210-RICR-40-05-1

TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 – MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES

SUBCHAPTER 05 – COMMUNITY MEDICAID

PART 1 – MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES: COMMUNITY MEDICAID

1.1 Overview

A. The Integrated Health Care Coverage (IHCC) groups established in this Section provide the principal Medicaid non-Long-Term Services and Supports (non-LTSS) eligibility pathways for elders and adults with disabilities who have Supplemental Security Income (SSI), receive the State Supplemental Payment (SSP), have an SSI characteristic, are medically needy (MN), 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 as well as Part 2 of this Subchapter.~~ The State uses the term "Community Medicaid" to distinguish ~~Integrated Health Care Coverage (~~non-LTSS IHCC~~)~~ group members from Medicaid LTSS beneficiaries ~~eligible using SSI financial eligibility requirements~~.

1.2 Authority

A. This Part is promulgated pursuant to Federal authorities as follows:

1. Federal Law: Title XIX of the U.S. Social Security Act; 42 U.S.C. §§ 1396a-1396w-~~7~~8; ~~§ 1413(b)(1)(A) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148; and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-115~~.

2. The Medicaid State Plan and the Section 1115 Waiver granted pursuant to § 1115 of the Social Security Act, 42 U.S.C. § 1315.

B. Applicable State authority is derived from R.I. Gen. Laws Title 40 and R.I. Gen. Laws Chapter 42-7.2.

1.3 Incorporated Materials

~~A. These Regulations hereby adopt and incorporate 8 C.F.R. Part 204 (2023) 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.~~

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~~B. These Regulations hereby adopt and incorporate 8 C.F.R. Part 213A (2023) 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.~~

B~~E~~. These Regulations hereby adopt and incorporate 20 C.F.R. Part 416 (2026~~3~~) 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.

C. These Regulations hereby adopt and incorporate 42 C.F.R. Part 406, Subpart B (2025) 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.

D. These Regulations hereby adopt and incorporate 42 C.F.R. Part 407 (2025) 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.

E~~F~~. These Regulations hereby adopt and incorporate 42 C.F.R. § 435.404 (2025~~3~~) 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.

F. These Regulations hereby adopt and incorporate 42 C.F.R. § 435.213 (2025) 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.

G. These Regulations hereby adopt and incorporate 42 C.F.R. § 435.541 (2025~~3~~) 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.

~~H. These Regulations hereby adopt and incorporate 42 C.F.R. § 447.56 (2023) 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.~~

A. The purpose of this Rule is to establish and describe the Community Medicaid IHCC groups and the eligibility requirements ~~for determining Medicaid eligibility~~for these groups. 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
Medically Needy	EOHHS
SSI Recipients	Social Security Administration (SSA)
SSP Recipients	SSA and ~~EOHHS~~Department of Human Services (DHS)
Pickle Amendment	EOHHS
Employed Adults with Disabilities under § 1619(a), 42 U.S.C. § 1382h(a)	SSA
Medicaid While Working under § 1619(b), 42 U.S.C. § 1382h(b)	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
Medicare Premium Payment Program (MPPP)	SSA and EOHHS
Breast and Cervical Cancer Screening and Treatment	Department of Health (DOH)

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Community Medicaid Eligibility Pathways	
IHCC Group	**Agency Responsible for Determining Eligibility**
~~Refugee Medicaid Assistance (RMA)~~	~~EOHHS~~
Sherlock Plan	EOHHS
Ticket to Work Plan	EOHHS
Emergency Medicaid	EOHHS

B. The following regulations apply to eligibility determinations made under this Part:

1. SSI methodology for treatment of income and resources, Part 40-00-3 of this Title.

2. Application and renewal process for IHCC groups, including Community Medicaid, Part 40-00-2 of this Title.

3. Non-financial eligibility requirements, Part 10-00-3 of this Title.

C. An applicant or beneficiary may appeal an adverse action under this Part according to Part 10-05-2 of this Title.

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1.5 Definitions

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

~~1. "Adult dependent child" means an unmarried person eighteen (18) years of age or older who has a disabling impairment that began before age twenty-two (22) that is collecting disability-related benefits from the U.S. Social Security Administration (SSA).~~

1~~2~~. "Applicant" means the person seeking initial or continuing eligibility for Medicaid.

2~~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~~Part.

3~~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. [illegible] considered for deeming purposes although the person is not seeking or is ~~unqualified~~not eligible for Medicaid.

5~~7~~. "Parent" means a natural or adoptive father or mother living in the same household as the eligible child.

1.6 Eligibility for Elders and Adults with Disabilities

1.6.1 Scope and Purpose

A. This Section identifies the primary Medicaid eligibility pathways for persons age sixty-five (65) and older and persons age nineteen (19) to sixty-four (64) with disabilities.

1.6.2 EAD Eligibility Pathway – Low-income Elders and Adults with Disabilities

A. Under § 1902(a)(10)(A)(ii)(X) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(A)(ii)(X), States have the option under the Medicaid State Plan ~~of~~ to expand~~ing~~ eligibility to elders and adults with disabilities (EAD) with income up to and inclusive of one hundred percent (100%) of the federal poverty level (FPL). R.I. Gen. Laws § 40-8.5-1 establishes the categorically needy EAD coverage group. The EAD coverage group has higher income and resource limits than the SSI program and ~~serves,~~ therefore serves~~,~~ as the State's primary 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 ~~§ 1.10 of this~~ Part 10-00-3 of this Title and the following:

    a. Characteristic Requirements. A person must ~~be without~~not receive SSI and must 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 (approximately seventy-five percent (75%) FPL) 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:~~established in R.I. Gen. Laws § 40-8.5-1.

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

1.6.3 Medically Needy (MN) Eligibility Pathway

A. Under the Rhode Island Medicaid State Plan, MN coverage is an option for elders and adults with disabilities, parents/caretakers, children, and pregnant people with excess income and high health care expenses. Non-LTSS MN~~Medically needy~~ eligibility is available ~~to certain IHCC group members who do not need LTSS~~under Part 40-05-2 of this Title. Different rules apply for LTSS MN eligibility as indicated in Part 50-00-2 of this Title. ~~Under the Rhode Island Medicaid State Plan, MN coverage is an option for elders and adults with disabilities, parents/caretakers, children and pregnant people. Adults age nineteen (19) to sixty-four (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 § 1.8.3 of this Part. See Part 2 of this Subchapter for provisions related to the Community Medicaid MN pathway.~~

1.6.4 SSI and SSP Recipients and SSI Protected Status

A. Federal law requires the States to provide Medicaid health coverage to SSI recipients. Under the State Plan, Medicaid coverage is also provided to ~~and~~ State Supplement Payment (SSP) recipients who do not receive SSI. 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 they are an SSI recipient for Medicaid eligibility purposes. Effective October 1, 2026, separate verification of Medicaid qualifying immigration status under Part 10-00-3 of this Title is required for SSI, SSP, and SSI protected status groups. 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~~generally follows from approval of SSI. The SSA determines eligibility for SSI and notifies the State of the SSI recipient's eligibility through an electronic data exchange under § 1634 of the Social Security Act, 42 U.S.C. § 1383c. 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 lost 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~~ generally eligible for Medicaid health coverage under the Medicaid State Plan. DHS determines eligibility for SSP in partnership with the SSA under 218-RICR-20-00-5, Supplemental Security Income and State Supplemental Payment Rules and Regulations. Medicaid eligibility based solely on SSP ceases when a recipient no longer qualifies for the payment unless there is another basis for coverage.

3. Pickle Amendment Eligibility Pathway – Since enacted in 1977, § 503 of Pub. Law No. 94-566, known as the "Pickle Amendment," has 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 them 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 § 1.9~~10~~ of this Part.

~~f. Table of RSDI Cost-of-Living Adjustments. For a history of automatic cost-of-living adjustments, see: https://www.ssa.gov/cola/#:~:text=Beginning%20in%201975%2C%20Social%20Security,value%20from%20Social%20Security%20benefits.~~

a. Working persons with disabilities who have gross earnings at or above the SSI income standard may qualify for continuing SSI payments, and thus Medicaid health coverage, provided~~ing~~ they meet all SSI non-disability requirements. ~~The following must be met for coverage under § 1619(a) of the Social Security Act, 42 U.S.C. § 1382h(a):~~

5. Medicaid While Working, § 1619(b) of the Social Security Act, 42 U.S.C. § 1382h(b), provides Medicaid to employed persons with disabilities who no longer qualify for coverage under the above provision (§ 1.6.4(A)(4) of this Part) 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. This pathway provides "Medicaid While Working" protection when SSI cash benefits are no longer available. Medicaid health coverage is preserved for both members of a couple if each is working, and their total combined income would result in the loss of SSI cash benefits, even if the income of one (1) would not alone trigger non-payment status. However, a non-working spouse has no protection and loses Medicaid when the earned income of their spouse exceeds the limits

for SSI cash benefits. For Community Medicaid health coverage through this pathway, the following apply: 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, are eligible for Medicaid through an alternative eligibility pathway.

6. Protected Surviving Spouses – In the Omnibus Budget Reconciliation Act of 1990, Pub. Law No. 101-508, Congress permanently revised eligibility standards set in § 1634(b) of the Social Security Act, 42 U.S.C. § 1383c(b), 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 fifty (50) and sixty-five (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 (1st) 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 on 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 – § 1634 of the Social Security Act, 42 U.S.C. § 1383c, 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 Insurance (SSDI)

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 eighteen (18) or older. When determining EAD eligibility for members of this group, the parent's RSDI or child's SSDI benefit is disregarded to preserve continuing Medicaid eligibility.

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

(1) ~~At~~Be at least eighteen (18) years of age;

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

(3) ~~An~~ Have been an SSI recipient based on blindness or a disabling impairment; and

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

b. Determination process. RSDI or SSDI 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 SSDI benefit is the ONLY source of additional income.

c. Continuing eligibility. Protected status as a result of the RSDI or SSDI 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~~are 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 who 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, Pub. Law No. 98-21, eliminated an actuarial reduction formula applied to the RSDI benefits of surviving spouses with disabilities who became entitled to RSDI benefits before age sixty (60). To offset the loss of Medicaid eligibility that occurred as a result, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Pub. Law No. 99-272, 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.

1.7 The Medicare Premium Payment Program (MPPP)

1.7.1 Scope and Purpose

A. The Medicare Premium Payment Program (MPPP) helps low-income ~~elders age sixty-five (65) and older and adults with disabilities~~Medicare beneficiaries pay all or some of the costs of Medicare Part A and Part B premiums, deductibles, and co-payments. Some MPPP participants also qualify for Medicaid and receive full Medicaid benefits, as explained below.

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 Medicaid ~~an IHCC or MACC group~~ and are also enrolled in Medicare Part A and Part 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~~ qualify for the MPPP~~,~~ are referred to as "partial dual eligible plus beneficiaries."

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

a. Medicare Part A. Pays for hospital services and limited skilled nursing services. Medicare Part A is provided at no~~-~~ cost to many older adults and individuals with disabilities under 42 C.F.R. Part 406, Subpart B (2025). Medicare beneficiaries who do not qualify for premium-free Part A must pay a monthly premium. ~~a person who: is insured under Social Security or Railroad Retirement Systems (e.g., paid into the system for forty (40) quarters of work) and sixty-five (65) years of age; has reached the twenty-fifth (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~~ The State ~~is authorized to purchase~~ pays the Part A premium through the MPPP for certain low-income Medicare beneficiaries ~~persons who are elderly or living with a disability~~ who do not qualify for no-cost Part A coverage as described in § 1.7.2 of this Part.

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 meet the eligibility requirements for Part B under 42 C.F.R. Part 407 (2025). ~~are sixty-five (65) years of age or older without regard to whether they are insured in the Social Security or Railroad Retirement Systems as well as anyone who has reached the twenty-fifth (25th) month of a permanent and total disability. Initial enrollment is a seven (7) month period that starts three (3) months before a person first qualifies for Medicare and extends three months past the sixty-fifth (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~~ as described in § 1.7.2 of this Part.

c. Medicare Part C. Medicare managed care ("Medicare 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 program, which ~~provides assistance in paying the costs for~~ assists with Part D costs, are automatically eligible for the MPPP. The ~~SSA~~federal government provides electronic notification to the State~~s~~ 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 in § 1.7.2 of this Part~~below~~.

1.7.2 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~~ To qualify for eligibility through this pathway, beneficiaries must be entitled to Medicare Part A or Medicare Part B for coverage of immunosuppressive drugs, have countable income of one hundred percent (100%) of FPL or less (one hundred twenty-five percent (125%) of FPL or less with the QMB-specific income disregard), and have resources that do not exceed the amounts set annually by the Federal government. ~~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 (1st) 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~~

for eligibility through this pathway, beneficiaries must meet the same eligibility criteria for QMBs except for countable income, which must be of greater than one hundred percent (100%) FPL, but less than one hundred twenty percent (120%) FPL, assuming the disregard, and are otherwise eligible for Medicaid. Medicaid pays the Medicare Part B premiums only. The income disregard for QMB effectively combines SLMB into QMB and provides additional coverage individuals who would otherwise be SLMB eligible.

a. Medicaid pays the Medicare Part B premium to SSA.

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 thirty-first (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.

de. Retroactive coverage may be available. Retroactive eligibility, as described at 40-05-3 of this Title, (of up to three (3) calendar months prior to application) applies if the individual met all QI eligibility criteria in the retroactive period, and the retroactive period is no earlier than January first (1st) of that calendar year.

46. Qualified Disabled and Working Individuals (QDWIs) – This pathway covers beneficiaries who lost their Medicare Part A benefits due to their return to work. To qualify for eligibility through this pathway, beneficiaries They must be eligible to purchase Medicare Part A benefits, have countable income of two hundred percent (200%) FPL or less, and have resources that do not exceed twice the limit for SSI eligibility EAD limits of (four thousand dollars ($4,000.00) for an individual or six thousand dollars ($6,000.00) 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.

C~~8~~. MPPP with Medicaid Coverage

1. ~~MN and QMB (+) and SLMB (+) –~~ MPPP participants with limited income and resources may qualify for full Medicaid as EAD (full dual eligible) or MN (partial dual eligible plus) depending on countable income. The QMB-specific and QI-specific income disregards do not apply in determining Medicaid eligibility as EAD or MN. Such beneficiaries receive Medicare cost-sharing assistance through the MPPP as well as Medicaid health coverage. Access to Medicaid retroactive coverage, continuing eligibility, and the full scope of Medicaid essential benefits is available.

2. 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~~ Because 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 cost~~s~~ services that are not fully 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~~An applicant or beneficiary who is concerned that enrolling in the MPPP will affect access to Medicaid health coverage should consult an agency eligibility specialist.

1.7.3 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~~ Extra Help – The Extra Help program helps to lower the cost of prescription drugs. An application for the SSA's Extra Help program starts the application process for the MPPP, unless the beneficiary objects. SSA transmits data from the Extra Help application decision to the state~~and Social Security Administration (SSA) – An application for the LIS program is available online at: https://secure.ssa.gov/i1020/start or by calling 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday, 7 a.m. – 7 p.m. The State uses information provided by the SSA for determining LIS eligibility~~ to initiate an application for the MPPP, when appropriate.

~~**1.7.4 MPPP Eligibility and Continuing Eligibility**~~

MPPP Eligibility Pathways			
Coverage Group	**Full or Partial Eligible**	**Income and Resource Limits Individual/Couple**	**Benefits**
QMB	Partial Dual	100% FPL All MPPP applicants receive a $20.00 income disregard. Resources may not exceed the maximum resource standard for the QMB group permitted by the federal Centers for Medicare and Medicaid Services (CMS)	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,
QMB+	Full Dual	100% FPL $4,000.00 / $6,000.00	All of the above AND Medicaid health coverage
SLMB	Partial Dual	101% – 120% FPL Resources may not exceed the maximum standard for the SLMB group published by	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums

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MPPP Eligibility Pathways			
Coverage Group	Full or Partial Eligible	Income and Resource Limits Individual/Couple	Benefits
SLMB +	Full Dual	101% – 120 % FPL $4,000.00 / $6,000.00	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
QI	Partial Dual	121% – 135% FPL Resources may not exceed the maximum standard for the QI group published by CMS	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums
QWDI	Partial Dual	200% FPL $4,000.00 – Individual $6,000.00 – Couple	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

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1.8 Special Coverage Groups

1.8.1 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.

1.8.2 Breast and Cervical Cancer

A. The Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, ~~amended Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396w-7, to include~~established an optional Medicaid coverage group for uninsured people who are screened and need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix. The ~~Rhode Island Department of Health (~~RIDOH~~),~~ Women's Cancer Screening Program~~,~~ is responsible for administering the screening required for Medicaid eligibility through this pathway.

1. Eligibility Criteria~~—~~

a. To qualify, an applicant must be under age sixty-five (65)~~, and~~ receive screening for breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program administered by RIDOH, 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~~and must not otherwise have creditable coverage (42 C.F.R. § 435.213 (2025)~~447.56 (2023~~). ~~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.~~

b. ~~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~~ Eligibility for this coverage group is limited to individuals with income at or below~~is set at~~ two hundred fifty percent (250%) of the FPL. There is no resource limit for this group.

c. ~~In addition, p~~Presumptive eligibility is ~~also~~ available to people who meet the screening requirements, prior to a full determination of Medicaid eligibility, if the person is a resident of the State. All general

[illegible] determination is required.

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

4. Agency Rresponsibilities – The RIDOH 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/bBeneficiary Rresponsibilities – Beneficiaries are responsible for providing timely and accurate information about the status of their condition /and treatment prior to the date of redetermination or at intervals specified.

1.8.3 Refugee Medical Assistance (RMA) – MN Option

A. The Sherlock and Ticket to Work Plans are Medicaid for Working People with Disabilities Program is an SSI-related IHCC groups comprised ofwith expanded income and resource limits for working adults with disabilities age sixty-five (65) and older pursuant to 42 U.S.C. § 1396a(a)(10)(ii)(XIII). The Ticket to Work Plan is an SSI-related IHCC group comprised of working adults with disabilities ages sixteen (16) to sixty-four (64) pursuant to 42 U.S.C. § 1396a(a)(10)(ii)(XV). Eligibility requirements for the Sherlock and Ticket to Work Plans isare included in Subchapter 15 Part 1 of this ChapterPart 40-15-1 of this Title, which focuses on Medicaid eligibility for adults with disabilities who are working.

1.8.45 Emergency Medicaid

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

1. Eligibility Criteria – To qualify for emergency Medicaid, a non-citizen must meet all of the financial, residency, and other eligibility requirements for a MACC or an IHCC group, except for immigration status as defined in Part 10-00-3 of this Title. Persons seeking emergency Medicaid are evaluated as follows:

a. Financial Eligibility.

i. Persons under age sixty-five (65). All persons in this group are evaluated for the MACC groups identified in Part 30-00-1 of this Title using the MAGI standard, at the income limit applicable for the population to which they belong – e.g., child, adult or parent/caretaker, pregnant person. There is no resource limit and no determination of disability.

iib. ~~Elder~~ Persons age sixty-five (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.

iiic. Medically Needy. Persons who ~~are ineligible under §§ 1.8.5(A)(1)(a) or (b) of this Part~~do not meet the financial eligibility criteria listed above because their income is too high~~,~~ may seek coverage through the IHCC pathway as MN ~~in accordance with § 1.6.3 of this Part and Part 2 of this Subchapter in detail~~.

bd. Emergency Medical Condition. ~~In addition, the~~Any person seeking emergency Medicaid must require treatment for an emergency ~~health~~ medical condition and must obtain such services from a Medicaid provider as defined in Part 20-00-1 of this Title. Pursuant to Section 1903(v)(3) of the Social Security Act (42 U.S.C. § 1396b(v)(3)), emergency medical conditions are medical conditions (including emergency labor and delivery) manifesting by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. ~~in accordance with the prudent layperson standard – as defined in the Balanced Budget Act of 1997, Pub. Law No. 105-33 – as specified below and obtain such services from a certified Medicaid provider. Such an emergency health condition is:~~

2. Determination Process – Emergency service providers~~,~~ ~~–~~ typically an acute care facility such as a hospital~~,~~ ~~–~~ provide~~s~~ assistance with completing any required forms upon determining, in conjunction with the presumptive eligibility process specified in Part 30-00-4 of this Title, 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 R~~r~~esponsibilities – 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~~ R~~r~~esponsibilities – Applicants must provide timely and accurate information on all eligibility factors unrelated to immigration status required ~~for making~~to make a determination for Medicaid health coverage.

~~1.9 Community Medicaid – LTSS Preventive Services~~

1.9~~10~~.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 where applicable.

1.9~~10~~.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 (1) 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 ~~Rhode Island Department of Health~~RIDOH, 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 SSDI. 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.

~~1.10.3 Non-Financial Criteria~~

1.10~~1~~.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 eligibility based upon disability status ~~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.

B. Adults applying for Medicaid are first evaluated by the State's eligibility system using the MAGI standard, then evaluated using the SSI methodology as needed. The application includes questions about a person's need for care, previous or pending disability determinations, and the need for retroactive Medicaid to determine whether IHCC coverage based upon disability status is an option.

C. Children applying for Medicaid are first evaluated by the State's eligibility system using the MAGI standard, then evaluated using the SSI methodology as needed. Children generally do not require a disability determination for Medicaid eligibility, outside of the Katie Beckett option (Part 50-10-03 of this Title). The disability review for Katie Beckett follows the MART process.

1.1~~0~~1.2 Disability Standards ~~for Community Medicaid~~

A. Disability Standards – ~~For the purposes of IHCC groups providing Community Medicaid, t~~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 twelve (12) consecutive months~~;~~ (20 C.F.R. § 416.909 (2026)).

2. Substantial Gainful Activity – The impairment or condition adversely affects the person's ability to engage in substantial gainful activity ~~or~~ (SGA), as defined at 20 C.F.R. § 416.910 (2026). ~~. 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:~~

~~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.~~C. Determinations Made by the MART – The MART makes a determination of disability under the circumstances described in 42 C.F.R. § 435.541(c)(1), (2), and (4) (2026).

1. Referral to the MART – Applicants who indicate on the Medicaid application that they have been determined by a government agency 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. MART Five Step Determination Process – The MART uses the five (5) step sequential review process described at 20 C.F.R. § 416.920 (2026) to determine whether an adult applicant meets the SSI disability criteria.

D~~c~~. Disability ~~b~~Based on Blindness (20 C.F.R. § 416.981 (2026)). ~~–~~ – 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 twenty degrees (20°) or less in the better eye with the use of a correcting lens.

E~~d~~. Working Persons with Disabilities – ~~.~~ 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 Part 40-15-1 of this Title~~Subchapter 15 Part 1 of this Chapter~~, or other related provisions for adults with disabilities.

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

B~~4~~. Limitations – The MART will not start a~~A~~ periodic review ~~is not required for any beneficiary with a disability determined by the SSA and/or~~during the period in which the beneficiary is authorized to work under the Sherlock Plan, Ticket to Work 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 sixty-five (65) and older are renewed on an annual basis in accordance with the provisions located in Subchapter 00 Part 2 of this Chapter.~~

A. The applicant must provide the health care authorizations and information necessary to make a timely and accurate determination of disability. The MART

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is responsible for assuring that determinations are made in accordance with 20 C.F.R. ~~§§~~Part 416.~~920-985~~ (202~~63~~) ~~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 1-800-325-0778)~~.

1.1~~12~~Financial Eligibility Determination

1.1~~12~~.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 financial responsibility unit (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 Subchapter 00 Part 3 of this Chapter, and/or the special eligibility requirements in § 1.8 of this Part.~~ This Section focuses on the financial eligibility determination process for the Community Medicaid pathways in which the State is responsible for determining initial and continuing financial eligibility.

1.1~~12~~.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~~IHCC applicant, including Community Medicaid and LTSS, is treated as an "individual" – that is – Medicaid eligibility group of one (1).

2. ~~Groups for~~ Adults with Spouses and Dependent Children – When two (2) spouses are living together, both the ~~person requesting Medicaid~~applicant and the applicant's spouse are considered members of the applicant's Medicaid eligibility group – a "couple" or group of two (2) – unless one (1) of the exceptions specified below applies. This is true whether or not the applicant's spouse is also requesting Medicaid.

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

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

      (2) When the number of days one (1) 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 Part 50-00-6 of this Title.

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

(1) When one (1) 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 (1) – 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 (1st) 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 Katie Beckett or MN Eligibility Only) – The Medicaid eligibility group for a dependent child up to age nineteen (19) applying for Katie Beckett or MN coverage using the SSI methodology is a group of one (1). Once reaching age nineteen (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 (2) Medicaid groups of one (1), 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 (2) and the child as a Medicaid group of one (1). When a parent/caretaker is seeking MN eligibility, any MAGI-eligible members of the household are excluded from the eligibility group.

1.112.3 Formation of the Financial Responsibility Unit (FRU)

A. Introduction – The financial responsibility unit (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 under Part 10-00-3 of this Title. 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 generally 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 a parent. If the child is under age nineteen (19) and seeking Medicaid LTSS through the Katie Beckett eligibility pathway under Part 50-10-3 of this Title, 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). ~~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 the Immigration and Nationality Act ~~(INA), 8 C.F.R. Part 204 (2023)~~, includes the income and resources of the sponsor and the sponsor's spouse; see Part 10-00-3 of this Title. ~~, if the spouse is living with the sponsor, when all four (4) of the following conditions are met:~~

1.112.4 General Rules for Counting Income – Community Medicaid

A. Income eligibility determinations for Community Medicaid follow the SSI methodology. This includes the application of income disregards as set forth in:

1. 20 C.F.R. § 416.1112 (2026), for earned income disregards; and

2. 20 C.F.R. § 416.1124 (2026), for unearned income disregards.

B. Additional provisions for the SSI treatment of income are found in Part 40-00-3 of this Title. ~~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 Subchapter 00 Part 3 of this Chapter. Unearned income exclusions and disregards are applied first.~~

1.11~~2~~.5 Income Deeming

A. Introduction – To deem income is to attribute one (1) 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 and without being subject to income deeming. ~~(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 § 1.12.4 of this Part 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~~Whether the income of a NAPP is deemed to an applicant is determined separately for each NAPP~~member of the FRU~~.

B. Income Counted When Deeming – The general rules for determining countable income related to the application of earned and unearned income exclusions identified ~~above~~ in § 1.11~~2~~.4 of this Part are applied when deeming income. ~~In addition:~~

~~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.~~

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1a. Deeming. The amount of income that is deemed to the applicant spouse is calculated by subtracting from the NAPP spouse's gross income:

a.(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 FBR for a single person, as defined in Part 40-00-3 of this TitleSubchapter 00 Part 3 of this Chapter, less any countable income from the child. The difference between the two (2) is the living allowance for the NAPP child, as indicated herein.

b.(2) Any portion of the NAPP spouse's income paid in court-ordered child support for a child living in another household.

c.(3) Exclusions and disregards that apply when calculating countable income for the applicant spouse.

d.(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.

2b. 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, tThe income of a biological or adoptive parent is deemed to a child who is under age eighteen (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. Exceptions – 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 Part 50-10-3 of this Title.

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 twenty dollar ($20.00) and sixty-five dollar ($65.00) plus one half (1/2) 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 twenty dollar ($20.00) income disregard from any remaining parental unearned income; subtracting sixty-five dollars ($65.00), plus any of the remainder of the twenty dollar ($20.00) disregard and one half (1/2) 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 (1) 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 twenty-one (21) living in the household;

3. Stepparent to a stepchild;

4. Grandparent to a grandchild; or

5. Relative caretaker to a child.

E. [illegible]

A. The State uses a more simplified process for counting resources for Community Medicaid, as explained in Part 40-00-3 of this TitleSubchapter 00 Part 3 of this Chapter, 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.

B. Resource counting for Community Medicaid follows the SSI methodology, including the application of resource exclusions as set forth in 20 C.F.R. § 416.1210 (2026).

C. Additional provisions for the SSI treatment of resources are found in 40-00-3 of this Title.

1. Process – The process rules identified in Subchapter 00 Part 3 of this Chapter are used in evaluating resources to determine which are included in the calculation.

A. To deem resources is to count one (1) 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 (1) 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 (2). 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 a 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 (1) 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 their own right plus whatever resources are deemed to the child from their parent(s). Resource deeming does not apply when the child is seeking LTSS through the Katie Beckett eligibility option in accordance with Part 50-10-3 of this Title.

   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 (1) home and one (1) vehicle are completely excluded, however. The equity value of a second (2nd) vehicle is counted in accordance with ~~Subchapter 00 Part 3 of this Chapter~~40-00-3 of this Title.

   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 (1) child.

   d. When there is more than one (1) 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 their 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 (1) – of four thousand dollars ($4,000.00)~~.