)
875.		210-RICR-40-05-1.11.4(A)(1)(b)(7)
876.		210-RICR-40-05-1.11.4(A)(1)(b)(8)
877.		210-RICR-40-05-1.11.4(A)(1)(b)(9)
878.		210-RICR-40-05-1.11.4(A)(1)(b)(10)
879.		210-RICR-40-05-1.11.4(A)(1)(b)(11)
880.		210-RICR-40-05-1.11.4(A)(1)(b)(12)
881.		210-RICR-40-05-1.11.4(A)(1)(b)(13)
882.		210-RICR-40-05-1.11.4(A)(1)(b)(14)
883.		210-RICR-40-05-1.11.4(A)(1)(b)(15)
884.		210-RICR-40-05-1.11.4(A)(1)(b)(16)
885.		210-RICR-40-05-1.11.4(A)(1)(b)(17)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
886.		210-RICR-40-05-1.11.4(A)(1)(b)(18)
887.		210-RICR-40-05-1.11.4(A)(1)(b)(19)
888.		210-RICR-40-05-1.11.4(A)(1)(b)(20)
889.		210-RICR-40-05-1.11.4(A)(1)(b)(21)
890.		210-RICR-40-05-1.11.4(A)(1)(b)(22)
891.		210-RICR-40-05-1.11.4(A)(1)(b)(23)
892.		210-RICR-40-05-1.11.4(A)(1)(b)(24)
893.		210-RICR-40-05-1.11.4(A)(1)(b)(25)
894.	(2) Order of Earned Income Exclusions	210-RICR-40-05-1.11.4(A)(2)
895.	(a) Federal Law	210-RICR-40-05-1.11.4(A)(2)(a)
896.	(b) SSI Methodology	210-RICR-40-05-1.11.4(A)(2)(b)
897.		210-RICR-40-05-1.11.4(A)(2)(b)(1)
898.		210-RICR-40-05-1.11.4(A)(2)(b)(2)
899.		210-RICR-40-05-1.11.4(A)(2)(b)(3)
900.		210-RICR-40-05-1.11.4(A)(2)(b)(4)
901.		210-RICR-40-05-1.11.4(A)(2)(b)(5)
902.		210-RICR-40-05-1.11.4(A)(2)(b)(6)
903.		210-RICR-40-05-1.11.4(A)(2)(b)(7)
904.		210-RICR-40-05-1.11.4(A)(2)(b)(8)
905.		210-RICR-40-05-1.11.4(A)(2)(b)(9)
906.	(3) Unused Exclusions and Disregards	210-RICR-40-05-1.11.4(A)(3)
907.		210-RICR-40-05-1.11.4(A)(3)(a)
908.		210-RICR-40-05-1.11.4(A)(3)(b)
909.		210-RICR-40-05-1.11.4(A)(3)(c)
910.		210-RICR-40-05-1.11.4(A)(3)(d)
911.		210-RICR-40-05-1.11.4(A)(3)(e)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
912.	1408.07 E. Income Deeming	210-RICR-40-05-1.11.5
913.		210-RICR-40-05-1.11.5(A)
914.		210-RICR-40-05-1.11.5(A)(1)
915.		210-RICR-40-05-1.11.5(A)(2)
916.		210-RICR-40-05-1.11.5(A)(3)
917.	(1) Spouse-to-Spouse	210-RICR-40-05-1.11.5(B)
918.		210-RICR-40-05-1.11.5(B)(1)
919.		210-RICR-40-05-1.11.5(B)(2)
920.		210-RICR-40-05-1.11.5(B)(2)(a)
921.		210-RICR-40-05-1.11.5(B)(2)(a)(1)
922.		210-RICR-40-05-1.11.5(B)(2)(a)(2)
923.		210-RICR-40-05-1.11.5(B)(2)(a)(3)
924.		210-RICR-40-05-1.11.5(B)(2)(a)(4)
925.		210-RICR-40-05-1.11.5(B)(2)(b)
926.	(2) Parent-to-Child	210-RICR-40-05-1.11.5(C)
927.		210-RICR-40-05-1.11.5(C)(1)
928.		210-RICR-40-05-1.11.5(C)(1)(a)
929.		210-RICR-40-05-1.11.5(C)(1)(b)
930.	(a) Deeming Rules	210-RICR-40-05-1.11.5(C)(2)
931.		210-RICR-40-05-1.11.5(C)(2)(a)
932.		210-RICR-40-05-1.11.5(C)(2)(b)
933.		210-RICR-40-05-1.11.5(C)(2)(c)
934.		210-RICR-40-05-1.11.5(C)(2)(d)
935.		210-RICR-40-05-1.11.5(C)(2)(e)
936.		210-RICR-40-05-1.11.5(C)(2)(f)
937.	(3) Other Household Members	210-RICR-40-05-1.11.5(D)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
938.		210-RICR-40-05-1.11.5(D)(1)
939.		210-RICR-40-05-1.11.5(D)(2)
940.		210-RICR-40-05-1.11.5(D)(3)
941.		210-RICR-40-05-1.11.5(D)(4)
942.		210-RICR-40-05-1.11.5(D)(5)
943.	(4) Sponsor Deeming	210-RICR-40-05-1.11.5(E)
944.	(a) Exceptions to Sponsor Deeming	210-RICR-40-05-1.11.5(E)(1)
945.		210-RICR-40-05-1.11.5(E)(1)(a)
946.		210-RICR-40-05-1.11.5(E)(1)(b)
947.		210-RICR-40-05-1.11.5(E)(1)(c)
948.		210-RICR-40-05-1.11.5(E)(1)(d)
949.	(b) General Rules of Sponsor Deeming	210-RICR-40-05-1.11.5(E)(2)
950.		210-RICR-40-05-1.11.5(E)(2)(a)
951.		210-RICR-40-05-1.11.5(E)(2)(b)
952.		210-RICR-40-05-1.11.5(E)(2)(c)
953.		210-RICR-40-05-1.11.5(E)(3)
954.		210-RICR-40-05-1.11.5(E)(3)(a)
955.		210-RICR-40-05-1.11.5(E)(3)(b)
956.		210-RICR-40-05-1.11.5(E)(3)
957.	1408.07 F. General Rules for Continuing Resources	210-RICR-40-05-1.11.6
958.		210-RICR-40-05-1.11.6(A)
959.	(1) Process	210-RICR-40-05-1.11.6(A)(1)
960.	(2) Application of Exclusions	210-RICR-40-05-1.11.6(A)(2)
961.		210-RICR-40-05-1.11.6(A)(2)(a)
962.		210-RICR-40-05-1.11.6(A)(2)(b)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
963.		210-RICR-40-05-1.11.6(A)(2)(c)
964.		210-RICR-40-05-1.11.6(A)(2)(d)
965.		210-RICR-40-05-1.11.6(A)(2)(e)
966.		210-RICR-40-05-1.11.6(A)(2)(f)
967.		210-RICR-40-05-1.11.6(A)(2)(g)
968.		210-RICR-40-05-1.11.6(A)(2)(h)
969.		210-RICR-40-05-1.11.6(A)(2)(i)
970.		210-RICR-40-05-1.11.6(A)(2)(j)
971.		210-RICR-40-05-1.11.6(A)(2)(k)
972.		210-RICR-40-05-1.11.6(A)(2)(l)
973.		210-RICR-40-05-1.11.6(A)(2)(m)
974.		210-RICR-40-05-1.11.6(A)(2)(n)
975.		210-RICR-40-05-1.11.6(A)(2)(o)
976.		210-RICR-40-05-1.11.6(A)(2)(p)
977.		210-RICR-40-05-1.11.6(A)(2)(q)
978.		210-RICR-40-05-1.11.6(A)(2)(r)
979.		210-RICR-40-05-1.11.6(A)(2)(s)
980.		210-RICR-40-05-1.11.6(A)(2)(t)
981.		210-RICR-40-05-1.11.6(A)(2)(u)
982.		210-RICR-40-05-1.11.6(A)(2)(v)
983.		210-RICR-40-05-1.11.6(A)(2)(w)
984.	1408.07 G. Resource Deeming	210-RICR-40-05-1.11.7
985.		210-RICR-40-05-1.11.7(A)
986.	(1) Spouse-to-Spouse	210-RICR-40-05-1.11.7(A)(1)
987.		210-RICR-40-05-1.11.7(A)(1)(a)
988.		210-RICR-40-05-1.11.7(A)(1)(b)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
989.	(2) Single Individual	210-RICR-40-05-1.11.7(A)(2)
990.	(3) Parent-to-Child	210-RICR-40-05-1.11.7(A)(3)
991.		210-RICR-40-05-1.11.7(A)(3)(a)
992.		210-RICR-40-05-1.11.7(A)(3)(b)
993.		210-RICR-40-05-1.11.7(A)(3)(c)
994.		210-RICR-40-05-1.11.7(A)(3)(d)
995.		210-RICR-40-05-1.11.7(A)(3)(e)
996.		210-RICR-40-05-1.11.7(A)(3)(f)
997.	1415 Medically Needy – Community Medicaid	210-RICR-40-05-2
998.	1415 A. Scope and Purpose	210-RICR-40-05-2.1
999.		210-RICR-40-05-2.1(A)
1000.		210-RICR-40-05-2.1(A)(1)
1001.		210-RICR-40-05-2.1(A)(2)
1002.		210-RICR-40-05-2.1(A)(3)
1003.		210-RICR-40-05-2.1(A)(4)
1004.		210-RICR-40-05-2.1(A)(5)
1005.		210-RICR-40-05-2.1(A)(6)
1006.		210-RICR-40-05-2.1(B)
1007.	1415 B. General Provisions Eligibility Criteria	210-RICR-40-05-2.2
1008.		210-RICR-40-05-2.2(A)
1009.	(1) Determination Process	210-RICR-40-05-2.2(A)(1)
1010.	(2) Continuing Eligibility	210-RICR-40-05-2.2(A)(2)
1011.	(3) Agency Responsibilities	210-RICR-40-05-2.2(A)(3)
1012.	(4) Applicant/Beneficiary Responsibilities	210-RICR-40-05-2.2(A)(4)
1013.	1415 C. Spenddown Calculation	210-RICR-40-05-2.3
1014.		210-RICR-40-05-2.3(A)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
1015.	(1) Spenddown Amount	210-RICR-40-05-2.3(A)(1)
1016.		210-RICR-40-05-2.3(A)(1)(a)
1017.		210-RICR-40-05-2.3(A)(1)(b)
1018.	(2) FPL Comparison	210-RICR-40-05-2.3(A)(2)
1019.		210-RICR-40-05-2.3(A)(2)(a)
1020.		210-RICR-40-05-2.3(A)(2)(b)
1021.	(3) Six-Month Spenddown Amount	210-RICR-40-05-2.3(A)(3)
1022.	(4) Application of Allowable Expenses	210-RICR-40-05-2.3(A)(4)
1023.	1415 D. Six-Month Spenddown Renewal	210-RICR-40-05-2.4
1024.	1415 E. Allowable Expenses	210-RICR-40-05-2.5
1025.		210-RICR-40-05-2.5(A)
1026.		210-RICR-40-05-2.5(A)(1)
1027.		210-RICR-40-05-2.5(A)(2)
1028.		210-RICR-40-05-2.5(B)
1029.	(1) Allowable Health Care Expenses	210-RICR-40-05-2.5(B)(1)
1030.		210-RICR-40-05-2.5(B)(1)(a)
1031.		210-RICR-40-05-2.5(B)(1)(b)
1032.		210-RICR-40-05-2.5(B)(1)(c)
1033.		210-RICR-40-05-2.5(B)(1)(d)
1034.		210-RICR-40-05-2.5(B)(1)(e)
1035.		210-RICR-40-05-2.5(B)(1)(f)
1036.		210-RICR-40-05-2.5(B)(1)(g)
1037.		210-RICR-40-05-2.5(B)(1)(h)
1038.		210-RICR-40-05-2.5(B)(1)(i)
1039.		210-RICR-40-05-2.5(B)(1)(j)
1040.		210-RICR-40-05-2.5(B)(1)(k)

	Existing MCAR Section Number	*Re-Codified RICR Section Number*
1041.		210-RICR-40-05-2.5(B)(1)(l)
1042.		210-RICR-40-05-2.5(B)(1)(m)
1043.		210-RICR-40-05-2.5(B)(1)(n)
1044.		210-RICR-40-05-2.5(B)(1)(o)
1045.	(2) LTSS (remedial care) Expenses	210-RICR-40-05-2.5(B)(2)
1046.	1415 F. Expense Exceptions	210-RICR-40-05-2.6
1047.		210-RICR-40-05-2.6(A)
1048.		210-RICR-40-05-2.6(A)(1)
1049.		210-RICR-40-05-2.6(A)(2)
1050.	1420 Retroactive Coverage	210-RICR-40-05-3
1051.	1420 A. Scope and Purpose	210-RICR-40-05-3.1
1052.		210-RICR-40-05-3.1(A)
1053.	1420 B. General Provisions	210-RICR-40-05-3.2
1054.		210-RICR-40-05-3.2(A)
1055.	(1) Eligibility Criteria	210-RICR-40-05-3.2(A)(1)
1056.		210-RICR-40-05-3.2(A)(1)(a)
1057.		210-RICR-40-05-3.2(A)(1)(b)
1058.		210-RICR-40-05-3.2(A)(1)(c)
1059.		210-RICR-40-05-3.2(A)(1)(d)
1060.	(2) Limits	210-RICR-40-05-3.2(A)(2)
1061.		210-RICR-40-05-3.2(A)(2)(a)
1062.		210-RICR-40-05-3.2(A)(2)(b)

1.82 FEDERAL POVERY LIMITS (FPLS) 2017

Federal Poverty Level - 2017

Family Size	Percent of Poverty 100%	108%	110%	116%	125%	133%	135%	138%	141%	145%	150%	155%	160%	175%	180%	185%	190%	195%
1	$ 12,060	$ 13,025	$ 13,266	$ 13,990	$ 15,075	$ 16,040	$ 16,281	$ 16,643	$ 17,005	$ 17,487	$ 18,090	$ 18,693	$ 19,296	$ 21,105	$ 21,708	$ 22,311	$ 22,914	$ 23,517
2	$ 16,240	$ 17,539	$ 17,864	$ 18,838	$ 20,300	$ 21,599	$ 21,924	$ 22,411	$ 22,898	$ 23,548	$ 24,360	$ 25,172	$ 25,984	$ 28,420	$ 29,232	$ 30,044	$ 30,856	$ 31,668
3	$ 20,420	$ 22,054	$ 22,462	$ 23,687	$ 25,525	$ 27,159	$ 27,567	$ 28,180	$ 28,792	$ 29,609	$ 30,630	$ 31,651	$ 32,672	$ 35,735	$ 36,756	$ 37,777	$ 38,798	$ 39,819
4	$ 24,600	$ 26,568	$ 27,060	$ 28,536	$ 30,750	$ 32,718	$ 33,210	$ 33,948	$ 34,686	$ 35,670	$ 36,900	$ 38,130	$ 39,360	$ 43,050	$ 44,280	$ 45,510	$ 46,740	$ 47,970
5	$ 28,780	$ 31,082	$ 31,658	$ 33,385	$ 35,975	$ 38,277	$ 38,853	$ 39,716	$ 40,580	$ 41,731	$ 43,170	$ 44,609	$ 46,048	$ 50,365	$ 51,804	$ 53,243	$ 54,682	$ 56,121
6	$ 32,960	$ 35,597	$ 36,256	$ 38,234	$ 41,200	$ 43,837	$ 44,496	$ 45,485	$ 46,474	$ 47,792	$ 49,440	$ 51,088	$ 52,736	$ 57,680	$ 59,328	$ 60,976	$ 62,624	$ 64,272
7	$ 37,140	$ 40,111	$ 40,854	$ 43,082	$ 46,425	$ 49,396	$ 50,139	$ 51,253	$ 52,367	$ 53,853	$ 55,710	$ 57,567	$ 59,424	$ 64,995	$ 66,852	$ 68,709	$ 70,566	$ 72,423
8	$ 41,320	$ 44,626	$ 45,452	$ 47,931	$ 51,650	$ 54,956	$ 55,782	$ 57,022	$ 58,261	$ 59,914	$ 61,980	$ 64,046	$ 66,112	$ 72,310	$ 74,376	$ 76,442	$ 78,508	$ 80,574

Federal Poverty Level - 2017

Family Size	Percent of Poverty 100%	200%	215%	220%	225%	250%	253%	261%	275%	300%	320%	325%	350%	400%
1	$ 12,060	$ 24,120	$ 25,929	$ 26,532	$ 27,135	$ 30,150	$ 30,512	$ 31,477	$ 33,165	$ 36,180	$ 38,592	$ 39,195	$ 42,210	$ 48,240
2	$ 16,240	$ 32,480	$ 34,916	$ 35,728	$ 36,540	$ 40,600	$ 41,087	$ 42,386	$ 44,660	$ 48,720	$ 51,968	$ 52,780	$ 56,840	$ 64,960
3	$ 20,420	$ 40,840	$ 43,903	$ 44,924	$ 45,945	$ 51,050	$ 51,663	$ 53,296	$ 56,155	$ 61,260	$ 65,344	$ 66,365	$ 71,470	$ 81,680
4	$ 24,600	$ 49,200	$ 52,890	$ 54,120	$ 55,350	$ 61,500	$ 62,238	$ 64,206	$ 67,650	$ 73,800	$ 78,720	$ 79,950	$ 86,100	$ 98,400
5	$ 28,780	$ 57,560	$ 61,877	$ 63,316	$ 64,755	$ 71,950	$ 72,813	$ 75,116	$ 79,145	$ 86,340	$ 92,096	$ 93,535	$ 100,730	$ 115,120
6	$ 32,960	$ 65,920	$ 70,864	$ 72,512	$ 74,160	$ 82,400	$ 83,389	$ 86,026	$ 90,640	$ 98,880	$ 105,472	$ 107,120	$ 115,360	$ 131,840
7	$ 37,140	$ 74,280	$ 79,851	$ 81,708	$ 83,565	$ 92,850	$ 93,964	$ 96,935	$ 102,135	$ 111,420	$ 118,848	$ 120,705	$ 129,990	$ 148,560
8	$ 41,320	$ 82,640	$ 88,838	$ 90,904	$ 92,970	$ 103,300	$ 104,540	$ 107,845	$ 113,630	$ 123,960	$ 132,224	$ 134,290	$ 144,620	$ 165,280

Federal Poverty Level - 2017 - Monthly

Percent of Poverty Family Size	100%	108%	110%	116%	125%	133%	135%	138%	141%	145%	150%	155%	160%	175%	180%	185%	190%	195%
1	$ 1,005.00	$ 1,085.40	$ 1,105.50	$ 1,165.80	$ 1,256.25	$ 1,336.65	$ 1,356.75	$ 1,386.90	$ 1,417.05	$ 1,457.25	$ 1,507.50	$ 1,557.75	$ 1,608.00	$ 1,758.75	$ 1,809.00	$ 1,859.25	$ 1,909.50	$ 1,959.75
2	$ 1,353.33	$ 1,461.60	$ 1,488.67	$ 1,569.87	$ 1,691.67	$ 1,799.93	$ 1,827.00	$ 1,867.60	$ 1,908.20	$ 1,962.33	$ 2,030.00	$ 2,097.67	$ 2,165.33	$ 2,368.33	$ 2,436.00	$ 2,503.67	$ 2,571.33	$ 2,639.00
3	$ 1,701.67	$ 1,837.80	$ 1,871.83	$ 1,973.93	$ 2,127.08	$ 2,263.22	$ 2,297.25	$ 2,348.30	$ 2,399.35	$ 2,467.42	$ 2,552.50	$ 2,637.58	$ 2,722.67	$ 2,977.92	$ 3,063.00	$ 3,148.08	$ 3,233.17	$ 3,318.25
4	$ 2,050.00	$ 2,214.00	$ 2,255.00	$ 2,378.00	$ 2,562.50	$ 2,726.50	$ 2,767.50	$ 2,829.00	$ 2,890.50	$ 2,972.50	$ 3,075.00	$ 3,177.50	$ 3,280.00	$ 3,587.50	$ 3,690.00	$ 3,792.50	$ 3,895.00	$ 3,997.50
5	$ 2,398.33	$ 2,590.20	$ 2,638.17	$ 2,782.07	$ 2,997.92	$ 3,189.78	$ 3,237.75	$ 3,309.70	$ 3,381.65	$ 3,477.58	$ 3,597.50	$ 3,717.42	$ 3,837.33	$ 4,197.08	$ 4,317.00	$ 4,436.92	$ 4,556.83	$ 4,676.75
6	$ 2,746.67	$ 2,966.40	$ 3,021.33	$ 3,186.13	$ 3,433.33	$ 3,653.07	$ 3,708.00	$ 3,790.40	$ 3,872.80	$ 3,982.67	$ 4,120.00	$ 4,257.33	$ 4,394.67	$ 4,806.67	$ 4,944.00	$ 5,081.33	$ 5,218.67	$ 5,356.00
7	$ 3,095.00	$ 3,342.60	$ 3,404.50	$ 3,590.20	$ 3,868.75	$ 4,116.35	$ 4,178.25	$ 4,271.10	$ 4,363.95	$ 4,487.75	$ 4,642.50	$ 4,797.25	$ 4,952.00	$ 5,416.25	$ 5,571.00	$ 5,725.75	$ 5,880.50	$ 6,035.25
8	$ 3,443.33	$ 3,718.80	$ 3,787.67	$ 3,994.27	$ 4,304.17	$ 4,579.63	$ 4,648.50	$ 4,751.80	$ 4,855.10	$ 4,992.83	$ 5,165.00	$ 5,337.17	$ 5,509.33	$ 6,025.83	$ 6,198.00	$ 6,370.17	$ 6,542.33	$ 6,714.50

Federal Poverty Level - 2017 - Monthly

Family Size	Percent of Poverty 100%	200%	215%	220%	225%	250%	253%	261%	275%	300%	320%	325%	350%	400%
1	$ 1,005.00	$ 2,010.00	$ 2,160.75	$ 2,211.00	$ 2,261.25	$ 2,512.50	$ 2,542.65	$ 2,623.05	$ 2,763.75	$ 3,015.00	$ 3,216.00	$ 3,266.25	$ 3,517.50	$ 4,020.00
2	$ 1,353.33	$ 2,706.67	$ 2,909.67	$ 2,977.33	$ 3,045.00	$ 3,383.33	$ 3,423.93	$ 3,532.20	$ 3,721.67	$ 4,060.00	$ 4,330.67	$ 4,398.33	$ 4,736.67	$ 5,413.33
3	$ 1,701.67	$ 3,403.33	$ 3,658.58	$ 3,743.67	$ 3,828.75	$ 4,254.17	$ 4,305.22	$ 4,441.35	$ 4,679.58	$ 5,105.00	$ 5,445.33	$ 5,530.42	$ 5,955.83	$ 6,806.67
4	$ 2,050.00	$ 4,100.00	$ 4,407.50	$ 4,510.00	$ 4,612.50	$ 5,125.00	$ 5,186.50	$ 5,350.50	$ 5,637.50	$ 6,150.00	$ 6,560.00	$ 6,662.50	$ 7,175.00	$ 8,200.00
5	$ 2,398.33	$ 4,796.67	$ 5,156.42	$ 5,276.33	$ 5,396.25	$ 5,995.83	$ 6,067.78	$ 6,259.65	$ 6,595.42	$ 7,195.00	$ 7,674.67	$ 7,794.58	$ 8,394.17	$ 9,593.33
6	$ 2,746.67	$ 5,493.33	$ 5,905.33	$ 6,042.67	$ 6,180.00	$ 6,866.67	$ 6,949.07	$ 7,168.80	$ 7,553.33	$ 8,240.00	$ 8,789.33	$ 8,926.67	$ 9,613.33	$ 10,986.67
7	$ 3,095.00	$ 6,190.00	$ 6,654.25	$ 6,809.00	$ 6,963.75	$ 7,737.50	$ 7,830.35	$ 8,077.95	$ 8,511.25	$ 9,285.00	$ 9,904.00	$ 10,058.75	$ 10,832.50	$ 12,380.00
8	$ 3,443.33	$ 6,886.67	$ 7,403.17	$ 7,575.33	$ 7,747.50	$ 8,608.33	$ 8,711.63	$ 8,987.10	$ 9,469.17	$ 10,330.00	$ 11,018.67	$ 11,190.83	$ 12,051.67	$ 13,773.33