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TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 30 - MEDICAID FOR CHILDREN, FAMILIES, AND AFFORDABLE CARE ACT (ACA) ADULTS

SUBCHAPTER 00 - AFFORDABLE COVERAGE GROUPS

Part 1 - Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways

1.1 Overview

A. The principal purpose of the federal Affordable Care Act of 2010 was to increase access to health care by leveraging resources, expanding choice, and removing the administrative, financial, and legal barriers that have prevented people from obtaining the coverage they need. Toward this end, the ACA:

1. Consolidated many of the existing Medicaid coverage groups associated with the now defunct federal Aid to Families with Dependent Children Program (AFDC) into three broad categories: children, pregnant women and newborns, and parents/caretaker relatives;

2. Created an optional Medicaid coverage group for adults between the ages of nineteen (19) and sixty-four (64) who otherwise do not qualify for Medicaid and are not eligible for or enrolled in Medicare;

3. Established a new standard - Modified Adjusted Gross Income (MAGI) -- for evaluating income eligibility for Medicaid and other publicly supported forms of affordable commercial coverage across these populations;

4. Eliminated distinctions in the financial criteria and standardized the income eligibility requirements for the Medicaid populations subject to the MAGI. This, in turn, made it possible for the states to reorganize the MAGI-eligible populations with similar characteristics into distinct, easily identifiable, Medicaid affordable care coverage (MACC) groups;

5. Mandated that the states automate the application and renewal process for populations subject to the MAGI by building the capacity to determine eligibility on-line and conduct electronic verifications through a variety of government approved data sources; and

6. Applied these changes not only to Medicaid, but also to the Children's Health Insurance Program (CHIP), which is administered through the

Medicaid program in Rhode Island, and HealthSource RI (HSRI), the State's health insurance marketplace.

1.2 Scope and Purpose

A. The purpose of this rule is to establish the Medicaid Affordable Care Coverage (MACC) groups and the eligibility pathways for individuals who share one or more of their characteristics and are exempt from MAGI and/or the provisions for the Integrated Health Care Coverage (IHCC) groups under Chapter 40 of this Title.

B. In Rhode Island, CHIP eligibility is administered as an expansion through the Medicaid program rather than through a separate state program as the principal distinction for most eligibility pathways relates to claiming of Title XIX versus Title XXI federal financial participation rates. The exceptions, as indicated in this rule, are the CHIP-only eligibility pathways for lawfully present qualified non-citizen children up to age nineteen (19) and qualified and non-qualified pregnant women who meet the income limits set forth herein.

1.3 Legal 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, Sections 1115, 1902, 1903, 1905, 1925,1931, 1937, 2107; Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa through 1397mm; 42 U.S.C. § 1396k; Section 1413(b)(1)(A) of the Affordable Care Act.

2. Federal Regulations: 42 C.F.R. §§ 431,435, 440, and 441.

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

B. Applicable State authority is derived from R.I. Gen. Laws, Chapters 40-8, 42-12.3, and §§ 40-8.4 and 40-8.12.

C. The rules in this Part supersede the Medicaid Code of Administrative Rules (MCAR), Sections 1301,1305, and 0342 unless otherwise indicated, pertaining to Medicaid MACC and non-MAGI eligibility for children and families and authorized services.

1.4 Definitions

A. For the purposes of Medicaid MACC and non-MAGI eligibility groups covered under this Part, the following definitions apply:

1. “ACA expansion adults” means the eligibility pathway established by the federal Affordable Care Act (ACA) of 2010 and by R.I. Gen. Laws § 40-8.12, for persons between the ages of nineteen (19) and sixty-four (64) who are not eligible for or enrolled in Medicare and do not qualify for Medicaid in any other eligibility group.

2. “Dependent child” means a child under the age of eighteen (18) or under age nineteen (19), if enrolled full-time in school.

3. “Hospital presumptive eligibility” means the temporary and time-limited Medicaid eligibility pathway for persons who meet certain requirements and are receiving care in a hospital pending submission of a complete application.

4. “Managed care organization” or “MCO” means a health plan system that integrates an efficient financing mechanism with quality service delivery and a "medical home" to assure appropriate preventive care and deter unnecessary services.

5. “Medicaid Affordable Care Coverage Group” or “MACC” means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility.

6. “Rhode Island Code of Regulations” or “RICR” means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State’s Administrative Procedures Act (R.I. Gen. Laws Chapter 42-35).

7. “Medicaid member” means a Medicaid beneficiary enrolled in a managed care plan.

8. “Modified Adjusted Gross Income” or “MAGI” means income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued.

9. “Navigator” means a person working for a State-contracted organization that provides certified assisters who have expertise in Medicaid eligibility and enrollment.

10. “Non-citizen” means anyone who is not a U.S. citizen at the time of application including lawfully present immigrants and persons born in other countries who are present in the U.S. without documentation.

11. “Non-MAGI coverage group” means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. For the purposes of this Part, it includes Medicaid for persons who qualify for Medicaid based on their eligibility for another publicly funded program, including children in the substitute care under the auspices of the DCYF such as current, and some instances, former foster care recipients and anyone receiving Supplemental Security Income (SSI).

12. “Qualified non-citizen” means a person legally present in the United States based on immigration status who, if otherwise eligible for Medicaid, is prohibited or “barred” under federal law from receiving Medicaid coverage for a period of five (5) years from the date the immigration status was secured from the U.S. Immigration and Naturalization Service (INS). Certain qualified non-citizens are exempt from the ban.

13. “Rhody Health Partners” means the Medicaid managed care delivery system for ACA expansion adults (see Part 05-2 of this Chapter) and adults with disabilities (See Chapter 40 of this Title).

14. “RIte Care” means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see Part 05-2 of this Chapter).

15. “RIte Share” means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial health insurance plans coverage.

16. “Self-attestation” means the act of a person affirming through an electronic or written signature that the statements the person made when applying for Medicaid eligibility are truthful and correct.

17. “Title XIX” means the section of the U.S. Social Security Act that established the Medicaid program and provides the legal basis for providing services and benefits to certain populations in each MACC group.

18. “Title XXI” means the section of the U.S. Social Security Act that established the Children’s Health Insurance Program (CHIP) and provides the legal basis for providing services and benefits to certain targeted low-income children and pregnant women through Medicaid.

1.5 Eligibility Pathways for MACC and Non-MAGI Groups

A. Rhode Island's Medicaid MACC groups are comprised of individuals and families who share an eligibility characteristic, such as age or relationship as follows, unless otherwise indicated below. MACC group members do not have access to retroactive coverage under the terms and conditions of the State's Section 1115 Demonstration Waiver.

1. Families and Parents (caretaker relatives). The defining characteristic of this coverage group is a relationship with a child up to age 18, or 19 if enrolled in school full-time, who is eligible for Medicaid. Parent/caretaker eligibility is a function of how the eligible child is claimed for tax purposes as a dependent when constructing a MAGI household. This coverage group includes:

    a. Families with income up to 116% of the Federal Poverty Level (FPL) who are eligible under the Medicaid State Plan through the authority provided by Section 1931 of Title XIX.

    b. Parents/caretaker relatives with income from 116% to 141% of the FPL who are eligible under the State's Section 1115 demonstration waiver.

    c. Parents/caretakers with income from 138% to 175% of the FPL who would have been eligible for Medicaid on December 31, 2013, may qualify for the Rhode Island Affordable Health Care Coverage Assistance Program. Parents/caretakers eligible for this program may obtain a State subsidized "silver" commercial plan through the Rhode Island's health insurance marketplace as specified in Part 10-1 of this Chapter. The State's integrated eligibility system automatically evaluates the parents/caretakers of Medicaid-eligible children for this Program if they do not qualify for coverage under this Part.

    d. Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP. The CHIP eligibility pathway is for pregnant women who are non-citizen residents of the State. In the case of CHIP, the unborn child's citizenship and residence is the basis for eligibility. Retroactive coverage is

available for up to ninety (90) days prior to the eligibility date for otherwise eligible pregnant women.

e. Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes:

(1) Infants under age one (1) unless a deemed newborn (see § 1.7(A) of this Part) up to age 19 who have family income up to 261% of the FPL; and

(2) Qualified and legally present non-citizen children up to the age of 19, who have income up to 261% of the FPL.

f. ACA Expansion Adults - The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicare or Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible awaiting a determination for Supplemental Security Income (SSI) or the receipt of Social Security benefits are also eligible under this coverage group during the two (2) year application pending and benefit waiting periods.

B. MACC Group Income Eligibility - The income thresholds and ceilings for the MACC groups eligible through these pathways are summarized as follows:

MACC Group	**Income Threshold - As percent of the FPL**	**Income Ceiling with the 5 percent disregard - As a percent of the FPL**
a. Families	116%	121%
b. Parents/Caretakers	116%	141%
c. Pregnant Women	253%	258%
d. Children/Young Adults	261%	266%
e. ACA Expansion Adults	133%	138%

C. There are currently multiple Medicaid coverage groups that are not subject to the MAGI. Eligibility for adults who are nineteen (19) years of age and older who are not subject to the MAGI standard is set forth as follows:

1. Persons twenty-one (21) years of age and older eligible for Medicaid based on receipt of Supplemental Security Income (SSI), Optional State Supplemental Payments (SSP), and/or SSI-protected status - § 40-00-1.5(A)(3) of this Title;

2. Low income elders sixty-five (65) and older, and adults with disabilities (EAD) between the ages of nineteen (19) and sixty-four (64) with income up to 100 percent of the FPL to who do not qualify for SSI and are eligible for or enrolled in in Medicare - § 40-00-1.5(A)(1) of this Title;

3. Full or partial Medicare-Medicaid dual eligible beneficiaries participating in the Medicare Premium Payment Program - § 40-00-1.5(A)(6) of this Title;

4. Women eligible for Medicaid through the Breast and Cervical Cancer Treatment Program (BCCTP) - § 40-00-1.6(A)(1) of this Title;

5. Adults seeking initial or continuing eligibility for Medicaid long-term services and supports (LTSS) who are eligible for or enrolled in Medicare or are age sixty-five (65) and older with service needs requiring the level of care typically provided in health institutions - § 50-00-1.9(A)(3) of this Title;

6. Otherwise ineligible children with serious disabilities up to age eighteen (18) who qualify under Katie Beckett process because they are receiving the level of care at home that is typically provided in a health institution -- Part 50-10-3 of this Title;

7. Medically needy eligible persons who become eligible for Medicaid by spending down excess income on allowable health expenses - § 40-00-1.5(A)(2) of this Title.

D. Children and families exempt from the MAGI with eligibility covered under this Part are as set forth below:

1. No income determination required – Individuals and families up to age twenty-one (21) whose eligibility does not require an income determination for Medicaid, including those eligible on the basis of:

    a. Supplemental Security Income (SSI). Children and young adults with disabilities determined by the federal Social Security Administration (SSA) to be eligible for SSI benefits who are up to age nineteen (19) or in the custody of the State, up to age twenty-one (21), including those residing in health institutions; and

b. DCYF programs. Children and youth eligible on the basis of their participation in a DCYF foster care, kinship or guardian program whether in a home-based, residential or institutional setting, including young adults aging out of foster care in Rhode Island, up to age twenty-six who are eligible under the federal Foster Care Independence Act of 1999 (Chafee Act).

2. Deemed eligibility -- Infants born to Medicaid-eligible pregnant woman are deemed eligible from date of birth to age one (1) without regard to changes in income or other factors as long as they remain residents of the State.

3. Transitional/extended Medicaid – Families with income above 116 percent of the FPL who no longer qualify for Medicaid coverage under Title XIX, Section 1931 due to earnings from work, including recipients of the RI Works Program administered by the RI Department of Human Services may qualify for continued coverage through this pathway. Eligibility for extended Medicaid is for six (6) months, renewable up to a year as long as gross income is at or below 175 percent of FPL.

1.6 MACC Group General Eligibility Requirements

A. All applicants for MACC Group eligibility must meet citizenship and residency requirements. These two requirements apply to all Medicaid applicants. There are also certain cooperation requirements. Adults must typically meet the cooperation requirements, whether applying for themselves or on behalf of a dependent child. Verification of these requirements is an automated process conducted through electronic data matches. Failure to meet Medicaid general eligibility requirements or provide supporting documentation upon request is considered non-cooperation and generally results in the denial or discontinuation of eligibility. Children are exempt from sanctions due to non-cooperation. The scope and application of each of these eligibility requirements are as follows:

1. Age - “Age” is one of the principal factors affecting eligibility for Medicaid and assignment to the appropriate Medicaid service delivery system MACC group.

2. MACC Group Age Limits - The age requirements associated with each of the MACC groups are as follows:

MACC Coverage Groups	Age Requirements
Families and Parents/Caretakers	Parents/Caretakers of any age

	Dependent child up to age 18 or 19 if enrolled in school full-time
Pregnant Women	Any age
Children and Young Adults	Up to age 19
ACA Expansion Adults	Ages 19 to 64

a. Verification – An applicant's self-attestation of age and identity is accepted at the time of application. Post-eligibility electronic verification of date of birth is conducted through the U.S. Social Security Administration (SSA) and/or the RI Department of Health, Division of Vital Statistics. This information is used to determine capitation rates for enrollees in Medicaid managed care plans; these rates vary by age. If electronic verification is unsuccessful, submission of paper documentation may be required for these purposes. See Part 5 of this Subchapter for satisfactory forms of documentation.

3. Social Security Number - Each individual (including children) applying for Medicaid must have a Social Security Number (SSN) as a condition of eligibility for the program.

a. Condition of Eligibility - Applicants must be notified prior to or while completing the application that furnishing an SSN is a condition of eligibility. Only members of a household who are applying for Medicaid coverage are required to provide a SSN. A SSN of a non-applicant may be requested to electronically verify income. However, unwillingness on the part of a non-applicant to provide a SSN upon request cannot be used as a basis for denying eligibility to an applicant who has provided a SSN. If unavailable, other proof of income must be accepted.

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

c. Verification - A SSN is verified through an electronic data-match with the SSA. Applicants must provide documentation of SSN if the data match fails. Acceptable forms of documentation are identified in Part 5 of this Subchapter.

4. State Residency - Anyone who is applying for eligibility must be a resident of the State. Any person living in the State voluntarily, who intends to reside in Rhode Island for any reason is a resident of the State. Under federal regulations a person does not need a fixed address in the State to be considered a Rhode Island resident. Therefore, homelessness is not a bar to eligibility.

    a. For individuals over age 21, or under 21 and capable of expressing intent as emancipated or married - If the applicant is not living in an institution, the state of residence is the state where the applicant is living voluntarily with the intention to reside; or entered voluntarily with a job commitment or seeking employment, whether or not currently employed.

    b. For individuals under age 21 who are not emancipated or married – If the applicant is not living in an institution, the state of residence is the state where the child/young adult resides or the state of the parent/care-taker with whom the child lives. The residence of a pregnant women's unborn child is, under the terms of this provision, the state in which the pregnant women resides. A non-citizen pregnant woman who lives in Rhode Island is considered to be a resident, irrespective of whether the woman's immigration status indicates she is in the country permanently or for a limited time (i.e., in the United States on a temporary visa of any kind).

    c. For individuals living in institutions - Most Medicaid applicants living in institutional settings are not included in the MACC groups.

    d. Disputes - If there is a dispute over residency for determining Medicaid eligibility, the applicant is a resident of the state in which the applicant is physically located. The MAGI standard of the state where the applicant is physically located applies when determining eligibility.

    e. Verification - Self-attestation of the intent to remain in the State is accepted. Evidence that an applicant is receiving public benefits in another state may result in a denial of eligibility if paper documentation of residency is not provided.

5. Citizenship and Immigration Status - The citizenship requirements for Medicaid eligibility for individuals and families in MACC groups vary depending on the basis of eligibility. All applicants must provide information about citizenship, whether U.S. citizens or lawfully present

non-citizens. Under federal law, non-citizens are categorized into two groups – qualified and non-qualified non-citizens.

a. Qualified non-citizens. The qualified non-citizens category includes persons who are citizens of other nations who are lawfully present in the United States. Qualified non-citizens are barred from Medicaid for a period of five (5) years under federal law. Certain exemptions from the bar apply:

b. Qualified non-citizen children up to age 19 who are lawfully present in the United States but were born in another nation are eligible for Medicaid as members of the MACC group for children and young adults. Children in this subcategory of qualified non-citizens are eligible during the five (5) year bar under an option in Title XXI, the Children's Health Insurance Program (CHIP). Qualified non-citizen pregnant women are also eligible for Medicaid in the MACC group, under an option in CHIP.

c. There are several other subcategories of non-citizens who are exempt from the five (5) year bar as specified in Part 10-00-3 of this Title. All non-exempt qualified non-citizens are eligible to obtain coverage through state and federal health insurance marketplaces, such as HealthSource RI.com in Rhode Island, and may be qualified for certain tax credits.

d. Non-qualified non-citizens. The non-qualified category of non-citizens includes citizens of other nations who are not considered to be immigrants under current federal law, including those in the United States on temporary or time-limited visa (such as visitors and students) and those who are present in the country without proper documentation (includes people with no or expired status).

e. Non-qualified non-citizens are not eligible for Medicaid, except in emergency situations (Part 10-00-3 of this Title). Non-emergency services may be obtained through Federally Qualified Community Health Centers. See Rhode Island Community Health Association at www.richa.org.

f. Non-qualified non-citizen pregnant women in the applicable MACC group are eligible for Medicaid coverage. The pregnant woman's eligibility is tied to the eligibility of the baby she is carrying. For the purposes of MACC group eligibility, the baby *in utero* is deemed to be a United States citizen and Rhode Island resident and remains so as a newborn as long the birth occurs in Rhode Island.

g. Verification of status — Any members of a household who are applying for Medicaid coverage must provide their immigration and citizenship status. Non-applicants are exempt from the requirement. Any information provided by an applicant or electronically must be used only for verifying state. Under the ACA, citizenship and immigration status are verified:

h. Electronically. The Medicaid agency must use electronic verification through the federal hub (see Part 5 of this Subchapter) to the full extent feasible through:

(1) Social Security Administration (SSA) or RI Department of Health, Division of Vital Statistics for citizens.

(2) U.S. Citizenship and Immigration Services (USCIS) for non–U.S. citizens via the Systematic Alien Verification for Entitlements (SAVE) database.

i. Non-electronic. If unable to verify immigration status electronically, enrollees have an opportunity to provide other documents or to fix the records.

j. Self-Attestation. An applicant's attestation is accepted without electronic verification providing appropriate paper documentation is provided to the Medicaid agency within ninety (90) days of the eligibility determination. Failure to provide the required documentation within that period results in a termination of Medicaid and the initiation of the Medicaid recoupment process.

6. Relationship - The State evaluates the relationship of household members applying for the MACC group for families and parent/caretakers using the following:

a. Caretaker Relative - For the purposes of MACC group eligibility, parent/caretaker is any adult living with a Medicaid-eligible dependent child who has assumed primary responsibility for that child. This definition includes, but is not limited to:

(1) Father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece;

(2) The spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

(3) Another relative of the child based on blood, adoption or marriage; domestic partner of parent or other caretaker relative. If the parents are in the household, it is presumed that other members in the household are not assuming primary responsibility for the child's care.

(4) Dependent child - For the purposes of determining eligibility the members of the MACC group for families and parents/caretakers, a dependent child is a child under the age of eighteen (18) or under age nineteen (19) if enrolled full-time in school.

b. Verification - Self-attestation on the application is accepted as verification of relationship, except for deeming of newborns.

1.7 MACC and Non-MAGI Special Eligibility Categories

A. Deemed Newborn Eligibility - Babies born to Medicaid-eligible pregnant women who are residents of Rhode Island are deemed eligible from the date of birth. Once deemed eligible as a newborn, the infant remains eligible for one (1) year and, as such, is a non-MAGI eligibility pathway. Accordingly, retroactive coverage is available for periods prior to the application date, if the newborn was otherwise deemed eligible. The Medicaid-eligible parent of the newborn must comply with the following:

1. Enumeration - The parents of a newborn must obtain a SSN for a newborn. Failure to enumerate the child results in a sanction against the mother, not the child. The child will remain eligible even if lacking an SSN because of mother's failure to cooperate. The sanction against the mother is loss of her eligibility for failure to cooperate. This sanction will be removed once the mother meets the enumeration requirements; or

2. Record of birth - If the newborn's SSN is not provided at birth, Medicaid eligibility is provided under the mother's SSN if the hospital record of birth is submitted by the parents. The hospital record of birth is a written document indicating that the newborn was discharged in the mother's care and information related to date of birth and verifying citizenship. The hospital record of birth must be signed by the appropriate authorized representative of the hospital. If the infant was not born in a hospital, proof of application for an SSN, self-attestation and signed attestation of an attending health provider or birthing assistant may be accepted as a record of birth.

3. Verification - The birth may be reported by the mother, or another family member or friend, the mother's Medicaid managed care plan, or the hospital in which the child was born. See § 1.7(A)(2) of this Part above for information pertaining to the hospital record of birth.

B. Federal law and regulations prohibit the use of federal matching funds for health care provided on the premises of correctional facilities to otherwise MACC-eligible persons while incarcerated. Accordingly, full Medicaid health coverage of such persons is suspended during periods of incarceration. While the suspension remains in effect, the State is responsible for reimbursing costs related to acute care hospital stays of twenty-four (24) or more hours, but only when the otherwise Medicaid-eligible incarcerated person receives that care off the premises of the correctional facility.

1. Reinstatement upon Release. Medicaid health coverage that has been suspended due to incarceration must be reinstated promptly by the Medicaid agency upon the person's release from a correctional facility.

2. Residency. Suspension of Medicaid health coverage is limited to Rhode Island residents while incarcerated in correctional facilities. Medicaid health coverage for Rhode Islanders incarcerated in the correctional facilities of other states or in a federal penitentiary is terminated in accordance with the residency requirements set forth herein.

C. Infants. An infant born to an incarcerated pregnant woman with suspended eligibility is treated as a deemed newborn in accordance with Subpart A above and is qualified to receive Medicaid health coverage until the end of the month of the infant's first birthday.

D. Hospital Presumptive Eligibility - Under the implementing regulations for the federal Affordable Care Act at 42 C.F.R.§ 435.1110, states must offer Medicaid coverage to individuals who are not already Medicaid members for a limited period. This form of "presumptive eligibility" is only available in certain circumstances when a qualified hospital determines, on the basis of preliminary information, that an individual has the characteristics for Medicaid eligibility. Such individuals are "presumed eligible" for Medicaid until the end of the following month or the date full eligibility is determined, whichever comes first. The State makes presumptive eligibility available to persons who have been determined by a qualified hospital to meet the characteristics of one of the MACC groups eligible for Title XIX coverage. Persons eligible under CHIP are excluded. See "Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals" promulgated by EOHHS for additional detail on the provisions governing hospital presumptive eligibility determinations in Rhode Island.

E. Section 1931 Extended/ Transitional Medicaid – Families eligible for Medicaid under section 1931 of Title XIX, the federal Medicaid law, may be eligible for an extension of Medicaid (referred hereinafter to “extended” Medicaid) for up to twelve (12) months when their family income exceeds the Section 1931 family eligibility ceiling. Although extended Medicaid is considered a non-MAGI pathway, families eligible under Section 1931 are a MACC coverage group. As such, their initial eligibility is determined using the MAGI standard and they are renewed on that basis until their income increases to the family limit of 116 percent of the FPL. Extended Medicaid is only one of several Medicaid coverage options available to members of a household that no longer meets Section 1931 income requirements. There are MACC group and, some instances, IHCC group and commercial insurance alternatives through HealthSource RI that may be more beneficial and/or appropriate for family members losing Section 1931 coverage. However, all these beneficiaries are evaluated for extended Medicaid along with these other alternatives before Sections 1931 coverage is terminated. Requirements for extended Medicaid are as follows:

1. Initial Eligibility Criteria - At the time a family becomes ineligible for Section 1931 Medicaid benefits, the State must verify and confirm, whether:

2. The family has a child living in the home who is under the age of eighteen (18) or between the age of eighteen (18) and nineteen (19) if the child is a full-time student in a secondary school, or at the equivalent level of vocational or technical training, and is reasonably expected to complete the program before or in the month of his/her nineteenth (19th) birthday. A student attending summer school full time, as defined by school authorities, is considered a full-time student for these purposes; and

3. Eligibility for Section 1931 Medicaid coverage was discontinued because of earned income of a parent /caretaker or other member of the family due to: employment; increased hours of employment; or an increase in wages.

4. Extended Medicaid is not provided to any beneficiary who has been legally determined to be ineligible for cash assistance because of fraud at any time during the last prior six months in which the family received benefits.

5. Notice Requirements - A notice is sent informing the family of the right to extended Medicaid for up to the maximum of twelve (12) months. The notice also sets forth the following beneficiary responsibilities. The family must:

    a. Submit a report which includes an accounting of the family's earned income and the "necessary child care" expenses;

b. Enroll in an employer's health plan (whether individual or family coverage) if it is offered at no cost to the parent / caretaker in accordance with the provisions related to the Rite Share Premium Assistance Program set forth in Part 30-05-3 of this Title; and

c. Report circumstances which could result in the discontinuance of extended benefits (e.g., no age appropriate child in the family or a move out-of-state).

6. Loss of Benefits Due to Employment - To receive extended Medicaid is employment of a parent / caretaker or other member(s) of the family whose earned income contributes to the family's loss of eligibility for Section 1931 Medicaid. Often employment linked with other changes, such as a parent returning to the home or a child turning eighteen, may combine to cause the loss of eligibility. While there must be a relationship between earned income and the loss of eligibility for Section 1931 Medicaid to qualify for extended Medicaid, the advent or increase in earned income need not be the only factor causing the loss.

7. Beneficiaries Eligible for Extended Medicaid - The first month of extended Medicaid is the first full or partial month in which the family loses eligibility for Medicaid health care coverage under Section 1931, but only in those instances in which eligibility under any other Medicaid coverage group is unavailable. If the family is eligible for Medicaid State Plan or waiver coverage, extended Medicaid will be denied.

8. Extended Medicaid is provided to those beneficiaries who:

a. Are living in the household, and whose needs and income were included in determining Section 1931 eligibility of the assistance unit at the time such benefits were discontinued;

b. Have needs and income would be taken into account in determining Section 1931 Medicaid eligibility using the MAGI standard if the family were applying for either of these programs in the current month. A child born after Section 1931 benefits are discontinued, or a child, parent or step-parent who returns home after Section 1931 benefits are discontinued, is included as a member of the family for purposes of providing extended Medicaid.

9. Receipt of Extended Medicaid - Extended Medicaid continues throughout the first seven (7) months following the loss of Section 1931 Medicaid eligibility unless:

a. No age-appropriate child is living in the family; or

b. The parent / caretaker refuses to apply for health coverage offered by the employer.

10. When it is determined that a family no longer has a child who meets the age requirements living in the home, Medicaid for all family members ends the last day of the month in which the family no longer includes such child.

11. Continuation of Extended Medicaid - To continue to receive the remaining months of extended Medicaid, up to the limit of the full twelve months of the transitional medical program, families must:

    a. Include a child who meets the age requirement living in the household; and

    b. Timely file the earned income report when due in the seventh (7th) month; and

    c. Pass the 175 percent of the FPL earned income test; and pass the parent / caretaker employment test.

12. Failure to Meet Continuation Requirements - If the family fails to pass the income test, the Medicaid agency discontinues extended Medicaid benefits on the last day of a reporting month.

13. Limits - The maximum amount of time under the extended Medicaid program is limited to twelve (12) months. The Medicaid agency must provide a notice of closing if eligibility is discontinued prior to the receipt of the maximum time allowed under the program's twelve (12) month time-limited benefits. Eligibility is always discontinued on the last day of a month.

14. Good Cause - A family may have reason to claim good cause for failure to comply with required action. Good cause may exist for any of the following which may lead to the termination of extended Medicaid:

    a. Failure to timely submit an earned income report;

    b. Failure of the parent / caretaker to be employed;

    c. Failure to comply with any extended Medicaid requirements other than the above;

    d. Failure to submit the earned income report or to include appropriate verifications, may exist if circumstances beyond the recipient's control prevent the requirement from being met when due.

e. Good cause includes circumstances beyond the beneficiary's control, such as, but not limited to: involuntary loss of employment; illness or incapacity; unanticipated household emergency; work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule.

15. Discontinuing Extended Medicaid - Notice from the State is required if a family becomes ineligible for Section 1931 Medicaid for reasons related to employment.

16. Prior to termination of extended Medicaid, each member of the family is evaluated for Medicaid coverage in every other possible MACC and IHCC group category as well as for commercial coverage subsidized by the federal and/or State government offered through HealthSource RI, the State's health insurance market. Notice to the beneficiary indicates the alternative forms of coverage available and how to enroll or if additional information is required to determine whether eligibility for these other cover options exists.

F. Children with Special Circumstances

1. This category includes children and youth who are or were in the care and custody of the RI Department of Children, Youth and Family and, by virtue of that status, are automatically eligible for Medicaid without a MAGI-based income determination. They are included in this rule as they share the characteristics of the MACC group coverage group for children and youth though eligible through a non-MAGI pathway. However, members of these groups may be eligible for up to ninety (90) days of retroactive coverage prior to the eligibility date.

2. The DCFY is responsible for certifying the eligibility of children and youth in the coverage group and in making the referral for Medicaid to the appropriate unit of the designated State agency and for notifying the agency when there is a change in circumstances that may affect a child's Medicaid eligibility, coverage, or service delivery options. The change in circumstance could be related to placement, the child's financial status, or a return to the family and/or termination of participation in the applicable programs. Prior to any change that may result in the end of Medicaid eligibility, the DCYF must ensure that the beneficiary and/or his/her family or guardians are aware that alternative forms of Medicaid are available and provide assistance as appropriate.

3. Adoption Subsidy/IV-E Foster Children - This non-MAGI coverage group is the eligibility pathway for children in DCYF substitute care under the

authority of Title IV-E of the U.S. Social Security Act. The coverage group includes foster children, children in kinship guardianship care and adopted children whose Medicaid eligibility is based on participation in the following DCYF administered, Title IV-E programs:

a. The Foster Care Maintenance Program - This Program provides federally funded foster care payments on behalf of the following children: Children previously eligible under the federal Title IV-A Foster Care Maintenance Program; Certain children voluntarily placed or involuntarily removed from their homes; and Children in public non-detention type facilities housing no more than 25 children. Children for whom a cash payment is made under the foster care program are deemed eligible for Medicaid. Medicaid eligibility for children in the Foster Care Maintenance program exists as long as the Title IV-E payment continues to be made for them or up to age twenty-one (21) if still in foster care.

b. The Adoption Assistance Program - The Title IV-E authorized and funded adoption assistance program provides federal funding for continuing payments for hard-to-place children with special needs. Children in this Program must be SSI beneficiaries at the time of adoption. An adoption subsidy cash payment is not a necessary condition of Medicaid eligibility for these adoption assistance children. They continue to be eligible for Medicaid as long as a Title IV-E adoption assistance agreement is in effect. An interlocutory order or final decree also need not exist.

c. Residency requirements - Title IV-E adoption assistance children, kinship guardianship assistance children, and Title IV-E foster care children are eligible for Medicaid in their states of residence. Accordingly, Rhode Island is required to provide Medicaid coverage to children eligible under this pathway as long as they remain residents of the State and under the care and custody of DCYF, even if services are being provided in a jurisdiction of another state.

4. Non IV-E Foster Child Under 18 - This coverage group is children under age 18, or if 18, will complete high school before his/her 19th birthday, who are in foster family care or in a kinship guardianship care and are not eligible for Title IV-E.

5. Non IV-E, State Adoption Assistance - This coverage group is hard-to-place children for whom the state provides adoption/guardianship assistance and who are not eligible for Title IV-E. The basis of eligibility

for Medicaid is deprivation of parental support occasioned by the child's separation from his/her family.

6. The determination of financial need. When a child is not living in a home maintained by the child's parents, the State considers only the child's own income and resources.

7. Age Limit. Medicaid under this coverage group may be provided until the child reaches age 21.

8. Post Foster Care Medicaid Eligibility - The Foster Care Independence Act of 1999 established the John H. Chafee Foster Care Independence Program (42 U.S.C. § 1396a(a)(10)). This Medicaid eligibility pathway is open to youth who were in foster care in Rhode Island on their eighteenth birthday. Medicaid eligibility for youth qualifying for this coverage continues until age twenty-six (26) years old as long as they remain residents of the State.

    a. Living arrangement. A post foster care adolescent may be residing independently or with others (including family members).

    b. Renewal. A renewal of Medicaid eligibility is completed once in a twelve (12) month period to ensure that the beneficiary eligible in this group is a resident of Rhode Island.

    c. Limits. Under the terms of the Chafee Act, young adults may only qualify for Medicaid under this group if not otherwise eligible through SSI or as aged, blind or disabled and/or in need of long term services and supports. In addition, although eligible for the full scope of Medicaid State Plan and Section 1115 waiver services available to all adults, the EPSDT benefit for children continues up to age twenty-one (21) only.

1.8 Cooperation Requirements

A. All applicants and beneficiaries subject to this Part must cooperate with an array of requirements as a condition of obtaining or retaining (post-eligibility) eligibility. Specific requirements related to application and renewal are located in Part 3 of this Subchapter and for the purposes of evaluating and verifying income are set forth in Part 5 of this Subchapter.

B. Cooperation requirements applicable across populations are as follows:

1. Third Party Liability (TPL) - Third Party Liability refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) that may be

liable for all or part of a Medicaid applicant's coverage. Under Section 1902(a)(25) of the Social Security Act, the State is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid beneficiary once determined eligible. Applicants/beneficiaries must furnish information about all sources of TPL. The State and Medicaid managed care organizations, under contractual agreements with the State, are responsible for identifying and pursuing TPL for beneficiaries covered by employer-sponsored health insurance plans through the RIte Share program. Failure to cooperate with the TPL requirement or to enroll in a RIte Share plan as required in Part 30-05-3 of this Title results in the ineligibility of the parent.

2. Referral to Office of Child Support Services (OCSS) - All applicants reporting an absent parent are referred to the Office of Child Support Services within the Department of Human Services, once they have been determined eligible for Medicaid and received appropriate notice. Compliance with the OCSS requirement is a condition of retaining eligibility. As a condition of eligibility, an applicant who can legally assign rights for a dependent child born out of wedlock is required to do so and cooperate in establishing the paternity of that child for the purposes of obtaining medical care support and medical care payments for both the applicant and the child. Failure to cooperate in assigning rights results in a determination of ineligibility for the parent, unless a good cause exemption has been granted by the State. In instances when domestic violence may be the basis for an exemption to the cooperation requirement, referral to the Family Violence Option Project may be made to assist the parent seeking an exemption.

3. RIte Share Premium Assistance Program - Individuals and families determined to have access to cost-effective employer-sponsored health insurance (ESI) are required to enroll in the ESI plan if so directed by the State. Members of the MACC groups with access to ESI who are eligible for Medicaid will be permitted to enroll in a Medicaid managed care plan, as appropriate. The Medicaid agency will conduct a post-enrollment review of those members with access to ESI to determine whether participation in RIte Share is required. The provisions governing the RIte Share program are located in Part 30-05-3 of this Title.

C. Duty to Report - All Medicaid applicants and beneficiaries have a duty to report changes in income, family size, address, and access to ESI within ten (10) days of the date the change takes effect. Failure to make timely reports may result in the denial or discontinuation of Medicaid eligibility.

D. A Medicaid applicant or member must have the opportunity to claim good cause for refusing to cooperate. Good cause may be claimed by contacting a DHS or EOHHS agency representative. To claim good cause, a person must state the basis of the claim in writing and present corroborative evidence within twenty (20) days of the claim; provide sufficient information to enable the investigation of the existence of the circumstance that is alleged as the cause for non-cooperation; or, provide sworn statements from other individuals supporting the claim.

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

F. State Requirements. The determination as to whether good cause exists must be made within thirty (30) days of the date the claim was made unless the agency needs additional time because the information required to verify the claim cannot be obtained within the time standard. The person making the claim must be notified accordingly, provided with the reason for the decision, and the right to appeal through the EOHHS Administrative Fair Hearing Process specified in Part 10-05-2 of this Title.

G. A Medicaid beneficiary may terminate Medicaid eligibility at any time. Such requests must be made in writing and submitted to a state agency or HSRI representative in-person, via U.S. Mail, fax, on-line via the beneficiary's secure account, or made by telephone to HSRI when telephonic recording capabilities exist. The Medicaid agency is responsible for providing the Medicaid beneficiary with a formal notice of the voluntary termination of Medicaid eligibility that indicates the effective date, the impact of terminating eligibility for each member of the household, and the right of the beneficiary to reapply for Medicaid health coverage at any time.

1.9 Information

A. For Further Information or to Obtain Assistance

1. Applications for affordable coverage are available online on the following websites:

   a. www.eohhs.ri.gov

   b. www.dhs.ri.gov

   c. www.HealthSourceRI.com

2. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-697-4347 and TTY 1-888-657-3173.3. For assistance finding a place to apply or for assistance completing the application, please call: 1- 855-840-HSRI (4774).

1.10 Severability

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

210-RICR-30-00-1

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 30 - MEDICAID FOR CHILDREN, FAMILIES, AND AFFORDABLE CARE ACT (ACA) ADULTS

SUBCHAPTER 00 - AFFORDABLE COVERAGE GROUPS

PART 1 - Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (210-RICR-30-00-1)

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Editorial Note: This Part was filed with the Department of State prior to the launch of the Rhode Island Code of Regulations. As a result, this digital copy is presented solely as a reference tool. To obtain a certified copy of this Part, contact the Administrative Records Office at (401) 222-2473.