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TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 – MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES

SUBCHAPTER 15 - DISABLED WORKING ADULTS

Part 1 – Working Adults with Disabilities

1.1 Scope and Applicability

A. One of the principal objectives of health and human services policymakers is to support Medicaid-eligible adults with disabilities who work by enabling them to obtain or maintain the coverage they need to retain their independence and optimize their health. Toward this end, an array of State and federal laws and regulations have been adopted that establish special provisions for disregarding all or a portion of the earned income of adults with disabilities who work. The State also provides Medicaid coverage for an array of employment services and supports to assist beneficiaries with disabilities who are employed. In addition, the State has taken the option under federal law to create a unique eligibility pathway – known as the Sherlock Plan – which enables working adults with disabilities who are otherwise Medicaid ineligible or unable to obtain needed employment supports to buy into the program at a low monthly cost.

B. To qualify for the Medicaid special income provisions, a person must be determined to have a disability by a federal or State government entity or appropriately designated contractual agent of the State in accordance with the standards set forth in Part 40-05-1 of this Title. Such entities include the U.S. Social Security Administration and the Medical Review Team (MART) and Office of Medical Review (OMR) within the Executive Office of Health and Human Services (EOHHS). Adults with disabilities who work and are seeking initial or continuing eligibility for Medicaid long-term services and supports (LTSS) may be subject to distinct “clinical/functional disability” criteria, as set forth in § 1.7.1 of this Part. A beneficiary who meets these disability criteria and qualifies for these special income provisions is eligible for the full range of Medicaid covered employment services and supports.

C. Employment services and supports may also be available to adults with disabilities, over age nineteen (19), who are eligible for Medicaid in accordance with the provisions of Part 30-00-1 of this Title in one of the Medicaid Affordable Care Coverage (MACC) groups based on the modified adjusted gross income standard – MAGI. Although a disability determination is not required, the scope of employment services and supports available may not be as extensive as through the other eligibility pathways for working adults with disabilities. Accordingly,

seeking eligibility based on a formal determination of disability is an option, as set forth in herein in the following sections.

1.2 Legal Authority

A. Federal Authorities:

1. Federal Law: Title XIX, of the federal Social Security Act at: 42 U.S.C. § 1396a-k and §§ 1902(a)(10)(A)(ii)(XIII) and (XV); §§ 1916(g) 1905(v)(1); § 1929(b)[2] and 42 U.S.C. §§ 1382(h), 1619(a) and (b);

2. Federal Regulations: These regulations hereby adopt and incorporate 42 C.F.R. §§ 435.120; 435.120(c) (1990); 435.121(b) (2013); 447.55(a) (2014) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations and 20 C.F.R.§§ 416.260-269 and 416.976.

3. The Rhode Island Medicaid State Plan and Title XIX, Section 1115 (a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.

B. State Authorities: R.I. Gen. Laws Chapters 40-6; 40-8; and 40-8.7.

1.3 Definitions

A.As used herein, the following terms are defined as follows:

1. “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.

2. “Executive Office of Health and Human Services" or "EOHHS” means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of state government which serves as the principal agency for managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

3. “Long-Term Services and Supports” or “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.

4. “Medicaid Affordable Care Coverage” or “MACC” means eligibility category for individuals and families subject to the Modified Adjusted Gross Income (MAGI) identified in Part 30-00-1 of this Title.

5. “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.

6. “Primary care essential benefits” means and includes 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 and providers. 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 (such as office visits, inpatient, home care, day care).

7. “Work supports” means the array of Medicaid services available to beneficiaries who have disabilities who need support to obtain or maintain employment. Depending on whether an LTSS level of care is required, these supports may include: pre-vocational services, education and training opportunities that build on strengths and interests, individually tailored and preference-based career planning, job development, job training, and job support that recognizes each person's employability and potential contributions to the labor market.

1.4 SSI-Eligible Beneficiaries

A. Rhode Island provides Medicaid coverage to anyone who is eligible for and receiving SSI, based on a determination by the federal SSA. The State automatically enrolls SSI beneficiaries in Medicaid upon receipt of electronic notification from the SSA and must continue to provide coverage unless or until SSI status changes. The SSA also determines whether working adults with disabilities receiving SSI qualify for continuing Medicaid eligibility under two special provisions in §§ 1619 (a) or (b) of Title XVI, the federal law establishing the SSI program.

B. Under §§ 1619 (a) and (b) of Title XVI, SSI beneficiaries who have increased earned income from work are able to retain their Medicaid coverage. The amount of the additional earned income affects whether §§ 1619 (a) or 1619 (b) provisions apply and, respectively, whether SSI cash assistance is reduced or eliminated. However, Medicaid primary care essential benefit coverage and, as applicable, LTSS continue without regard to changes in SSI status until the State is notified otherwise by the SSA.

1. 1619 (a) – “Special cash assistance” is available when an SSI beneficiary with a disability has gross earned income for the month that exceeds the amount ordinarily allowed to obtain or retain SSI eligibility. Both the special cash payments and Medicaid coverage are authorized in this instance under § 1619(a). Any beneficiary may qualify for 1619(a) as early as his or her second month on the SSI rolls. To qualify, a person must:

    a. Continue to have a disabling impairment and meet all other non-disability requirements.

    b. Have been eligible for and received a regular SSI cash payment based on disability for a previous month within the current period of eligibility. The prerequisite month does not necessarily have to be the immediate prior month.

2. 1619 (b) -- SSI beneficiaries who have earnings too high for an SSI cash payment may be eligible for Medicaid if they meet certain requirements. To qualify for continuing Medicaid coverage under § 1619 (b), a person must:

    a. Have been eligible for an SSI cash payment for at least one (1) month before the month when § 1619(b) is established;

    b. Continue to have a disabling impairment and, except for earnings, meet all other non-disability requirements;

    c. Need Medicaid benefits to continue to work; and

    d. Have gross earnings after excluding all work-related impairment expenses, blind work expenses, and earnings used to achieve an approved plan for self-support that are insufficient to replace SSI, Medicaid, and publicly funded attendant care services.

        (1) SSA uses a threshold amount to measure whether a person’s earnings are high enough to replace his/her SSI and Medicaid benefits. This threshold is based on the: amount of earnings which would cause SSI cash payments to stop in the person’s State and average Medicaid expenses for persons who are blind or living with a disability in the State. The amount is recalculated annually and is available on the SSI program operations page titled: "SI 02302.200 Charted Threshold Amounts" and is available at: https://secure.ssa.gov/poms.nsf/lnx/0502302200

        (2) If a SSI beneficiary has gross earnings higher than the threshold amount, SSA calculates an individual threshold amount, taking into account:

            (AA) Impairment-related work expenses;

(BB) Blind work expenses;

(CC) A plan to achieve self-support; or

(DD) The value of any personal attendant services that are publicly funded through the DHS Office of Rehabilitative Services; and

(EE) Medical expenses above the average State amount or, if higher, the person's actual medical expenses.

C. The respective roles and responsibilities of the State and beneficiaries eligible for continuing Medicaid coverage through §§ 1619 (a) or (b) are as follows:

1. State -

a. Benefits. The State must ensure that all required primary care essential benefits and any necessary work supports covered under the Medicaid State Plan or Section 1115 demonstration waiver are available to members of this coverage group on a timely basis.

b. Continuing eligibility. All SSI Medicaid-eligible beneficiaries are auto-renewed unless or until the State receives notification of termination of SSI. The State must evaluate whether Medicaid eligibility is available in all other coverage categories before initiating the termination process in accordance with Part 40-00 2.6.3(A)(3) of this Title.

2. Applicants/Beneficiaries -

a. Applicants and beneficiaries must provide timely, accurate and complete information about any eligibility factors subject to change, including any changes in work circumstances or earnings that may affect continuing access to coverage through the pathways identified in this Part. In addition:

(1) Consent – At the time a Medicaid beneficiary eligible on the basis of SSI no longer qualifies for continuing coverage under § 1619 (a) or (b), the State may request that he or she 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 eligibility determinations and 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. Flexibility in reporting is allowed when a beneficiary changes work status and employers do not provide timely documentation of such changes.

1.5 Community Medicaid Eligibility for Low-income Elders and Adults with Disabilities (EAD)

A. Working adults with disabilities who do not qualify for SSI due to excess income may be eligible for initial or continuing Medicaid coverage through the EAD pathway pursuant to Part 40-05-1 of this Title or as medically needy under Part 40-05-2 of this Title. All EAD beneficiaries are entitled to primary care essential benefits and any necessary work supports covered under the Medicaid State Plan or Section 1115 Demonstration Waiver.

B. Working adults with disabilities may obtain initial or continuing eligibility through the following:

1. Work-related protections -- Some applicants/beneficiaries may qualify for several of the same special provisions available to applicants and beneficiaries that reduce or protect earned income set forth in Part 40-00-3 of this Title, including but not limited to:

a. 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 age 65 or older, unless the applicant was receiving SSI or State Supplemental Payment (SSP) before reaching that age. For additional information on the PASS, see the federal SSI regulations at 20 C.F.R. §§ 416.1180 through 416.1182.

b. 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 have a disability and be under age 65 or have been eligible for and received SSI based on disability for the month before reaching age 65. In addition, the following must be met:

(1) The severity of the impairment must require the person to purchase or rent items and services in order to work;

(2) The expense must be reasonable given the nature of the disability or impairment and the type of employment, as determined by the agency;

(3) 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, such as Medicare or private insurance; and

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

(5) Impairment-related work expenses that may qualify for this disregard are described in federal SSI regulations at 20 C.F.R. § 416.976.

b. 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 of living. The amount of the exclusion is set by the federal government and updated on an annual basis. The amount of the exclusion is located in Part 40-00-3.1.7 A (6) of this Title.

c. 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 of 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 Part 40-00-3.3.2 A (3) of this Title.

d. RI Works Under a PASS. In accordance with RI Works regulations, RI Works payments administered by the RI Department of Human Services under a PASS are excluded. However, RI Works payments unless excluded under a PASS, are countable income.

2. Community Medicaid Medically Needy – Coverage is available to elders and persons with disabilities with high medical expenses who have

income above the EAD countable income limit of 100 percent (100%) of the FPL, but otherwise meet all of the general eligibility requirements for Medicaid as set forth in Part 40-05-1.9 of this Title. Work related disregards identified in Part 40-15-1.5(B) of this Title are taken into account when determining financial eligibility for the Community Medicaid pathway Medically needy. Beneficiaries have the option of consulting with an agency eligibility specialist when considering whether the Medically needy pathway provides them with the level Medicaid benefits and coverage they need while continuing to work. The Sherlock pathway may be a more appropriate option in some instances due to the following:

a. Scope of coverage. Until excess income over the eligibility limit has been exhausted during the six (6) month spenddown period, beneficiaries who choose this pathway are responsible for paying out-of-pocket for all health care expenses that are not covered by a third-party such as Medicare or a commercial plan, including for any necessary work supports. Expenses associated with third-party coverage, such as premiums, co-pays and deductibles do count toward the spenddown. See Part 40-05-2 of this Title on the Medically needy eligibility pathway for additional information.

b. Continuing eligibility. Renewal of Medically needy eligibility and the initiation of another spenddown period may require a redetermination of countable income through the integrated eligibility system (IES).

3. Sherlock Plan for Working People with Disabilities – Applicants who qualify for Medicaid coverage under more than one eligibility pathway may choose the one most suited to their unique needs. Accordingly, the Sherlock eligibility pathway is also available for applicants and beneficiaries who qualify through the medically needy pathway but are unable to obtain the supports they need through a spenddown.

C. The respective roles and responsibilities of the State and applicants/beneficiaries with disabilities who are working and seeking initial or continuing Medicaid coverage through the EAD are set forth in Part 40-05-1.5 of this Title.

1.6 Medicaid Affordable Care Coverage (MACC) MAGI-eligible Adults

A. Working adults with disabilities who are eligible through the Medicaid Affordable Care Coverage groups in: the ACA adult expansion pathway for persons ages nineteen (19) through sixty-four (64); the parent/caretaker pathway; or pregnant women pathway may obtain the work-related services and supports they need through their Medicaid managed care plan or, if enrolled in fee-for-service or a RIte Share approved employer-sponsored insurance plan, through certified Medicaid providers. Pre-authorization of services by the plan or Medicaid provider is required unless a disability determination has been made by the

EOHHS Medicaid Review Team (MART) or another government entity such as the federal Social Security Administration (SSA).

B. There are no special disregards for working adults with disabilities available through the MAGI method for determining income eligibility. However, MACC eligible beneficiaries, including those who qualify for Medicaid LTSS, are not liable under federal law to pay a share of the costs of their care.

C. If earnings from work increase income above the applicable MACC group eligibility limit, applicants and beneficiaries must seek coverage through an alternative Medicaid eligibility pathway that uses the SSI method and requires a formal disability determination by the MART, unless such a determination has already been made by another government authority including the SSA. The IES automatically evaluates persons for these alternative forms of eligibility if they do not qualify for MACC group coverage due to excess income. Depending on a person's income and resources and level of need, the available pathways are as follows:

1. Community Medicaid (Non-LTSS) – The two alternative eligibility pathways for MACC eligible working adults with disabilities who do not require or meet the level of care criteria for the full scope of Medicaid long-term services and supports are: Community Medicaid EAD, including the Medically needy pathway as specified in Part 40-05-1.5 of this Title and above, and the Sherlock pathway, as set forth in § 1.8 of this Part. The SSI work-related income disregards indicated in §1.4 (B) (1) of this Part are applied and a disability determination by the MART or SSA is required;

2. Medicaid LTSS – MAGI-eligible working adults with disabilities who meet the level of care requirements for Medicaid long-term services must be determined disabled to obtain work-related services and supports. If income exceeds the MACC group limit due to earnings from work, eligibility may continue to be available through the LTSS/SSI-related pathways including LTSS Medically needy (§ 1.7 of this Part), or the Sherlock pathway (§ 1.8 of this Part). The SSI work-related income disregards indicated in §1.4 (B) (1) of this Part are applied and a disability determination by the MART or SSA is required.

1.7 Medicaid Long-term Services and Supports (LTSS)

1.7.1 Eligibility Determination Process

Adults with disabilities who are seeking LTSS - both current Medicaid beneficiaries and new applicants – who do not qualify for MACC group LTSS are evaluated for eligibility across the pathways set forth in §1.6 of Chapter 50 of this Title using the SSI method. Accordingly, they may qualify for the work-related income disregards identified in § 1.4 (B)(1) of this Part (above) in the eligibility determination process. A separate disability determination by the MART is not

required for applicants/beneficiaries who meet the clinical/functional level of care criteria for Medicaid LTSS.

1.7.2 Service Plan

All Medicaid LTSS beneficiaries must have a service plan that ties benefits to their functional and clinical needs. If employment supports are needed, the role of work, if any, and any associated employment supports must be a component of this plan. For LTSS beneficiaries choosing home and community-based services, the service plan must reflect the decisions they make about their health goals established in the person-centered planning process set forth in 42 C.F.R. § 441.725 and in Part 50-10-1 of this Title. The development of a service plan is guided by agency representatives as the components may vary depending on the type of a person's disability, program requirements, and associated provisions under the Section 1115 waiver and Medicaid State Plan. Accordingly, specific guidance is provided on this process. EOHHS will postpone in - person person centered planning that occur during the novel Coronavirus Disease (COVID-19) declaration of emergency for sixty (60) days or until the termination of the novel coronavirus declaration of emergency, whichever is longer.

1.7.3 Cost of Care

A. In accordance with federal requirements, under the State's Medicaid State Plan and Section 1115 waiver, all LTSS Medicaid beneficiaries eligible based on the SSI method who can afford to do so must pay a portion of income toward the cost of their care. A beneficiary's liability for the cost of care is calculated in the post-eligibility treatment of income process in accordance with Part 50-00-8 of this Title and is based on gross monthly income – earned and unearned – less certain deductions or "allowances." To encourage LTSS beneficiaries who have disabilities to work, there are special allowances which require the State to exclude some or all of the beneficiary's earned income when determining the amount available to be applied toward the cost of care.

1. HCBS – The following are special allowances for Medicaid LTSS working adults with disabilities who are receiving home and community-based services:

    a. Programs for persons with intellectual/developmental disabilities. The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) Development Disabilities (DD) Program administers programs for persons with DD, including those who work and qualify for Medicaid HCBS integrated employment supports. To further BHDDH employment first goals, the State has implemented the I/DD-Special Maintenance Needs Allowance (I/DD-MNA).

(1) Purpose. The I/DD-MNA reduces the amount of income that is available to pay toward the LTSS cost of care through a series of standard and special allowances that protect a higher portion of the earned income of working adults with disabilities than is permitted for other beneficiaries.

(2) Allowance order. In determining available income, all other allowances identified in Part 50-00-8 of this Title pertaining to the post-eligibility treatment of income are applied first. (The sequence of deductions is contained in § 8.5(C) of Part 50-00-8 of this Title). Once this calculation is complete, available income is reduced further by the I/DD-MNA which deducts any earned income up to but not to exceed 300 percent of the SSI income standard. The amount of income remaining after this final allowance is applied constitutes the beneficiary's liability for LTSS. The SSI income standard changes annually and is located in Part 40-00-3 of this Title.

b. Habilitation program. The EOHHS administers the Medicaid HCBS habilitation program for adults with disabilities. Beneficiaries who are participating in integrated community employment support activities under the auspices of the habilitation program receive the full scope of Medicaid State Plan and waiver benefits and qualify for the same I/DD-MNA and earned income allowances available to persons with development disabilities identified in paragraph (a) above.

2. Health institutions -- LTSS beneficiaries residing in health institutions including long-term acute and psychiatric hospitals may be eligible for the therapeutic employment allowance, identified in Part 50-00-8.6(A)(2)(a) of this Title.

B. A beneficiary's liability may increase or decline when there are changes in income. The State provides timely notice of any changes in beneficiary liability that may result at least ten (10) days before the start of the month when the change takes effect.

1.7.4 LTSS Options and Responsibilities

A. There are alternative LTSS eligibility pathways if employment affects a beneficiary's financial state. If income increases, eligibility is automatically evaluated for each pathway with a higher limit, from SSI through the Sherlock pathway. The process proceeds as follows:

1. LTSS Medically Needy pathway – The LTSS Medically needy pathway for working adults with disabilities functions like all other SSI-related LTSS eligibility categories even though there is a spenddown period. The

income limit for the LTSS Medically needy pathway is set at the actual reimbursement rate paid by the State; the spenddown period is one (1) rather than six (6) months. Therefore, a beneficiary is and remains eligible for coverage as LTSS Medically needy without interruption providing countable income, less any allowances permitted, is applied toward the cost of care each month. The scope of coverage available to an LTSS Medically needy eligible working adult with disabilities is the same as with all other LTSS eligibility pathways.

2. LTSS Sherlock pathway – Working adults with disabilities seeking initial or continuing Medicaid LTSS who have countable assets (liquid resources and real property) above the resource eligibility limits of $4,000 for a single person and $6,000 for a couple may qualify for coverage through the Sherlock pathway. Income, whether earned or unearned, does not affect Medicaid LTSS eligibility unless the total exceeds the cost of care at the private pay rate, in accordance with § 50-05-2.5 of this Title. As indicated in § 1.8 of this Part below, to qualify for the LTSS Sherlock pathway, a formal disability determination must be made by the MART or the SSA and the SSI for calculating countable income and resources applies, including the applicable work-related disregards. EOHHS will continue eligibility for individuals that may have a change in employment status that occur during the novel Coronavirus Disease (COVID-19) declaration of emergency for sixty (60) days or until the termination of the novel coronavirus declaration of emergency, whichever is longer.

B. The respective roles and responsibilities of the State and LTSS applicants/beneficiaries with disabilities who are working seeking initial or continuing LTSS Medicaid coverage are as set forth in Part 50-00-1 of this Title.

1.8 The Sherlock Plan

A. The Sherlock Plan for Working People with Disabilities is an SSI-related eligibility pathway for working adults with disabilities established pursuant to the Balanced Budget Act of 1997 (42 U.S.C. § 1396a(a)(10)(ii)(XIII)) and R.I. Gen. Laws at § 40-8.7-1. The State law is based on the option under the federal law to establish a Medicaid eligibility pathway for adults with disabilities who are either unable to afford or obtain health coverage and/or the services and supports they need to work.

B. Adults with disabilities eligible through the Sherlock pathway are entitled to the full scope of Medicaid benefits and home and community-based services and supports necessary to facilitate and/or maintain employment. This is the same scope of coverage available to all Medicaid-eligible adults with disabilities who work, without regard to eligibility pathway. The special provisions in the SSI method established in Part 40-00-3 of this Title, and reiterated herein at § 1.4, of this Part may apply. EOHHS will continue eligibility for individuals that may have a change in employment status that occur during the novel Coronavirus Disease

(COVID-19) declaration of emergency for sixty (60) days or until the termination of the novel coronavirus declaration of emergency, whichever is longer.

C. The Sherlock eligibility pathway is open to adults with disabilities who are working and seeking:

1. Non-LTSS Medicaid primary care essential benefit coverage with HCBS services including employment supports; or

2. Medicaid LTSS coverage including integrated employment supports.

D. To qualify through the Sherlock pathway, a person must be determined disabled by a State or federal government authority using the criteria established for the SSI program except for the provisions related to substantial gainful.

1. General eligibility requirements – To be Sherlock-eligible, a person must:

a. Meet the non-financial eligibility requirements set forth in Part 10-00-3 of this Title and:

b. Be between 19 and 64 years of age; and

c. Have proof of active, paid employment such as a pay stub or current quarterly U.S. Internal Revenue Service (IRS) tax statement (for those who are self-employed).

2. Financial eligibility – Applicants for Sherlock eligibility are subject to the requirements for counting income and resources set forth in Part 40-00-3 of this Title. The following income and resource standards apply:

a. Income. Countable earned net income must be no greater than 250 percent of the FPL. Countable income is defined as the total of earned income remaining after all SSI-related disregards are applied; and

b. Resources. Total countable resources must be no greater than $10,000 (individual) or $20,000 (couple). Medical savings accounts, retirement accounts, or accounts determined to be for the purposes of maintaining independence are not counted as a resource; approved items that are necessary for a person to remain employed are also not counted as a resource (such as a wheelchair accessible van).

3. Retroactive coverage – As an SSI-related coverage group, applicants may be eligible for up to ninety (90) days of retroactive coverage. Eligibility for retroactive coverage is determined in accordance with Part 40-05-2 of this

Title once the premium or cost of care requirements set forth below in § 1.8.2 of this Part have been met.

1.8.1 Access to Employer-Based Health Insurance

Sherlock applicants who have access to employer-based health insurance are required to enroll in the plan as a condition of eligibility if the plan has been determined by EOHHS to meet the cost-effective criteria established for the RIte Share program in Part 30-05-1 of this Title. Medicaid will pay the employee's share of the monthly premium. Enrollment of the applicant in the employer-based health insurance plan is without regard to any enrollment season restrictions. All Medicaid services that are unavailable through the employer plan are covered through a wrap-around by Medicaid certified providers.

1.8.2 Types of Cost Sharing

A. Depending on their gross countable income from all sources, both LTSS and non-LTSS Sherlock beneficiaries may be required to pay a share of the cost of coverage. Non-LTSS Sherlock beneficiaries subject to a cost share are required to pay a premium; LTSS Sherlock beneficiaries who have a cost share have the choice of paying a portion of income or premium.

1. Sherlock Premium – To calculate a premium, the earned income of the Sherlock beneficiary and his or her spouse are added together and then all SSI-related disregards are applied. The remaining earned income is added to the unearned income of the beneficiary or couple and are assigned a premium based on the buy-in payment rates in Part 30-05-3 of this Title, entitled "RIte Share Premium Assistance Program."

    a. Premiums must be paid in full before retroactive coverage for allowable health care expenses is made available by the State.

    b. Sherlock beneficiaries may deduct premium amounts from the total amount of any unpaid medical bills in the retroactive coverage eligibility period.

2. LTSS Sherlock beneficiary liability – The State bases its calculation of a LTSS Sherlock beneficiary's liability for the cost of care in accordance with the post-eligibility treatment of income rules set forth in Part 50-00-8 of this Title. A LTSS Sherlock beneficiary is entitled to all the allowances set forth therein when determining the amount of income available to pay toward the cost of care.

3. Sherlock LTSS beneficiary choice – The State calculates both the monthly premium and the beneficiary liability for Sherlock LTSS beneficiaries. An LTSS eligibility specialist is responsible for informing the beneficiary of the premium versus beneficiary liability costs and assisting the beneficiary in making an appropriate choice. The State does not impose or collect a cost

share until a Sherlock LTSS beneficiary has been so informed and made a choice. Coverage may not be delayed or denied pending the beneficiary's decision.

1.8.3 Cost-Share Collection Methods

A. Sherlock beneficiaries are required to make monthly cost share payments, without regard to type. A Sherlock LTSS beneficiary opting to pay beneficiary liability – if any – rather than a premium, must pay his or her provider each month in accordance with the provisions set forth in Part 50-00-8 of this Title.

B. All Sherlock beneficiaries required to pay a premium have payment options as follows:

1. Electronic Funds Transfer (EFT) – The beneficiary may request that a financial institution of choice withdraw the monthly payment from a personal account and make payment directly to the State through an electronic funds transfer to EOHHS. The State provides the required form for making such a request and withdraws the premium amount on the third day of the month. Notification is provided by the State if the transfer fails.

2. Wage Withholding -- The Sherlock beneficiary may request that an employer withhold the premium amount and then make the payment to Medicaid through an EFT. The Sherlock beneficiary is given a special form requesting wage withholding and deposit or transfer to take to his/her employer to be completed and mailed.

3. Direct Pay – The Sherlock beneficiary may pay the premium to Medicaid by check or money order every month. A premium payment coupon and pre-addressed envelope will be provided to the family before the premium is due. The check or money order and the premium payment coupon are mailed or delivered to the Medicaid fiscal agent.

1.8.4 Non-Payment Sherlock Cost Share

A. Non-payment of premiums is treated in the same manner as for RIte Share participants as detailed in Part 30-05-3 of this Title.

B. The provisions governing non-payment of beneficiary liability are set forth in the LTSS post-eligibility treatment of income rule contained in Part 50-00-8 of this Title.

1.8.5 Loss of Employment or Eligibility

A. A Sherlock beneficiary who loses employment may retain eligibility for up to four (4) months by continuing to pay the applicable cost share, whether a premium or beneficiary liability payment. If the person is still unemployed at the end of the four (4) month period, Sherlock eligibility is terminated. Prior to taking this action,

the State evaluates the Sherlock beneficiary for all other forms of Medicaid eligibility as well as for coverage for a commercial plan through HSRI, the State's health insurance marketplace.

B. A person who is no longer eligible for Medicaid through the Sherlock pathway may retain approved medical savings accounts and retirement account assets in the amount held on the last full day of eligibility. These medical savings account and/or retirement account assets will be considered non-countable assets for purposes of Medicaid eligibility under any other coverage group. Paper documentation must be provided verifying the balances of these accounts as of the last date of Sherlock eligibility if it is to be disregarded for other forms of Medicaid coverage.

1.8.6 Available Services

A. Services include the full scope of categorical Medicaid benefits, home and community-based services, including personal care services provided through an agency or through a self-directed program, and services needed to facilitate and/or maintain employment. The applicant /beneficiaries' services are coordinated through the appropriate unit in EOHHS, DHS or BHDDH or a contractual designee of the agency. Long-term care services and supports are listed in Part 50-00-1 of this Title entitled, "Medicaid Long-Term Services and Supports: Overview and Eligibility Pathways."

B. Services to maintain and support employment are determined when developing a service plan, or through an assessment of need utilizing a state approved assessment instrument or an EOHHS approved prior authorization plan. Authorized personal care services may be provided in the home, workplace or other necessary setting (such as a physician office).